

report

Tasmanian HACCC Program Client Group Analysis

FINAL REPORT

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Tasmanian HACC Program Client Group Analysis: Final Report

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ACRONYMS

<i>ABS</i>	<i>Australian Bureau of Statistics</i>
<i>AIHW</i>	<i>Australian Institute for Health and Welfare</i>
<i>ARIA+</i>	<i>Accessibility/Remoteness Index of Australia</i>
<i>ATSI</i>	<i>Aboriginal or Torres Strait Islander</i>
<i>CALD</i>	<i>Culturally and Linguistically Diverse</i>
<i>CCD</i>	<i>Census Collection Districts</i>
<i>CHSP</i>	<i>Commonwealth Home Support Programme</i>
<i>COAG</i>	<i>Council of Australian Governments</i>
<i>CSDA</i>	<i>Commonwealth/State Disability Agreement</i>
<i>CSTDA</i>	<i>Commonwealth State/Territory Disability Agreement</i>
<i>CURF</i>	<i>Confidentialised Unit Record File</i>
<i>DS</i>	<i>Disability Services</i>
<i>DS-NMDS</i>	<i>Disability Services National Minimum Data Set</i>
<i>DHHS</i>	<i>Department of Health and Human Services</i>
<i>DSP</i>	<i>Disability Support Pension</i>
<i>DVA</i>	<i>Department of Veterans' Affairs</i>
<i>EDIS</i>	<i>Emergency Department Information Systems</i>
<i>FAHCSIA</i>	<i>Department of Families, Housing, Community Services and Indigenous Affairs</i>
<i>GP</i>	<i>General Practitioner</i>
<i>HACC</i>	<i>Home and Community Care</i>
<i>HREC</i>	<i>UTAS Health and Medical Human Research Ethics Committee</i>
<i>ICD-10-AM</i>	<i>International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification</i>
<i>ISP</i>	<i>Individual Support Package</i>
<i>ISSR</i>	<i>Institute for Social Science Research</i>
<i>NDA</i>	<i>National Disability Agreement</i>
<i>NDIA</i>	<i>National Disability Insurance Agency</i>
<i>NDIS</i>	<i>National Disability Insurance Scheme</i>
<i>NHRA</i>	<i>National Health Reform Agreement</i>
<i>NMDS</i>	<i>National Minimum Data Set</i>
<i>PHaMs</i>	<i>Personal Helpers and Mentors</i>
<i>RFT</i>	<i>Request for Tender</i>
<i>SA4</i>	<i>ABS Statistical Area 4</i>
<i>SCRGSP</i>	<i>Steering Committee for the Review of Government Service Provision</i>
<i>SDAC</i>	<i>Survey of Disability, Ageing and Carers</i>
<i>SES</i>	<i>Socio-economic status</i>
<i>SLA</i>	<i>Statistical Local Areas</i>
<i>SLK</i>	<i>Statistical Linkage Key</i>
<i>THO</i>	<i>Tasmanian Health Organisations</i>
<i>TSRAC</i>	<i>Tasmanian Scientific Research Advisory Committee</i>
<i>UNCAREP</i>	<i>Unpaid Assistance to a Person with a Disability</i>
<i>UQ</i>	<i>University of Queensland</i>
<i>UTAS</i>	<i>University of Tasmania</i>
<i>WHO</i>	<i>World Health Organization</i>

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EXECUTIVE SUMMARY

The aged and community care reforms agreed to by the Council of Australian Governments (COAG) in 2011 created a need and opportunity to review the purpose, objectives and operations of the Tasmanian Home and Community Care (HACC) Program. Now, with significant further change occurring in the form of the National Disability Insurance Scheme (NDIS) and other health policy and strategy developments, this research report addresses the question:

Who is the Tasmanian HACC Program now assisting, and what are the implications of the client profile for the future of the HACC Program in Tasmania?

The findings are based on data from document analysis, stakeholder interviews, secondary data analysis (including HACC Minimum Data Set and Australian Bureau of Statistics data) and the findings of a custom survey administered to HACC clients (the HACC Client Survey).

HACC has a place in the new health services environment

As a program with deliberately wide and flexible eligibility criteria, multiple entry points and numerous service types, the Tasmanian HACC Program is susceptible to changes in its policy and services environment. Its client profile inevitably reflects the demands and requirements of related service systems and the rapid changes taking place in the related fields of disability, primary health care and mental health.

The HACC Program has provided basic community care services to those who have not established eligibility for Specialist Disability Services. It has also supplemented the assistance provided to clients of the Specialist Disability Services program.

The phased introduction of the NDIS from 2013 to 2019 is expected to increase the number of people with disabilities receiving specialised disability support and the comprehensiveness of the support they receive. This is expected to lead to some clients of the HACC Program transferring to the NDIS and reduced demand for certain HACC services from people with disabilities. However, it is too early to determine with any precision the extent of the impact of the NDIS on the HACC Program.

The HACC Program's involvement in primary health care is extensive but appears to be under-acknowledged. The program:

- provides community care pre- and post-hospitalisation
- supports people with long-term chronic illness living at home
- case manages individuals with complex health conditions and social circumstances
- assists individuals to access health services via community transport.

The vital role of primary health services in health services reform was emphasised in recent papers published by the Tasmanian Health and Human Services (DHHS) (Tasmania DHHS 2014b; 2014c; 2015b). The reform process set out in these papers provides an opportunity to position the HACC Program as part of the primary health care system.

The HACC Program's role in assisting people with mental health issues may have been under-estimated by both mental health services and the HACC Program itself. There is also an opportunity to deepen linkages with mental health services and position the HACC Program as a key element of the community support system for people with mental health issues.

HACC clients are characterised by social disadvantage

In most respects, the demographic profile of adult HACC clients is similar to that of the overall Tasmanian population aged 18-64. However, there are three vulnerability factors - older age, low socio-economic

status, and relatively limited informal support - that distinguish HACC clients from the population as a whole.

Adult HACC clients comprise 1.7 per cent of the Tasmanian population aged 18-64 and are concentrated in the older age groups - 73.5 per cent of clients are aged 45-64 years. The age distribution reflects the positive correlation between older age and activity limitations in the general population, mainly as a result of the onset of chronic illness.

HACC clients have low household income relative to the overall population, a high level of dependence on the Disability Support Pension and other government payments, and very low rates of workforce participation and employment. Approximately half have not attained Year 12 education. HACC clients are over-represented by a factor of three in public housing and are under-represented in home ownership and purchase. This disadvantaged profile reflects the positive correlation in the wider community between disability and ill-health and low socio-economic status.

HACC clients are three times more likely than all Tasmanians aged 18-64 to live alone and only one in four has a carer. Almost 40.0 per cent reported that they did not have family, friends or neighbours to help with everyday activities. These figures suggest that an absence of informal support is one factor resulting in use of HACC services for a considerable number of clients.

Women are also over-represented as users of HACC Program services. Women make up 60.0 per cent of all adult HACC clients, and the over-representation of women is unrelated to the distribution of activity limitations in the population. HACC provides basic community care services to support tasks that are typically undertaken by women in the broader population. Therefore, it is possible women are more likely to seek assistance for these tasks.

HACC clients with chronic health conditions are unlikely to qualify for the NDIS

Almost all (97.9 per cent) HACC Program clients have chronic health conditions or disabilities including (in order of frequency):

- physical disabilities
- joint, bone and muscle diseases
- mental health problems
- respiratory diseases
- neurological conditions
- digestive disorders
- diabetes
- heart disease
- cancer
- acquired brain injury
- intellectual disability
- stroke.

In the majority of cases these conditions were first experienced during adult life (which accounts for the relatively older age profile of HACC clients) and are longstanding.

In many instances, HACC clients have multiple and complex needs requiring case coordination and case management services. 52.2 per cent of HACC clients for whom we have complete data on functional status have four or more functional limitations.

Most clients expect their conditions to remain the same or deteriorate in the future. The average number of long-term health conditions reported by HACC Client Survey respondents was 3.3 conditions.

Some HACC clients (15.2 per cent) with these conditions are also clients of Specialist Disability Services. As the NDIS replaces Tasmania's Specialist Disability Services program over the next four years it is possible that more of those with long-term chronic health conditions will meet the criteria of having a

permanent disability that substantially reduces capacity, and they will transition to the NDIS for their disability support.

However, given our knowledge of the functional status of HACC clients, it seems likely that many clients with chronic health conditions may not be eligible for the NDIS. 41.7 per cent of HACC clients for whom complete data on functional limitations is available do not meet the threshold of inclusion within the ABS categories of profound and severe activity limitations, let alone the more demanding requirements of eligibility for Specialist Disability Services or the NDIS.

One key role for HACC is to provide support for persons with long-term chronic health conditions who do not meet the eligibility criteria for Specialist Disability Services, and this will likely continue to be true in a future service environment characterised by the NDIS.

The demographic profile of HACC clients is quite different to that of clients of Specialist Disability Services, although both groups have high reliance on government payments and consequentially low income. HACC Program clients are significantly more concentrated in older age groups than clients of Specialist Disability Services, reflecting the time of onset for chronic illness. In addition, they are:

- more likely to be living in private housing in the community
- more likely to be living alone
- less likely to have a carer
- somewhat less likely to be receiving the Disability Support Pension.

The data on length of time as a HACC client shows that many HACC clients are currently receiving support over lengthy periods of time. 60.1 per cent of adult HACC clients in 2013-14 had been clients for longer than six months, including 32.6 per cent of all adult HACC clients who had been clients for more than two years (no data on length of time as a client was available for 16.1 per cent of clients). Almost all clients who had been with the program for more than six months were continuing clients, i.e. they remained clients at the end of the period under review (30 June 2014).

Once a client has been with the HACC Program for 12 months, there is a high likelihood of that client continuing to receive services into the future. Some service providers believe that one reason clients remain in the HACC Program is the lack of adequate review processes and insufficient attention to achieving improved functioning. Apart from improved functioning, the factors resulting in long-term clients leaving the HACC Program include changed family circumstances; turning 65 (or 50 in the case of Indigenous clients); acceptance into the Specialist Disability Services program; moving geographically; or dying.

HACC clients are high users of services for short-term health issues

The HACC Program also plays an active role in assisting clients to manage short-term or immediate health issues. This role is not entirely separate to HACC's role in assisting people with long-term chronic illnesses as longer-term clients frequently experience adverse health events and hospitalisation and require assistance to cope with these specific short-term issues.

Our HACC Client Survey showed that 72.8 per cent of long-term clients and all short-term non-continuing clients had experienced a short-term health issue (illness/injury/surgery) since July 2013. These short-term non-continuing clients comprise 10.3 per cent of HACC clients on the MDS and 90.4 per cent leave the HACC Program after 3 months.

HACC clients are high users of formal health system services, namely hospitals, emergency departments, community nursing, hospital-based services and GP services. This reflects the extent and nature of chronic illness amongst this group. Client survey data (which is consistent with Health Central data) shows that 54.2 per cent of HACC clients had at least one hospital admission in the 18-21 months prior to the HACC Client Survey.

The HACC Client Survey findings showed that adverse health events were the main triggers for use of HACC services and that health service providers were the most common referrers to HACC services. The

HACC Program receives a higher proportion of referrals from the health service system than any other source. HACC MDS data shows that health services (including GPs, hospitals, community nurses, mental health services and palliative care facilities) were responsible for 68.9 per cent of 2013-14 HACC client referrals. This is far higher than referrals from Specialist Disability Services (12.8 per cent).

HACC provides assistance to users of health services in three (overlapping) sets of circumstances:

- adverse health events such as illness
- injury or surgery
- pre-hospitalisation and post-hospitalisation.

HACC-funded services, together with nurses and health workers, were instrumental in providing assistance to over 40 per cent of those experiencing illness, injury and surgery (41.7 per cent) and those recovering after hospitalisation (46.0 per cent). The most common forms of assistance were (in order):

- housework
- personal care
- home nursing
- transport to medical appointments
- provision of meals.

Future demographics have limited impact but some groups could be better served

Many factors impact future demand for the HACC Program including developments in related program areas such as the NDIS and the roles that the HACC Program develops within the health and human services system. With regard to demographic change, there will be more people with a disability but the proportion of people with a disability, relative to the total population, is expected to decline slightly. The number of Tasmanians with core activity limitations aged between 15 and 64 years is projected to remain steady, based on current demographic trends.

Overall demand may look less likely to change but there are some HACC client groups whose needs might be increasingly addressed through the HACC Program in the future. Mental health issues are part of the constellation of health issues and disabilities often faced by clients. There is a strong case for further consideration of the needs and circumstances of this group and for closer collaboration between Mental Health Services and the HACC Program. 20 per cent of all HACC clients are referred from mental health agencies, and 35.7 per cent of respondents to the HACC Client Survey reported a mental health problem.

21.4 per cent of HACC clients are referred from palliative care services and there appears to be some interest from service providers in the role of the HACC Program in assisting this group. However, little was revealed through the client profile about the nature of need and demand for HACC services from this area of health services and further investigation is required.

The future of HACC is in primary health care as well as disability services

The client profile data in this report shows that the central roles of the HACC Program are to provide long-term support for people with chronic health conditions and to assist people (including long-term clients) to manage short-term or immediate adverse health issues.

The client profile data also shows that clients often experience mental health issues and that a substantial number of referrals are received from palliative care providers.

Given these findings, there is a case for rebadging the Tasmanian HACC Program as a primary health care program as well as a disability program.

Based on the client profile data from 2013-14 as represented in this report, and in view of the changes taking place in disability, primary health and mental health services, the current and future roles of the program might reasonably include:

1. Providing long-term, ongoing, home-based support and assistance to people with chronic illnesses resulting in reduced functional capacity.
2. Providing short-term support and assistance to enable people experiencing adverse health events such as accidents and illnesses resulting in reduced functional capacity to manage these events at home.
3. Providing support and assistance to enable people with reduced functional capacity to manage at home in the periods prior to and after hospitalisation.
4. Providing case coordination and case management for people with complex needs who are living in their own homes and require a range of health and human services.
5. Providing a community transport service to facilitate access to health and human services for people with long and short-term functional incapacities.
6. Paying particular attention to the needs and requirements of people with mental health issues for the above range of services.
7. Paying particular attention to the needs and requirements of people receiving palliative care at home or in community settings for the above range of services.

1 RESEARCH OVERVIEW

The *Tasmanian HACC Program Client Group Analysis Report* (the Report) was funded by the Tasmanian Department of Health and Human Services (DHHS).

The University of Queensland's Institute for Social Science Research (ISSR) completed a statistical review and mapping exercise of the Tasmanian HACC Program client group and its target population and considered the interface of the HACC Program with multiple reform agendas.

RESEARCH OBJECTIVES

1. To develop a comprehensive profile of current clients of the Tasmanian HACC Program.
2. To develop estimates of potential future demand for the basic community care services provided by the Tasmanian HACC Program.
3. To estimate the impact on need and demand for HACC services of policy changes in related service areas including disability, primary health and mental health services.
4. To consider the policy and program management implications for the Tasmanian HACC Program of findings in these three areas.

1.1 RESEARCH CONTEXT

The HACC Program in Tasmania has evolved since the 1980s when it was a joint initiative of the Commonwealth and State and Territory Governments to provide assistance to frail aged people, young people with disabilities and their carers.

The reforms to aged and community care agreed by the Council of Australian Governments in 2011 created a new division of responsibility. The Commonwealth Government took responsibility for home and community care services for people aged 65 and over (or aged 50 and over for Aboriginal and Torres Strait Islanders). The States and Territories (excluding Victoria and Western Australia) maintained responsibility for providing basic community care services to those aged under 65 years.

Now the HACC Program is facing further significant change with the introduction of the National Disability Insurance Scheme (NDIS), a nationwide initiative designed to create a greatly expanded and more comprehensive service system for people with disabilities. When fully operational, the NDIS is expected to largely replace existing arrangements for funding of specialist disability services through State and Territory Governments.

1.2 RESEARCH PURPOSE

Rapid change in the areas of specialist and other disability services, primary health care and mental health raise important questions about the current and future role of the HACC Program in Tasmania. This research seeks to better understand who uses HACC Program services in Tasmania. What are their needs? What services do they use? What is likely to be the future demand given the evolving demographic and service environment?

This research was undertaken between August 2014 and April 2015 and involved:

1. A review of the policy and service environment, drawing from existing literature and interviews with stakeholders
2. Client analysis, using existing data and a survey of existing HACC Program clients (the HACC Client Survey) to develop a comprehensive client group profile

3. Estimation of future demand, based on the actual and projected incidence of persons with activity limitations in the Tasmanian population.

A detailed technical report on methodology is provided as [Appendix I](#). All research was conducted in compliance with the ethical requirements of relevant regulatory bodies and the study was undertaken with stakeholder consultation.

A report of this kind necessarily involves the use of specialised terms and concepts that are given a particular meaning and used in particular ways. In the Australian service context, *disability* is defined in various ways. For clarity, we make limited use of this term in profiling HACC Program clients; rather, we use more explicit concepts such as *long term or chronic health condition, impairments and restrictions, functional or activity limitations, and core activity limitations*. A detailed definition of the key terms use in this report is included in the Concepts and Definitions at the end of this report.

The purpose of the report is to inform DHHS future policy and service development, ensuring that basic community care remains a safety net for the Tasmanian community and that it is appropriately targeted in the contemporary service context.

In the body of this report, we cover:

- the policy and service environment in which the Tasmanian HACC Program operates ([HACC Program overview](#) and [Service and policy environment](#))
- the Tasmanian HACC Program client profile ([Statistical overview of HACC clients](#), [Client sub-group analysis](#) and [Comprehensive HACC client profile](#))
- evidence of future need and demand for HACC Program services ([Current and projected client needs](#))
- the implications for the HACC Program in Tasmania, moving forward ([Conclusions](#)).

2 HACC PROGRAM OVERVIEW

FACTS UP FRONT

- In 2014-15, \$20.3 million was distributed to HACC service providers for delivery of basic community care services.
- A total of 64 HACC MDS reporting outlets provided HACC services to 5,178 clients aged 18-64 years in the year 2013-14 (according to the HACC Minimum Data Set).
- Tasmanian Health Organisations (THOs) represent 24.6 per cent of all HACC MDS reporting outlets and deliver services to one-third (33.3 per cent) of all clients.
- There are 13 HACC MDS reporting outlets with more than 200 clients, and 29 HACC MDS reporting outlets serving 20 clients or less.
- Community organisations predominate as the providers of all major service types except nursing care and allied health care, where THOs and DHHS units are the majority providers.

2.1 BACKGROUND TO THE HACC PROGRAM

The Home and Community Care (HACC) Program began in the mid-1980s as a joint initiative of the Commonwealth and State and Territory Governments to provide assistance to frail aged people, younger people with disabilities, and their carers. Its aim was to enable these groups to live independently in their own homes and to prevent or delay admission to residential care. Both levels of government contributed to the cost of the program. Broad strategic directions were set nationally and the States and Territories were responsible for program management and service delivery primarily through non-government and local government organisations.

These longstanding arrangements were ended by the aged and community care reforms agreed by the Council of Australian Governments (COAG) in 2011. These reforms created a new division of responsibility for home and community care services in Australia based on the age of those receiving assistance under the program. The Commonwealth Government was given full funding and management responsibility for people aged 65 and over (50 and over for people identifying as Aboriginals or Torres Strait Islanders). This complemented the Commonwealth's responsibilities for residential aged care. The States and Territories (except Western Australia and Victoria which did not sign up to the new arrangements at that time) maintained responsibility for the provision of basic community care services for the younger age group, (i.e. those aged under 65 years, or under 50 for people identifying as Aboriginal or Torres Strait Islanders). These arrangements came into effect under transitional arrangements during 2011 and 2012.

This division of responsibilities for funding, policy and management left each level of government with the opportunity to develop new directions for community care policy for their respective client groups. At the Australian Government level the Commonwealth HACC Program will be incorporated into the Commonwealth Home Support Programme (CHSP) which is due to commence in July 2015. As well as the change of name, the new program involves a strong commitment to the principles of wellness, reablement and restorative care approaches in working with older people and their carers (Australian Government, Department of Social Services 2014).

At the state level, NSW replaced the HACC Program for younger people with a new Community Care Supports Program with revised goals (NSW, Department of Family and Community Services, 2012). In South Australia there was no change of program name, but there was a strong emphasis on the role of the HACC Program as part of '*a continuum of [specialist] disability services, supports and programs for people living with a disability, which includes both [specialist] disability services and basic community care services*' (South Australia, Department for Communities and Social Inclusion 2014). Tasmania has also

been faced with the need to articulate the goals and purposes of its original HACC Program for a younger age-group.

2.2 THE TASMANIAN HACC PROGRAM

In Tasmania, the new program began by deliberately emphasising continuity with the pre-existing HACC Program (Tasmania DHHS 2012; n.d.a). The HACC Program Manual for the transition year 2012-13 emphasised that initially changes would be minimal, *'while further policy work is being undertaken'* (Tasmania DHHS 2012: 6).

The objectives of the Tasmanian HACC Program as set out in the 2012 Program Manual (Tasmania DHHS 2012) were:

1. To provide a comprehensive, coordinated and integrated range of basic maintenance, support and care services for younger persons with a disability and their carers.
2. To support these people to be more independent at home and in the community thereby enhancing their quality of life and/or preventing or delaying their admission to long-term residential care.
3. To provide flexible, timely services that respond to the needs of clients.

These goals were left largely unchanged from the earlier iteration of the program, other than to state the new focus on people aged under 65 years (or under 50 if Indigenous). However, the Program Manual set out clear policy parameters to guide the new program during its first full year of operation, including clarification of the target group, service delivery principles, the repertoire of service types, and links with other services.

The targeted client group for the Tasmanian HACC Program is described as:

'younger persons with a disability and their carers who live in the community and whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long-term residential care' (Tasmania DHHS 2012: 5).

Disability is defined in terms of functional limitations, hence the target group comprises of those *'with functional limitations as a result of moderate, severe and profound disabilities'*.

To be eligible for the program, a person must *'have difficulty performing everyday tasks without help due to functional limitations'* (Tasmania DHHS 2012: 9). Assessment of these limitations is viewed as integral to determining eligibility and priority for the program. Within this framework, particular attention is paid to ensuring that special needs groups can access the program, including people from culturally and linguistically diverse (CALD) backgrounds, Aboriginal and Torres Strait Islander people, people with dementia, financially disadvantaged people, and people living in remote or isolated areas.

Three service providers, the Accesspoint and one DHHS manager made mention of the diversity of the under 65 group and the difficulty in pinning down exactly who these people are and what they need. One service provider stated that this diversity makes it hard to predict need and respond accordingly, and that this client group often has more complex needs which are more costly to manage.

The Tasmanian HACC Program Manual also sets out a number of principles to underpin service delivery. Particular mention is made of the *'wellness approach'* and the need to move away from service models that continue or increase dependency on services. The Program Manual gives support to the wellness service model:

'based on the principle that people want to retain their autonomy and build their capacity, which in turn has a positive impact on their self-esteem and ability to manage day-to-day life' (Tasmania DHHS 2012: 8).

The service types comprising the basic community care provided by the HACC Program are largely unchanged from the previous national HACC Program. A total of 19 service types are listed in the Program

Manual. It is emphasised that these comprise of basic maintenance, support and care, and that the services focus on:

'supporting different areas of need that an individual may have due to a limitation in their ability to undertake tasks of daily living' (Tasmania DHHS 2012: 14).

Services are grouped into seven service areas on the basis of similarity or complementarity in their mode of delivery and policy intent, and in their units of output and costs per unit. Clients can receive one service only or a combination of services depending on their assessed need:

- *Service Group One* includes domestic assistance, personal care, social support, respite care, assistance with food preparation ('other meal services') and home maintenance. These services have in common their role in providing assistance in everyday household management, including self-care and social engagement.
- *Service Group Two* includes indirect services focused on assessment of need and planning and coordinating services to clients. The specific service types are assessment, client care coordination, case management for clients with complex needs, and counselling, support, information and advocacy for clients and carers.
- *Service Group Three* comprises the two forms of direct health service provision included in the HACC service repertoire: nursing care by a registered or enrolled nurse, and allied health care including podiatry, occupational therapy, physiotherapy, social work, speech pathology and dietary advice.
- The remaining Service Groups include centre-based day care (*Service Group Four*); home modification, provision of goods and equipment, and formal linen services (*Service Group Five*); meals (*Service Group Six*); and transport (*Service Group Seven*).

The Tasmanian HACC Program is managed by Service Planning and Design in the Department of Health and Human Services (DHHS). It is delivered on a state-wide basis with regional forums bringing together service providers in the three HACC regions which correspond to the boundaries of the Tasmanian Health Organisations (THOs).

2.3 HACC SERVICE PROVIDERS

The HACC MDS lists a total of 65 reporting outlets that provided HACC services to 5,178 HACC clients aged 18-64 in 2013-14. Two of these MDS reporting outlets no longer provide services, but have been retained for the purpose of the analyses during the study period.

2.3.1 Client distribution

Our research found that the largest group of MDS reporting outlets were community organisations. A total of 49 community organisations were involved in providing HACC services in 2013-14, although 44.9 per cent of these had only a small number of clients (between 1 and 20). The second group of providers were the three THOs and one DHHS business unit (the Disability and Community Services Individual Funding Unit).

In 2014-15, \$20.3 million was distributed to HACC service providers for delivery of basic community care services.¹ 22.9 per cent of HACC clients access services from more than one HACC MDS reporting outlet. Only 6.7 per cent of HACC clients access more than two reporting outlets, however one client accessed a total of seven reporting outlets.

While there were 65 MDS reporting outlets providing HACC services in 2013-14, the number of major service providers was much smaller as shown in Table 1.

¹ Information provided by Community Care Reform, DHHS.

Table 1 Number and proportion of HACC MDS reporting outlets - by number of clients and organisation type, 2013-14

No. of clients	Community organisations		THOs		DHHS business unit		All HACC MDS reporting outlets	
	No.	%	No.	%	No.	%	No.	%
1-20	22	44.9	5	33.3	1	100.0	28	43.1
21-50	9	18.4	3	20.0	0	0.0	12	18.5
51-100	4	8.2	2	13.3	0	0.0	6	9.2
101-200	6	12.2	0	0.0	0	0.0	6	9.2
201-400	5	10.2	4	26.7	0	0.0	9	13.8
401+	3	6.1	1	6.7	0	0.0	4	6.2
<i>Total</i>	49	100.0	15	100.0	1	100.0	65	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Note: Some clients use services from more than one organisation.

A total of 40 reporting outlets had 50 clients or fewer, leaving only 25 outlets with more than 50 clients in total. This is due to the split of HACC services. At this time a policy decision was made to maintain all service providers to ensure there was continued service delivery across geographic regions and special need groups until a full investigation of the needs of the target population had been undertaken. It is also important to note that service providers are able to provide services under a number of different funded programs and the number of HACC clients may not accurately reflect the size of the provider.

There were 13 major MDS reporting outlets with more than 200 clients. These included the THOs in each of the three regions and the state-wide THO business units of Continence and Podiatry. The largest community organisations - with more than 200 clients each - who report on the HACC MDS were:

- Community Based Support South
- Community Transport Services Tasmania
- Family Based Care North West
- The District Nurses
- Australian Red Cross
- Family Based Care North
- Care Assess
- Anglicare.

2.3.2 Service delivery

The larger MDS reporting outlets are a mix of specialised and generalised service providers. Of the 25 MDS reporting outlets with 50 or more clients, 7 provided 3 service types or less. These specialist providers included three specialist THO services (podiatry, and physiotherapy services in the South and North West) and community organisations with a specific focus such as Community Transport Services Tasmania, Meals on Wheels, Fusion Australia, and GC Services. Often the specialist providers were focused on one direct service type (such as transport, meals, home modifications and maintenance, or centre-based care) combined with indirect services such as assessment, client care coordination and case management.

Other larger MDS reporting outlets provide a wide range of HACC service types and could be described as generalist community care providers. Eight community organisations located in various parts of the state had a similar broadly-based community care profile. The THOs also provide diverse community care services; their services were spread amongst 15 (North, n=436), 12 (North-West, n=508) and 13 (South, n=774) service types. THO South was the HACC MDS reporting outlet with the highest number of clients (774), and it provides domestic assistance, social support, nursing care, allied health, personal care,

centre-based care, respite care, home maintenance, transport, meals as well as assessment, case management and coordination.

Table 2 and Table 3 provide overall data on the number of HACC MDS reporting outlets involved in the delivery of the 17 HACC service types.

Table 2 shows the total number of HACC MDS reporting outlets for each service type. The overall pattern shown in this table is one of multiple reporting outlets across most service types. More than half of all reporting outlets are involved in three of the largest service types (social support, assessment, and transport) and more than one-quarter are involved in seven other service types (domestic assistance, personal care, centre-based care, client care coordination, home maintenance, counselling, and meals). Community organisations are the main providers of all major service types, except nursing care and allied health care where THOs are the majority providers.

The picture presented in Table 2 of multiple reporting outlets of many of the HACC service types is, however, somewhat misleading. While there are many reporting outlets for some service types, many of these reporting outlets have only a small number of clients. Table 3 balances the overall picture by showing the number of HACC MDS reporting outlets with more than 50 clients for each individual service type.

The number of HACC MDS reporting outlets with a significant role in providing a particular service (defined as more than 50 clients) is considerably less than the number with some role in provision. The largest number of significant reporting outlets was in the area of assessment where 16 organisations had more than 50 clients. Domestic assistance had 10 significant reporting outlets, client care coordination and transport had 7 each, and allied health 6. For all other service types, there were five or fewer significant reporting outlets across the state. Five of the six large providers of allied health care was from a THO. In all other areas (except home maintenance) community organisations predominated amongst the large reporting outlets.

The dominant role of the largest reporting outlets of HACC services can be demonstrated by calculating the proportion of all clients served by the 13 organisations with 200 or more clients. These 13 organisations (20.0 per cent of the 65 HACC MDS service outlets) provided services to 72.6 per cent of all clients. The 13 organisations included 3 THOs, 2 state-wide THOs (Podiatry and Continence) and 8 community organisations. The largest community organisations are:

- Community Transport Services Tasmania
- Australian Red Cross
- The District Nurses
- Community Based Support South
- Care Assess
- Family Based Care North
- Family Based Care North West
- Anglicare.

The THOs represent 16 of the 65 HACC MDS reporting outlets (24.6 per cent) and provide community services to 33.3 per cent of the clients (2,235 of the 6,720 clients² recorded across the reporting outlets).

Table 4 and Table 5 show the distribution of HACC service provision across locations (capital city, rural, remote, and interstate). As shown in Table 4, there are only a small number of reporting outlets who provide 6 of the 17 service types to clients in remote locations. The number of organisations serving the rural locations exceeds those servicing the capital city.

In summary, the HACC Program is delivered predominantly through a large number of community organisations (49 organisations servicing 66.7 per cent of the clients). Most of the 65 HACC service

² Total number of clients is 6,720 (some individuals are clients of more than one organisation). The top thirteen organisations by number of clients had a total of 4,879 clients, i.e. 72.6 per cent of all HACC clients in 2013-14.

providers have a relatively small number of clients, with only 13 organisations (including the THOs) having more than 200 HACC clients.

While most service types have a large number of providers, the number of significant providers (defined as more than 50 clients) of each service type is much smaller. In fact, provision of services is highly concentrated with the largest 13 organisations (20%) serving 72.6 per cent of all clients (4,879 of 6,720). The THOs comprise 16 of the 65 HACC MDS reporting outlets (24%) and provide community services to 33.3 per cent of the clients (2,235 clients).

While there are 12 organisations in total that offer case management services, the need for more case management was mentioned by one DHHS manager, four service providers and one service manager. This was often in relation to managing clients with multiple comorbidities or complex needs, who had been allocated HACC funded services.

Table 2 Number of HACC MDS reporting outlets with one or more client - by HACC service type and type of service provider

Service type	Community organisations (49)		THOs (15)		DHHS business units (1)		All HACC MDS reporting outlets (65)	
	No.	%	No.	%	No.	%	No.	%
<i>Domestic assistance</i>	17	77.3	4	18.2	1	4.5	22	100.0
<i>Social support</i>	30	85.7	5	14.3	0	0.0	35	100.0
<i>Nursing care</i>	4	57.1	3	42.9	0	0.0	7	100.0
<i>Allied health care</i>	4	30.8	9	69.2	0	0.0	13	100.0
<i>Personal care</i>	13	68.4	5	26.3	1	5.3	19	100.0
<i>Centre-based care</i>	25	80.6	6	19.4	0	0.0	31	100.0
<i>Other food services</i>	0	0.0	1	100.0	0	0.0	1	100.0
<i>Respite care</i>	10	90.9	1	9.1	0	0.0	11	100.0
<i>Assessment</i>	30	76.9	8	20.5	1	2.6	39	100.0
<i>Case management</i>	8	66.7	4	33.3	0	0.0	12	100.0
<i>Client care coordination</i>	17	80.9	3	14.3	1	4.8	21	100.0
<i>Home maintenance</i>	16	84.2	3	15.8	0	0.0	19	100.0
<i>Counselling</i>	13	81.3	3	18.7	0	0.0	16	100.0
<i>Home modification</i>	2	100.0	0	0.0	0	0.0	2	100.0
<i>Meals</i>	25	86.2	4	13.8	0	0.0	29	100.0
<i>Linen service</i>	1	33.3	2	66.7	0	0.0	3	100.0
<i>Transport</i>	33	84.6	6	15.4	0	0.0	39	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Note: Some clients use services from more than one organisation.

Table 3 Number of HACC MDS reporting outlets with over 50 clients in the corresponding service type

Service type	Community organisations (18)		THOs (15)		All HACC MDS reporting outlets (65)	
	No.	%	No.	%	No.	%
<i>Domestic assistance</i>	7	70.0	3	30.0	10	100.0
<i>Social support</i>	4	100.0	0	0.0	4	100.0
<i>Nursing care</i>	2	40.0	3	60.0	5	100.0
<i>Allied health care</i>	1	16.7	5	83.3	6	100.0
<i>Personal care</i>	5	100.0	0	0.0	5	100.0
<i>Centre-based care</i>	1	100.0	0	0.0	1	100.0
<i>Other food services</i>	0	0.0	0	0.0	0	0.0
<i>Respite care</i>	1	100.0	0	0.0	1	100.0
<i>Assessment</i>	12	75.0	4	25.0	16	100.0
<i>Case management</i>	3	60.0	2	40.0	5	100.0
<i>Client care coordination</i>	6	85.7	1	14.3	7	100.0
<i>Home maintenance</i>	2	50.0	2	50.0	4	100.0
<i>Counselling</i>	2	100.0	0	0.0	2	100.0
<i>Home modification</i>	0	0.0	0	0.0	0	0.0
<i>Meals</i>	3	100.0	0	0.0	3	100.0
<i>Linen service</i>	0	0.0	0	0.0	0	0.0
<i>Transport</i>	7	100.0	0	0.0	7	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Note: Some clients use services from more than one organisation.

Table 4 Number of HACC community organisation service providers with one or more client - by HACC service type and location

Service type	Inner regional		Outer regional		Remote & very remote		All locations	
	No.	%	No.	%	No.	No.	%	No.
<i>Domestic assistance</i>	18	42.9	18	42.9	6	14.2	42	100.0
<i>Social support</i>	28	51.9	21	38.9	5	9.2	54	100.0
<i>Nursing care</i>	7	43.8	6	37.5	3	18.7	16	100.0
<i>Allied health care</i>	12	48.0	10	40.0	3	12.0	25	100.0
<i>Personal care</i>	16	42.1	17	44.7	5	13.2	38	100.0
<i>Centre-based care</i>	23	51.1	19	42.2	3	6.7	45	100.0
<i>Respite care</i>	0	0.0	1	100.0	0	0.0	1	100.0
<i>Assessment</i>	9	50.0	8	44.4	1	5.6	18	100.0
<i>Case management</i>	34	44.1	29	37.7	14	18.2	77	100.0
<i>Client care coordination</i>	9	39.1	11	47.8	3	13.1	23	100.0
<i>Home maintenance</i>	16	41.0	16	41.0	7	18.0	39	100.0
<i>Counselling</i>	16	47.0	14	41.2	4	11.8	34	100.0
<i>Home modification</i>	12	52.2	10	43.5	1	4.3	23	100.0
<i>Meals</i>	1	25.0	2	50.0	1	25.0	4	100.0
<i>Linen service</i>	22	52.4	15	35.7	5	11.9	42	100.0
<i>Transport</i>	2	50.0	2	50.0	0	0.0	4	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Note: Some clients use services from more than one organization and some reporting outlets service more than one location type.

Table 5 Number of THOs with one or more clients - by HACC service type and region

Service type	Inner regional		Outer regional		Remote & very remote		All locations	
	No.	%	No.	%	No.	No.	%	No.
<i>Domestic assistance</i>	3	33.3	5	55.6	1	11.1	9	100.0
<i>Social support</i>	1	16.7	3	50.0	2	33.3	6	100.0
<i>Nursing care</i>	3	33.3	3	33.3	3	33.3	9	100.0
<i>Allied health care</i>	8	40.0	9	45.0	3	15.0	20	100.0
<i>Personal care</i>	5	41.7	5	41.7	2	16.6	12	100.0
<i>Centre-based care</i>	3	37.5	4	50.0	1	12.5	8	100.0
<i>Other food services</i>	0	0.0	1	100.0	0	0.0	1	100.0
<i>Respite care</i>	0	0.0	1	100.0	0	0.0	1	100.0
<i>Assessment</i>	7	36.8	8	42.1	4	21.1	19	100.0
<i>Case management</i>	3	42.9	4	57.1	0	0.0	7	100.0
<i>Client care coordination</i>	2	33.3	3	50.0	1	16.7	6	100.0
<i>Home maintenance</i>	3	33.3	3	33.3	3	33.3	9	100.0
<i>Counselling</i>	1	25.0	3	75.0	0	0.0	4	100.0
<i>Meals</i>	1	25.0	2	50.0	1	25.0	4	100.0
<i>Linen service</i>	1	33.3	2	66.7	0	0.0	3	100.0
<i>Transport</i>	3	33.3	5	55.6	1	11.1	9	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Note: Some clients use services from more than one organization and some reporting outlets service more than one location type.

2.4 ACCESS TO HACC AND THE ROLE OF ACCESSPOINT

The issue of how individuals access HACC services, including the assessment process, is centrally important to the question of targeting services to particular population groups.

Individuals are able to access services directly by contacting the service provider or by the 'preferred pathway' (Tasmania DHHS n.d.a: 6) of using a centralised access point for the HACC Program. This is referred to as the Accesspoint.

The Accesspoint was established as a demonstration project in 2009 as part of an initiative covering the Southern region and was subsequently rolled out across the state. The rationale for the establishment of the Accesspoint was that a centralised, single point of access providing screening, referrals and information would avoid duplication and streamline client access to services.

The Accesspoint provides services to clients of all ages, not only the under 65s and receives referrals from hospitals, community organisations, clients, carers, general practitioners and other primary health services, and makes referrals to HACC service providers. According to the interview with Accesspoint, 80-85 per cent of these referrals come from health professionals although contact from the community is beginning to increase.

The Accesspoint has come to play a key role in the access and assessment processes for the Tasmanian HACC Program. Part of the function of the Accesspoint is to test prospective clients for eligibility and to undertake client screening for needs identification. This means that clients who approach the Accesspoint directly for services receive a functional screening to determine eligibility. Where a client is referred to the Accesspoint from another organisation or professional, they do not routinely receive a functional screening unless there is no clinical history available. This practice is motivated in part by the aim of not overburdening the client with additional and possibly unnecessary questions.

The Accesspoint model has considerably streamlined access to HACC services for those aged under 65 and has increased the capacity for the program to control access, eligibility and prioritisation processes. An issue identified by both the Accesspoint and one of the service providers was the post-acute referral process – if a client is discharged late in the afternoon or on a Friday, mobilising services is more difficult. It is intended that all clients entering the HACC Program are assessed to determine their eligibility, need and appropriate service type (Tasmania DHHS 2012: 11). However, it remains the case that determining access to HACC services for a considerable number of clients remains with individual service providers. While this may mean that an unstandardized approach to determining eligibility may continue to occur, there are also benefits to service providers conducting the assessment as indicated by a number of providers in the interviews, such as providing immediate support and identification of support needs that may not be evident through a non-contact assessment over the phone. For example, while providing domestic assistance, a cleaner may notice a client has incontinence or that the pillowcase was encrusted with blood and pus and could then alert the service provider. For example, service providers noted that not getting a full history on the referral can be problematic in terms of occupational health and safety. For instance, a potential client is unlikely to tell you they have a vicious dog, or that they only have an outside shower with cold water. Generally speaking, service providers were of the opinion that people don't disclose their true circumstances over the phone as they are often afraid they will lose their independence that the family may sell their home, or the rental agent may become aware they are unable to look after the house anymore. Overall, service providers have seen the benefit of the Accesspoint, but they believe they should retain the right to continue assessments for clients under 65.

3 SERVICE AND POLICY ENVIRONMENT

SUMMARY OF KEY POINTS (Material in the following chapter is mainly drawn from interviews with Tasmanian HACC program managers and service providers)

Prevalence of disability

- The proportion of the Australian population with a disability has decreased slightly from 2003 to 2012. The rate of profound or severe core activity limitation for the population as a whole has remained constant at around 6 per cent.
- Overall rates of disability and profound and severe activity limitations are higher in Tasmania than in Australia as a whole.
- 18.4 per cent of the Tasmanian population under 65 years have a disability, compared with 13.6 per cent of all Australians.
- 4.9 per cent of Tasmanians aged under 65 years have profound or severe core activity limitations, compared with 3.9 per cent of all Australians.

Relationship of the HACC Program to current Specialist Disability Services

- 15.2 per cent of HACC clients are also clients of the Specialist Disability Services program and there are overlaps in the repertoire of services provided by the two programs.
- The primary differences between Specialist Disability Services and the HACC Program are:
 - scope of service provision (narrow vs. wide)
 - intensity of service support (extensive vs. basic)
 - client demography (younger vs. older clients).
- The HACC Program also functions as a first support service for prospective clients seeking Specialist Disability Services. Disability Gateway Services suggested that in the absence of the HACC Program, there would be more people on the Specialist Disability Services Needs Register.

The introduction of the NDIS

- The Tasmanian Government has been an active participant in the roll out of the NDIS during 2013-15, participating in a pilot targeting young people aged 15-24 years. By December 2014, 853 of the estimated 1,000 15-24 year olds eligible for the NDIS had joined the scheme.
- HACC Program service providers generally viewed the NDIS as increasing funding into the disability sector, speeding up the process of assessing clients' needs and delivering services, and increasing accountability to clients.
- The Productivity Commission recognises '*There are no available data to test whether all current HACC users would be covered by the scheme. Indeed, very little is known about the current characteristics of HACC users, including about the nature and severity of their disabilities.*' (Productivity Commission 2011b: 196). This Report goes some way to fill this gap.

Broader healthcare reforms impacting HACC

- HACC services are located at the intersection of specialist disability services and health services, providing services to some individuals whose needs are primarily met through specialist disability services and to others whose needs are primarily met through the health services.
- The HACC Program assists the primary health care system through the management of chronic illness and by reducing pressure on hospital services. It is therefore surprising that HACC-funded home-based support services in the primary health care system have received little mention in

strategy and policy documents seeking to advance health services reform in Tasmania.

- Service providers consider the primary role of the HACC Program in the broader healthcare system to be:
 - aiding recovery after discharge from hospital
 - long-term care for chronic illness, often to people living in disadvantaged circumstances not qualifying for the NDIS
 - improving access to healthcare through transportation
 - providing case management
 - providing healthcare services such as community nursing and allied health.
- The service gaps within the HACC Program, according to service providers, are:
 - services aimed at re-enablement
 - hospital avoidance programs
 - social support for mental health clients

In this chapter we review the policy and service environment for the Tasmanian HACC Program, reflecting on its evolution over time and the implications of recent changes in the health and community services sector. We draw on the results of a literature review, interviews with stakeholders of the Tasmanian HACC Program, and program information contained in the HACC Minimum Data Set (MDS) to position the Tasmanian HACC Program in the current operating context, and we pose a series of key questions about its future amid rapid change.

We begin with an examination of the field of disability policy and services more broadly. Until recently, this primarily meant the specialist disability services provided to Tasmanians through the Department of Health and Human Services (DHHS) in association with non-government Specialist Disability Services organisations, under the National Disability Agreement (NDA).

However, the provision of specialist disability services is currently in a state of flux both nationally and in Tasmania as a result of the commencement of the NDIS in 2013. When fully operational, the NDIS will replace existing arrangements for funding and management of specialist disability services. Instead, a nationwide scheme run by the National Disability Insurance Agency (NDIA) will provide choice and control over service options for people with disabilities. The history of, and decisions underlying, the NDIS will be described and the implications for the HACC Program considered in this chapter.

This chapter also focuses on the critically important changes taking place in health care policy in Tasmania. These are equally as significant for the future of the HACC Program as the introduction of the NDIS, and this is supported by the findings of our research.

The importance of strengthening the community care system for patients was one of the central themes of a Green Paper released in late-2014 by the Tasmanian Government as part of a health care reform process designed to improve the efficiency and effectiveness of Tasmanian health services (Tasmania DHHS 2014a; Tasmania DHHS 2014b). The potentially significant role of the HACC Program in a reformed health care system is considered in this chapter. We also look at the policy and services context for mental health specifically, noting that this is a part of the health care system that has placed strong emphasis on community support and care in recent years.

We conclude by identifying specific issues about the Tasmanian HACC Program and its relationship with other services, and we explore these issues in our subsequent client group analysis in order to draw conclusions about the potential future of the Tasmanian HACC Program.

For further information on the research method for our review of the policy and service environment, please refer to our technical report at [Appendix I](#).

3.1 SERVICE LINKAGES

The Program Manual setting out the parameters of the Tasmanian HACC Program in 2012 paid considerable attention to the links between the HACC Program and other services and the Program's place in the overall service network. It was emphasised that the Program was part of the broader system of community and health services and that assistance '*should be delivered as an integrated combination of services that responds to the assessed needs of the individual*' (Tasmania DHHS 2012: 12).

The Program Manual also acknowledged the overlap of HACC with other services and the issue of drawing boundaries for the HACC Program. Consistent with the previous joint State/Commonwealth funded program, it was stated that HACC services should not be provided to those already receiving other government subsidised services that are similar to HACC service types, in order to reduce overlap. The example given was Individual Support Packages provided through the state Specialist Disability Services Program, and it was stated that, '*HACC services are designed to provide basic levels of support. There are other programs available for people with more complex needs*' (Tasmania DHHS n.d.a: 6). Elsewhere it was remarked that '*It is not the intention of HACC services to "top up" or permanently substitute for other forms of packaged care and support*' (Tasmania DHHS 2012: 7).

To address the issue of boundaries, a list was also provided of services that fell outside the scope of the Tasmanian HACC Program. This included:

- services for people aged 65 and older
- accommodation services
- health aids and appliances available through other programs
- rehabilitation services
- disability-specific service responses
- family crisis services
- specialist palliative care services
- direct treatment for acute illness including post-acute care services.

To provide clearer guidance around the scope of the HACC Program, it provides basic maintenance, support and care services for eligible clients requiring post-acute care, but health services are responsible for providing the specialist component of post-acute care.

The issue of the links between HACC and other services and the place of the program in the broader system of community and health services is a central management and policy concern and was instrumental in the commissioning of this report. Specifically, the main sets of relationships with other service systems that the HACC Program needs to manage must be considered. Based on discussions with the program managers and staff of the HACC Program in Tasmania, and other data cited below, there appear to be three key sets of relationships. These are represented in Figure 1. In this figure, health services comprise short-term health conditions as well as palliative care.

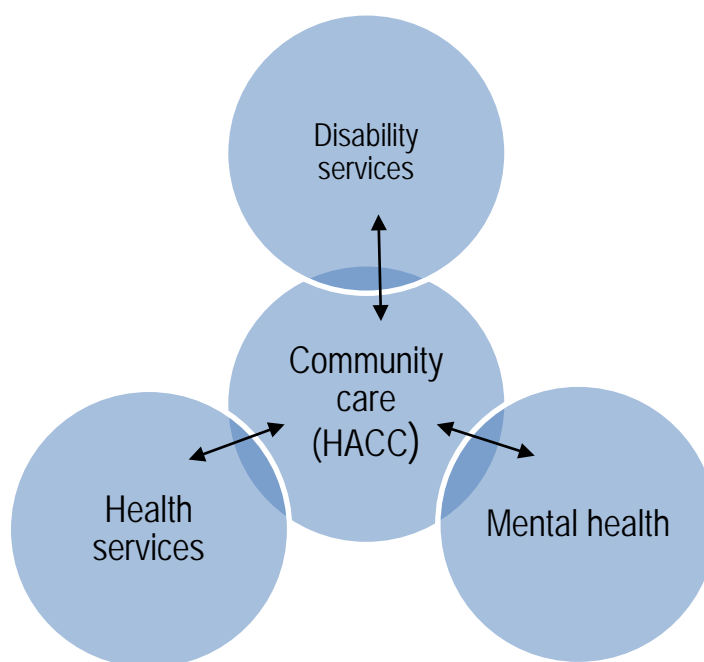


Figure 1 Key relationships between HACC and other service areas

The HACC Program for persons aged under 65 years supports specialist disability services, health services and mental health services, although this latter relationship is less explicitly acknowledged.

The aims of community care services need to be defined in large part in terms of their roles in these wider service systems. A dominant theme throughout the interviews with DHHS managers, service providers, service managers, disability services gateway staff and the Accesspoint was the flexibility of the HACC program, which has utility in meeting client needs within the current framework. The lack of cohesion between different service types, funding bodies and between and within systems was also a common theme among those interviewed,

Potentially problematic aspects of the boundaries between the HACC Program and these service systems were referred to in the Program Manual, but the issues involve more than boundary demarcation. Data presented in this report show that specialist disability services, health services and mental health services are the major referrers to the HACC Program. However, understanding the relationships charted in Figure 1 requires a more detailed account of recent developments in each of the three cognate service areas. This is provided in the remaining sections of this chapter, and subsequent chapters provide data from a number of sources to show the extent to which clients associated with each of these service systems are currently clients of the Tasmanian HACC Program.

3.2 TASMANIAN SPECIALIST DISABILITY SERVICES

The linkages between the HACC Program and the specialist disability services sector is one of the key factors impacting on future demand for the HACC Program and on the profile of current and future HACC clients. In this section the current and likely future characteristics of Specialist Disability Services in Tasmania are described and impacts on the HACC Program considered.

Specialist Disability Services and the HACC Program have a number of points of intersection. The stated target group of both programs is people with a disability requiring assistance to address functional limitations. 15.2 per cent of HACC clients are also clients of the Specialist Disability Services program and there are overlaps in the repertoire of services provided by the two programs. The expansion of specialist

disability services envisaged under the NDIS may result in a proportion of HACC clients becoming clients of the NDIS rather than HACC, however many HACC clients will still not be eligible and the balance of this needs to be understood.

3.2.1 The prevalence of disability

The two main sources of information on the prevalence of disability are the *Survey of Disability, Ageing and Carers* (SDAC) and the Census; of these two sources, the SDAC is widely seen as the more authoritative (Productivity Commission 2011: 97).

The term disability is used in SDAC as an umbrella term to refer to impairments, activity limitations and participation restrictions which have lasted, or are likely to last, for at least six months. Within the population with a disability are a smaller group who need help, have difficulty with core activities, or use aids or equipment to undertake core activities (self-care, mobility and communication). Those who always or sometimes need assistance with core activities are referred to as having profound or severe core activity limitation, and government funded specialist disability services are broadly targeted to people who belong to this group and who are aged under 65 (Australian Government FAHCSIA 2011: 6).

The last three SDAC surveys were conducted in 2003, 2009 and 2012. The estimated number of people in Australia with a disability increased from 3.96 million in 2003 to 4.23 million in 2012 (ABS 2013: Table 1), continuing a trend evident for several decades. Causes of this long-term increase include:

- population growth
- the structural ageing of the population
- increases in life expectancy accompanied by an increase in expected years of life lived with a disability
- increase in some disabling conditions associated with childhood (Australian Government FAHCSIA 2011: 6-8).

While there are now more people with disabilities than in 2003, taking into account the overall population growth, the proportion of the population with a disability has actually decreased. The proportion of the population with a disability has declined from 20.0 per cent in 2003 to 18.5 per cent in 2012. Taking into account the effects of the changing age structure (using age standardised proportions), the decline was from 19.8 to 17.4 per cent (ABS 2013a: Table 1). Tasmania has the highest proportion of reported disability in the population aged under 65 years (ABS 2013a: Table 5.2)

Of more direct relevance to the provision of specialist disability services are the changes in the estimated prevalence of persons with a profound or severe core activity limitation. Over the period 2003 to 2012 the rate of profound or severe core activity limitation for the national population as a whole was virtually constant at 6.3 per cent in 2003 and 6.1 per cent in 2009 (adjusted for the changing age structure the rates were 6.2 and 5.8 per cent) (ABS 2013a: Table 2). For the under-65s, the estimated number of persons with a profound or severe core activity limitation increased from 683,100 to 729,800, a rise of 6.8 per cent. The proportion of the population with a profound or severe activity limitation in each age group fell or remained the same between 2003 and 2012.

Table 6 shows the number and proportion of the under-65 population in Tasmania and Australia with a disability *and* with a profound or severe activity limitation, as estimated by the 2012 SDAC. The table shows that overall rates of disability and profound and severe activity limitations are higher in Tasmania than in Australia as a whole. This holds true for all age groups for disability and for all but two age groups for profound and severe activity limitations.

Table 6 also shows that rates of disability and profound and severe activity limitations rise with age in both Australia and Tasmania in the 0-64 age range, and that rates generally go up more sharply in the older age groups. The number of persons aged under 65 in Tasmania with a profound or severe activity limitation - estimated by the ABS as 20,200 - is a significant figure as government funded specialist disability services are targeted for this group (Australian Government FAHCSIA 2011: 6).

Table 6 Estimates of the number and proportion of persons aged 0-64 with a disability and with a profound or severe activity limitation - in Australia and Tasmania, 2012

Age groups	Disability				Profound and severe activity limitations			
	Australia		Tasmania		Australia		Tasmania	
	No. ('000)	%	No. ('000)	%	No. ('000)	%	No. ('000)	%
0-4	53.3	3.6	2.0	6.6	36.4	2.5	1.3	4.0
5-14	244.4	8.8	7.9	12.3	134.8	4.8	2.7	4.3
15-24	245.3	7.8	7.9	11.9	69.3	2.2	1.6	2.4
25-34	288.9	8.7	7.0	12.2	68.0	2.0	1.5	2.6
35-44	365.6	11.4	9.9	15.4	92.1	2.9	4.2	6.5
45-54	553.4	18.1	16.9	23.7	136.6	4.5	3.3	4.6
55-59	355.0	25.8	11.7	33.0	83.9	6.1	2.1	5.8
60-64	407.6	32.8	12.9	39.5	108.7	8.7	3.5	10.8
All 0-64	2,513.5	13.6	76.2	18.4	729.8	3.9	20.2	4.9

Sources: ABS 2013a: Tables 1 and 2; ABS 2014a: Tables 3_1 and 3_2; ABS 2012a; ABS2012d.

Note: The reliability (relative standard error) of the estimates is provided in the original sources.

3.2.2 National specialist disability policy

During the past 25 years, the Australian Government has played an influential role in the provision of specialist disability services across Australia via a series of agreements with the States and Territories to contribute to the funding of specialist disability services and to establish national policies, targets and standards.

The first Commonwealth/State Disability Agreement (CSDA) was signed in 1991 and was substantially revised in 1998 when the second CSDA was signed. In 2002 further revisions were incorporated into the Commonwealth State/Territory Disability Agreement (CSTDA). In 2009 a new National Disability Agreement (NDA) was agreed to (COAG 2012a); this was revised in 2012 in part to take account of the changes in responsibility for aged care and disability services agreed to in the *National Partnership Agreement on Transitioning Responsibilities for Aged Care and Disability Services* (COAG 2011a).

The 2012 NDA committed the Commonwealth, State and Territory Governments to working towards the objective that, '*People with disability and their carers have an enhanced quality of life and participate as valued members of the community*'. Disability services were defined as comprising both '*specialist disability services*' and '*basic community care services*' (i.e. HACC). The Agreement reaffirmed the Commonwealth Government's responsibility for providing employment services and income support for people with a disability, as well as the '*provision of funds to States and Territories to contribute to the achievement of the objective and outcomes*'.³ The Commonwealth's responsibility for specialist disability services for those aged 65 years and over was also restated.

In 2012, the States and Territories retained responsibility for disability services for those under 65 years of age. This responsibility covered both specialist disability services and basic community care services (COAG 2012a).

³ This refers to the Commonwealth's payments to the States and Territories for specialist disability services under the National [Specialist] Disability Services Specific Purpose Payment (ND SPP). See SCRGSP 2015: 14.1-14.2.

3.2.3 Tasmanian disability policy and services

While Specialist Disability Services and the changes that are occurring in this area do not directly affect the HACC Program, these changes may affect the proportion of HACC clients under 65 that access specialist disability services (15.2 per cent).

The national policy direction for specialist disability services has been developed in partnership with states and territories and the Commonwealth. The states and territories have had the primary responsibility for the provision of specialist disability support services.

It is therefore necessary to examine the policy framework, management structure and service repertoire of specialist disability services in Tasmania, and their interaction with the Tasmanian HACC Program.

Specialist disability services in Tasmania are managed by Disability and Community Services, within the Department of Health and Human Services. Area offices are located in the North, North West and Southern regions. Services are provided in accordance with the *Disability Services Act 2011* which was passed after a period of major reform to specialist disability services in the state which also resulted in new service structures and processes (KPMG 2008; Tasmania DHHS 2009a; 2009b). Disability and Community Services has responsibility for policy, planning and reporting at state and national level, and overall policy directions are set out in the *Disability Services Strategic Plan, 2015-18* (Tasmania DHHS 2015a).

One of the changes introduced in the *Disability Services Act 2011* was to the definition of disability for purposes of eligibility which was amended to reflect a broader human rights of disability (Tasmania DHHS n.d.b). The Act defines disability as an impairment that:

is attributable to a cognitive, intellectual, psychiatric, sensory or physical impairment

- is permanent or likely to be permanent
- results in a substantial reduction in the capacity of the person to participate in everyday life
- requires significant support services and
- that may or may not be episodic (Tasmania 2014a).

This is a more demanding eligibility test than that applied in the HACC Program, which is not covered by Legislation. As a result there are many people eligible for HACC who are not eligible for specialist disability services.

Unlike HACC, which permits direct access to service providers as well as access via the Accesspoint, access to specialist disability services is only via the Disability Gateway which was established in 2010.

The Disability Gateway is delivered by two community organisations: Baptistcare in the South West and North and by Mission Australia in the South East and North West. The main purposes of the Gateway are to assist people with disabilities and their families to navigate their way through the specialist disability services system and to coordinate services at the regional level (Tasmania DHHS 2013a: 13). The Gateway provides a visible point of entry to:

- specialist disability services
- information and advice to individuals and referring organisations
- intake and assessment
- referral to agencies and programs
- a range of related functions.

The Disability Gateway has experienced high levels of demand. During its first three years of operation from 2010-2013 it undertook over 5,000 assessments using a Common Assessment Framework. High levels of demand mean that not all clients can be provided with services straightaway and these clients are placed on a Needs Register which provides one measure of unmet need. For example, in early 2013 there were 380 people on the Needs Register for Individual Support Packages (ISPs), 181 for community access, and 121 requiring urgent accommodation. Clients on the Needs Register and others who may be at risk are actively monitored to identify changing needs and emerging risks. In May 2013 it was reported that there were almost 800 clients being monitored in this way (Tasmania DHHS 2013a: 24-25). These

figures indicate a substantial gap between expressed demand and the availability of several types of specialist disability services.

The Specialist Disability Services program offers some different services to HACC, including accommodation support, community support, community access, respite and advocacy and information (AIHW 2014). Specialist Disability Services programs that overlap with HACC services include personal care, in-home accommodation support (which covers several types of HACC services such as domestic assistance), allied health services, counselling, case management and service coordination.

There are differences in the mode of delivery of services. Many clients of Specialist Disability Services who live in the community have an ISP that provides a package of services designed to meet their particular set of needs. Under a pilot project that commenced in 2013, a number of these clients operate under a self-directed funding model designed to give them the capacity to exercise greater control over the services they receive.

For most clients, Specialist Disability Services provides a higher level of support, given that the HACC Program is designed to provide basic community care, and Specialist Disability Services can accommodate the needs of clients with greater functional limitations. The Specialist Disability Services program has a much younger client profile than the HACC Program, with approximately 50 per cent of clients aged 0-17 (AIHW 2014b: 24). It also has a clearly defined client group and a tightly regulated assessment and entry process leading, for many clients, to intensive service provision. By contrast, the HACC Program has been deliberately designed to have quite broadly defined eligibility guidelines, a less regulated and standardised entry process and, for most clients, less intensive provision of services.

Material in the following paragraphs is mainly drawn from the interviews with service providers.

The interaction between Specialist Disability Services and the HACC Program has a number of elements. In broad terms, service providers see the distinction between the two programs as being primarily in the amount of support required by a person with a disability to continue to live in the community. People living in supported accommodation in all cases need high levels of support and are primarily served through Specialist Disability Services. However, those living in typical housing arrangements and needing assistance may receive this from either program. HACC primarily supports those with lower level needs requiring only a few hours of care per week. Specialist Disability Services are for those with permanent, more complex or higher level needs. However, at times the historic limited availability of Specialist Disability Services has meant that sometimes HACC clients have received assistance at a level more often associated with clients of Specialist Disability Services.

One role that HACC plays, from both the disability services and HACC providers perspective, is to provide assistance to persons who have been assessed as not eligible for specialist disability services but who nevertheless require support to live independently for a short period or permanently. It was reported that in these circumstances the Disability Gateway often refers individuals to the Accesspoint or to a HACC service provider the Accesspoint reported on the difficulties presented by these '*borderline*' clients. Often they are confused about their ineligibility for specialist disability services. Furthermore, their needs are often greater than those that HACC can readily meet, e.g. if a person requires personal care assistance five days per week.

HACC also provides assistance to persons who have been assessed as eligible for specialist disability services but who are not able to be provided services due to funding limitations. This includes people who have been placed on the Needs Register. In these circumstances, HACC is used to '*tide people over*' until resources become available or until their circumstances change and they are given a higher priority. One of the gateways mentioned that people can stay using HACC for years, even though they are on the needs register, due to demand and funding limitations.

For the Disability Gateway, the Accesspoint and HACC generally play an important role for the Disability Gateway in providing a stop-gap for eligible but lower need clients. For most people, HACC is the only affordable source of personal care services outside of Specialist Disability Services. While people in these circumstances can self-refer to HACC, often it is the Gateway that links people who are waiting for

specialist disability services to HACC. The Disability Gateway Services reported multiple points of contact with HACC and indicated that in the absence of HACC there would be more people on the Specialist Disability Services Needs Register.

A further aspect of the dynamic relationship between HACC and Specialist Disability Services concerns the usage by clients of the two programs over time and at different stages of the onset of disability. It was observed that due to limited resources, Specialist Disability Services has had to work on a crisis model, i.e. access to services requires a client to have progressed to a point in their illness and disability that their independence is jeopardised. For example someone who has experienced a stroke, may receive HACC services until it can be determined whether the effects from the stroke will be long-term. HACC services may also be used until the level of functional limitation reaches a point that higher levels of support services are required. This may mean that a new client for Specialist Disability Services may have been previously accessing HACC services for a period of time.

HACC is also sometimes used to top up services for clients of the Specialist Disability Services program who have a shortfall in particular service types, although the intent of the HACC Program is not to duplicate other funded services. One form of topping up involves supplementing the quantity of a given service type common to both programs, such as personal care, that may be in short supply from within the resources of the Specialist Disability Services program.

Where HACC provides services not available through Specialist Disability Services another use of the program is in widening the service repertoire available to a client. HACC includes a number of services not usually provided through the specialist disability program including community nursing, delivered meals, community transport, home maintenance and certain types of home modifications. A person may receive most of their support through the specialist disability support program, but use HACC-funded community transport to attend medical appointments. Or a person may have a community access package through specialist disability services and attend a HACC-funded day centre program. A specialist disability services client living in a group home use an additional HACC service type such as community nursing. Local Area Coordinators within the Disability Gateway would typically work with specialist disability clients to meet their needs from both specialist disability and HACC funded services depending on the person needs, goals and aspirations.

Later in this report, the proportion of HACC clients who are also clients of specialist disability services is examined and the different characteristics of specialist disability services clients only, joint specialist disability/HACC clients and HACC only clients are compared (section 3.7). From the above information, it can be drawn that the major differences between Specialist Disability Services and the HACC Program is one of scope (narrow vs. wide), intensity (extensive vs. basic) and client demography (younger vs. older). The crossover between the two is complex and the AIHW's analysis of people using both DS and HACC concludes that the wide range of combinations of DS and HACC services received by clients of both programs reflects the complementary nature of combined DS and HACC provisions and that the overlaps between the programs constitute an appropriate response to the heterogeneity of people with disability (AIHW 2014c: 65). This overlap will be discussed in later chapters in relation to how it influences the profiling of HACC clients.

3.2.4 The National Disability Insurance Scheme

The origins of the National Disability Insurance Scheme (NDIS) are to be found in a major review of disability care and support published by the Productivity Commission in 2011 at the request of the Australian Government (Productivity Commission 2011a). The Productivity Commission's review concluded that the existing disability support system was '*unsustainable on multiple grounds*' and that existing arrangements were '*inequitable, underfunded, fragmented and inefficient and give people with disability little choice*' (Productivity Commission 2011a: 5).

It recommended the creation of a new national scheme funded by government that would provide insurance cover for all Australians in the event of disability. The Commission proposed that this scheme should be managed by a national agency that would assess the eligibility of individuals for the scheme and

allocate funding. Services would be provided by non-government organisations, state and territory disability service providers and businesses. Those receiving services would have support packages tailored to their individual needs and would have a high level of control over how those services were provided (Productivity Commission 2011a: 2-3).

The Productivity Commission argued that all Australians would benefit from the proposed scheme. The general public (referred to as Tier 1) would benefit in that they would have the assurance that, if disabled, they or their family members would be eligible for the NDIS. Tier 2 which comprised all people with disabilities not meeting the entry requirements of the proposed program would benefit from improved information and referral services. However, the main direct beneficiaries of the scheme (Tier 3) would be those with needs sufficient to enable them to be eligible for disability support and early intervention (Productivity Commission 2011a: 10-16). The Commission anticipated that while there were just over 265,000 people using specialist disability services under the NDA, the new scheme would provide services to around 410,000 people, an increase of over 50 per cent.

Participants in the NDIS (Tier 3) would receive a support package comprising a mix of services tailored to their needs. Most importantly, participants would be given a high level of choice and control over what services they require and which organisations provide their services. The range of services available to participants would be broad including:

- aids and appliances
- home and vehicle modifications
- personal care
- community access supports
- respite
- specialist accommodation support
- domestic assistance
- transport assistance
- supported employment services
- therapies
- local area coordination and development including case management;
- crisis and emergency support
- guide dogs and assistance dogs (Productivity Commission 2011a: 23).

The main intent of the Productivity Commission's proposal, and many of the detailed recommendations, were accepted by the Australian Government and by the States and Territories with the partial exception of Western Australia.

However, the Australian Government never formally responded to the Productivity Commission's report recommendations and it cannot be assumed that services (particularly the Tier 2/3 categories) will work as the Productivity Commission originally envisioned. If participants are Tier 2 they are seen as still part of the NDIS. In July 2012 the Council of Australian Governments (COAG), with the support of the Tasmanian Government, agreed to proceed with the launch of the NDIS. The *National Disability Insurance Scheme Act 2013* set out the objects, principles and operational parameters of the new scheme. The Tasmanian Government signed a formal agreement to take part in the NDIS in May 2013. Subsequently, the National Disability Insurance Agency (NDIA) was established to manage the roll out of the NDIS and trials were commenced in a number of locations around the country.

The Tasmanian Government has been an active participant in the roll out of the NDIS during 2013-15. Tasmania was chosen as one of the NDIS trial sites with the Tasmanian trial focusing on young people with disability aged 15-24 years. Eligible young people began entering the scheme from July 2013 and by 30 June 2014, 786 young people were receiving supports under an approved plan. This compares with 859 persons aged 15-24 who were receiving services from Specialist Disability Services in Tasmania in 2012-13 (AIHW 2014b: 24).

By August 2014 the number of approved plans had increased to 820 and included 186 participants not previously known to Specialist Disability Services in Tasmania.⁴ Of those approved by June 2014, 75 per cent were accessing mainstream services as well as NDIS-funded services.

Participants' satisfaction with the Tasmanian trial was high and was recorded at 1.9 on a scale from -2 (extremely dissatisfied) to +2 (extremely satisfied). This compared with an average of 1.66 for participants across all trial sites (SCRGSP 2015: 14.8 and 14.90).

An updated report in December 2014 indicated that 786 of the 792 DS clients aged 15-24 had made the transition to the NDIS and that 853 of the estimated 1,000 15-24 year olds eligible for the NDIS had joined. The NDIS trial has also resulted in the number of registered providers of services increasing from 84 to 129 (Tasmania DHHS 2014d).

The Tasmanian Government's budgeted commitment to the NDIS in Tasmania in 2014-15 is \$8.06 million. In addition, the Disability Gateway has played an active role in the Tasmania trial providing local area coordination to some participants. It is planned that all Tasmanians with a disability will begin the transition from Specialist Disability Services to the NDIA from July 2016, and that the transition will be completed by the end of 2018-19.

When the NDIA is fully operational in Tasmania, it is estimated that 10,600 Tasmanians will be supported compared with the 6,547 who received support from the state specialist disability program in 2012-13. It is anticipated that the cost to the Tasmanian Government in the first year of full implementation will be \$232 million compared with the \$169 million currently allocated to provide specialist disability services (Tasmania DHHS 2013b: 5; AIHW 2014b; Tasmania DHHS 2015a: 10).

One of the fundamental intentions of the NDIS is to expand the coverage of disability support services to include all persons deemed eligible for support. There is universal agreement that the number of persons covered by the NDIS will be considerably greater than the number currently serviced through specialist disability services provided under the NDA. However, estimates of the number of participants in a fully implemented NDIS are still somewhat speculative. Of the service providers interviewed who estimated the proportion of their clients who would transition, two believed a high proportion would transition, two believed most would transition and one believed quite a few would switch over to the NDIS.

For more than a decade, the AIHW and other organisations have attempted to estimate the number of persons requiring support as a result of disability (e.g. AIHW 2002). In recent years, the potential population of NDA specialist disability services has been estimated in order to measure access to NDA specialist disability services, one of the NDA's performance measures. Potential population has been defined as:

'the number of persons aged 0-64 years who are most appropriately supported by [specialist] disability services, requiring ongoing and/or long-term episodic support, have a permanent or chronic impairment and with a substantially reduced capacity in one or more core activities' (SCRGSP 2015: 14.102).

This definition closely corresponds to the eligibility requirements for the NDIS. 31.7 per cent of HACC clients have profound or severe activity limitations (based on the ABS definition) which seems to suggest that these clients will move across to the NDIS. Interesting to note, is that 11.1 per cent (97) of the 785 HACC clients (15.2 per cent) who receive specialist disability services do not have a profound or severe activity limitation.

3.2.5 Implications for the HACC Program. (Material in this section is based in part on the interviews with service providers).

The roll-out of the NDIS in Tasmania has major implications for the HACC Program including service providers, clients and the program itself. It is viewed by Tasmanian HACC program managers' as a major shift in the way of doing business in the disability sector.

⁴ Interview with NDIA official in August 2014.

Based on their experience of the pilot, service providers generally viewed these changes positively. They emphasised that the NDIS was increasing funding into the disability sector, speeding up the process of assessing clients' needs and delivering services, and increasing accountability to clients. However, service providers also spoke of the uncertainties associated with the transition to the NDIS and the issues still requiring resolution.

One issue causing uncertainty was the impact of a fully operational NDIS on the client profile of the HACC Program. There were varying views concerning the proportion of current HACC clients who would transition to the NDIS. The experience of service providers with a high proportion of clients with long-term disabilities was that most of their clients aged 15-24 had transitioned to the pilot project. Other interviewees expressed the view that perhaps half of their HACC clients would eventually become NDIS participants.

This issue was given consideration by the Productivity Commission in its report on *Disability Care and Support* (Productivity Commission 2011b: 195-197). The Commission assumed that current users of services provided under the NDA would overwhelmingly receive funding support under the NDIS. However, they were less certain about HACC clients, stating that,

'There are no available data to test whether all current HACC users would be covered by the scheme. Indeed, very little is known about the current characteristics of HACC users, including about the nature and severity of their disabilities' (Productivity Commission 2011b: 196).

The Commission then speculated that some high level HACC users would be covered by the NDIS, and that some lower-level users who had not been prioritised services due to the extent of rationing in specialist disability services might also be eligible.

The Commission also considered that some low level HACC users may not be eligible for the NDIS, and that States and Territories may have, *'a small, residual role in meeting the care and support needs of these individuals'* (Productivity Commission 2011b: 197), as well as supporting people with support needs arising from short-term health conditions. However, this assumption has not been tested and it is acknowledged by States and Territories that it will likely not be the case. Elsewhere, the Commission implied that some current HACC users would fit into Tier 2, i.e. people with, or affected by, a disability whose level of need did not meet the threshold of the NDIS. State and Territory Governments, the Commission suggested

'would continue to support a range of community and carer services, including some existing or modified Home and Community Care services, for people with lower-level or shorter term disabilities' (Productivity Commission 2011a: 13).

The Commission's remarks about HACC clients' eligibility for the NDIS were speculative and, by its own admission, based on little or no evidence concerning the characteristics of HACC clients. There are several key elements to the disability eligibility requirements of the NDIS (as set out in section 24 of the NDIS Act). The person's disability must be attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or to a psychiatric condition. The impairment(s) must be permanent and result in substantially reduced functional capacity to undertake communication, social interaction, learning, mobility, self-care and self-management activities. The impairment(s) must affect the person's capacity for social and economic participation and the person must be likely to require support under the NDIS for their lifetime (NDIA 2014a). An impression given by the NDIA interviewee was that as the consumer now had choices, the impact on HACC itself is hard to quantify – it may be that individual elements of HACC could have increased demand depending on the choices of consumers.

The client profiling undertaken in the later chapters attempts to quantify the number of HACC clients likely to meet these tests and thus transition to the NDIS. Definitive information about HACC clients' eligibility for the NDIS would require a detailed assessment of each individual. However, the information provided in later chapters goes some way towards meeting the gap in information about the disabilities of HACC clients noted by the Commission. Broadly speaking, we determined that 39.8 of the clients in the HACC program may be eligible based on 8 activity limitations from the MDS data. However, this estimate is unable to take into account policy decisions and discussions from National and State government officials guiding the implementation of the NDIS. These are the best estimates we can determine using the available data, the

HACC MDS has a high proportion of missing data and the survey will have sampling error associated with its estimates.

3.3 PRIMARY HEALTH CARE

Just as the Tasmanian HACC Program intersects with disability policy and services, it is also influenced by its relations with primary health care policy and health services in Tasmania. The HACC Program is viewed by many both in HACC and in the health services as part of the primary health care component of Tasmanian health services. Hence, consideration of its current and potential role in primary health care is an essential part of this review of the policy environment.

The review is in three parts. Firstly, the national policy interest in primary health care is examined as this provides the backdrop for consideration of primary health care policy in all of the states and territories, including Tasmania. Secondly, the current processes of redesigning Tasmanian health services are outlined, focusing on the potential roles envisioned for community care services. Thirdly, the current and possible future roles for the HACC Program are considered, based in part on the interviews with service providers.

3.3.1 National primary health care policy

The National Health Reform Agreement (NHRA) reached between the Commonwealth, States and Territories in August 2011 set in train major reforms to the organisation, funding and delivery of health and aged care services in Australia (Australian Government 2011a). A year earlier, the Australian Government had released a *National Primary Health Care Strategy* and the NHRA provided a vehicle for implementation of many of its main proposals.

One consequence of the NHRA was to focus national interest in the role of primary health care in meeting the objectives of the health care system. The area of GP and primary health care was identified as one of the key reform areas and one of the implementation principles adopted was the importance of coordination between hospital, GP and primary health care agencies (Australian Government 2011a: 4). This was emphasised in the publication *Improving Primary Health Care for all Australians*, which announced the aim, under National Health Reform, 'to shift the centre of gravity of the health system from hospitals to primary health care' (Australian Government 2011b).

Definitions of the scope of primary health care in the various documents cited above are somewhat imprecise. GPs are widely assumed to be central to primary health care, commonly defined 'as the first level of care or as the entry point to the health care system for consumers' (Australian Government 2009a: 22). However, other health providers including general practice nurses, community nurses, nurse practitioners, allied health professionals, midwives, pharmacists, dentists and Aboriginal health workers are also viewed in the National Strategy as part of primary health care (Australian Government 2013: 6).

In some documents, primary health care is viewed simply as health care '*delivered in the community, outside of hospitals*' (Australian Government 2011b). Community-based settings are identified as the home and places such as general practices, other private practices, community health centres, and local government and non-government organisations (Australian Government 2013: 6). The scope of primary health care set out in the National Strategy is broad ranging including health promotion, prevention and screening, early intervention, treatment and management of health conditions. Primary health care services can be targeted on specific populations groups or health conditions. The National Strategy pays particular attention to the social determinants of health and the impact of socio-economic factors on health outcomes (Australian Government 2013: 6).

Four main drivers of interest at the national level in primary health care reform can be identified. The first is the prevalence and burden of chronic disease which is growing as a consequence of demographic and lifestyle factors. Chronic diseases are estimated to be responsible for more than 80 per cent of the burden of disease and injury. Rates of chronic disease in the community are increasing particularly amongst older

population age groups (aged 65 and over) as are the numbers of persons suffering from more than one chronic health condition at the same time (Britt et al 2008: Knox et al. 2008).

There is a considerable increase in the prevalence of chronic disease in the 45-64 age group compared with younger age groups, although the highest prevalence is in the over 65 population (AIHW 2006: 4). Because chronic conditions can be alleviated but not cured by medical interventions, there is a need for community-based management strategies that are effective for those who are living with these conditions (Francis, Feyer and Smith 2007). However, despite the increasing prevalence of chronic disease and its impact on the health system and society, health services tend to continue to be oriented towards responding to acute conditions. Reforming primary health care services is viewed as a way of improving the prevention and care of chronic disease (Australian Government 2009a: 8-10).

The second driver is the increasing cost of health services, especially in the acute care sector based in hospitals. Primary health services are viewed as a key means of reducing pressure on hospitals and of complementing and enabling the trend towards day surgery and shorter stays in hospital. Shorter hospital episodes of care result in a need for greater and more complex care from primary care providers. Similarly, the move towards care of people with mental health issues in the community increases the demand on primary health services (Australian Government 2009a: 11).

The third driver is increasing awareness of the shortcomings of the primary health care system itself. It has been argued that the primary health care system is poorly suited to the needs of people with complex conditions and to population groups that are 'hard to reach'. Relationships between GPs and other health and community services have been a particular issue of concern. It is widely believed that, '*primary health care tends to operate as a disparate set of services rather than as an integrated system*' (Australian Government 2009a: 19).

The final reason for the national interest in emphasising and reforming primary health care is the international evidence that health systems with strong primary health care are more efficient, have lower rates of hospitalisation, fewer health inequalities and better health outcomes than those that do not (Australian Government 2009a: 8). There is strong support from bodies such as the World Health Organisation (WHO) for greater emphasis on primary health care to improve the performance of health care services world-wide. These views are controversial and there are arguments that the case for community-based health care has been oversold (Cunningham 2012). Nevertheless, the emphasis on the importance on reforming primary health care is well established on the national health policy agenda.

In order to implement these objectives, the Australian Health Minister, together with her counterparts in the States and Territories, formally agreed in 2013 to a strategic framework for the development of primary health care (Standing Council on Health 2013). It was described as a '*mechanism for coordinated action at the Commonwealth, state and local levels to enable a more harmonised approach in primary health care planning and service delivery*' (Standing Council on Health 2013: 1).

A cooperative approach between the Commonwealth and the States and Territories was required given that both levels of government play significant roles in primary health care, alongside private providers and community organisations. The Commonwealth's primary roles are via Medicare, which underpins the provision of GP, specialist medical services and some allied health services outside of hospitals and the Pharmaceutical Benefits Scheme. It also provides funding of Medicare Local primary health care organisations, specific program funding to non-government organisations and private providers of health services, and payments to the States and Territories (Standing Council on Health 2013: 3). The role of the States and Territories in primary health care is also extensive. The Tasmanian Government provides cancer screening programs, community health services, drug and alcohol support programs, support for people living with a wide range of health conditions, health promotion programs, dental and oral health programs, and community mental health services.

In the discussions leading up to the adoption of the strategic framework for development of primary health care, HACC services were viewed as part of the repertoire of primary health services (Australian Government 2009a: 18). HACC services for persons under 65 years are more commonly described as

disability services than as primary health services, but it is probably more accurate to view HACC services as located at the intersection of disability services and health services, providing services to some individuals whose needs are primarily met through specialist disability services and to others whose needs are primarily met through the health services. This issue of the intersection between health and disability services is important to the future of the Tasmanian HACC Program and requires further discussion.

The intersection between health and specialist disability services was discussed extensively by the Productivity Commission in its consideration of whether people with chronic health conditions should be eligible for the proposed NDIS (Productivity Commission 2011b: 182-185). The Commission noted that chronic medical conditions can be disabling, hence raising the issue of whether specialist disability services and eventually the NDIS should be responsible for all people with disabilities that are the result of chronic illness. In this context, it is worth noting that the National Chronic Disease Strategy argued that

'chronic diseases are the leading causes of disability in the community and are associated with high use of disability and community support services' (Australian Health Ministers' Conference 2005: 3).

The Productivity Commission's approach to this issue was to argue that while distinguishing between disability and chronic illness was sometimes difficult, eligibility for the NDIS should be limited to people whose chronic condition is permanent and who have *'significant long-term support needs in order to participate in the community'* (Productivity Commission 2011b: 184). While many people with chronic illness have significant activity limitations, only those who meet these two criteria should have access to the NDIS.

No such limitations need to be applied to the State and Territory HACC Programs for persons aged under 65 years. However, the idea that the Tasmanian HACC Program is both a disability service and a primary health service for people with chronic illness is one that accords with the data presented in later chapters of this report. Viewed from this perspective, HACC clients are people with activity limitations who fall into one of the following sub-groups:

1. Individuals with a disability who are eligible for specialist disability services (or the NDIS) but who are also using HACC services while they wait for specialist disability services to become available or to top-up their specialist disability services package.
2. Individuals with a disability that is insufficiently severe or prolonged to qualify for specialist disability services or the NDIS.
3. Individuals with chronic illness who have short term needs for support associated with an acute health episode or health treatment
4. Individuals with chronic illness who have persisting support needs but who are nevertheless unable to qualify for specialist disability services.

Viewed in this way, HACC services for people under 65 are unambiguously part of the primary health care system. Their roles as part of this system are to assist in the management of chronic illness and in reducing pressure on expensive hospital services.

3.3.2 Tasmanian health care policy

The national primary health care policy context provides a broad framework in which to locate state-provided HACC services for the population aged under 65. However, the more pressing and immediate context in Tasmania is the review of health services that was initiated by the Tasmanian Government in July 2014 (Tasmania, Minister for Health 2014). A Press Release from the Minister of Health on 24 July 2014, headed *Rebuilding Tasmania's Health System*, announced a full-scale review of Tasmanian health services involving the *'structural reforms needed to deliver a better health system in the future'*. Fundamental to the review was a commitment to replace the three Tasmanian Health Organisations (THOs) with a state-wide Tasmanian Health Service by July 2015. It was announced that a public

consultation involving a Green Paper at the end of 2014 and a White Paper in March 2015 would precede the structural reforms.

The Press Release was primarily focused on the broad aims of the structural reform process, but there were indications that the role of primary care services would be one of the areas under review. One area of possible improvement was identified as improved alignment of health services with the Tasmanian Medicare Local, and it was stressed that the reform measures would deliver '*alternatives to hospital care for those with chronic conditions to reduce demand on hospital beds*' (Tasmania, Minister for Health 2014: 4).

The Green Paper, published in December 2014 to invite public discussion on the main directions of health reform, focused on the aim of '*delivering safe and sustainable clinical services*' (Tasmania DHHS 2014b). It set out the perceived advantages of a unified, state-wide health service and the need to reform the delivery clinical services and the hospital system. However, there was also a strong emphasis on the primary health care sector. The Executive Summary stressed the need to ensure that

'we have an effective and responsive primary health care sector to promote wellness, limit the long-term impact of complex and chronic conditions, keep people out of hospital, and, ultimately, improve the quality of life for Tasmanians' (Tasmania DHHS 2014b: 5).

Later in the paper, it was argued that the acute, hospital-based care system had been growing at the expense of primary care and that there had been inadequate investment in primary and community care. A restructured health services system should aim to give:

- greater access to local primary care services
- more opportunities for treatment in the community, progressing to hospitalisation only when it is the most appropriate treatment option
- timely return to home or a facility close to home (Tasmania DHHS 2014b: 20).

It was also stated that:

'Community support services such as care coordination and home assistance provide access to low cost support to help people stay well in their own homes. In some instances this form of care may be all that is required to prevent a decline in health with a resulting presentation to hospital' (Tasmania DHHS 2014b: 21).

Overall, the Green Paper was highly supportive of a shift in the balance of care from the hospital to the community. To achieve this it proposed four strategies:

- design services to meet the needs of people with multiple health problems to keep them out of hospital unless absolutely necessary
- provide more out-of-hospital services to patients who have traditionally received their care in a hospital
- improve community management of people with chronic and complex conditions
- provide non-admitted 'hospital-type' services in health centres, clinics and people's homes (Tasmania DHHS 2014b: 22).

Much of the analysis underpinning the Green Paper's proposals concerning primary health care was provided in a supplementary document entitled, *Building a Stronger Community Care System* (Tasmania DHHS 2014c). This document made a more detailed case than the Green Paper for innovative reform of the community care system. It argued that managing demand on hospital services required '*investing more in existing services that keep people out of hospital and continuing to develop new and innovative models of community care*' (Tasmania DHHS 2014c: 3). It identified six primary health care activities that can be strengthened to keep people out of hospital:

1. chronic disease management programs
2. non admitted 'hospital type' services
3. community nursing services
4. hospital avoidance and diversion programs

5. community palliative care, and
6. community support services (Tasmania DHHS 2014c: 4-6).

The Exposure Draft of the White Paper published in March 2015 restated the main themes of the Green Paper with respect to primary health care. While strengthening the acute care system continued as the primary reform focus, improving primary care services and the linkages between primary care and hospitals remained as central themes. It is interesting to note that the White Paper contained the first direct reference in any of the health reform documents to the Tasmanian HACC Program.

Under the heading *Alternatives to Hospital*, the White Paper noted that there are already '*programs and services that help maintain people in their own home and community*'. These were listed as rapid response community nursing, hospital avoidance and diversion assistance and '*community support for under 65 year old Home and Community Care clients*' (Tasmania DHHS 2015b: 54).

Given the extent of involvement of the HACC Program with the Tasmanian health system, documented in the next section and in later chapters, it is surprising that the role of HACC-funded home-based support services in the primary health care system has received so little mention in the health services reform documents.

3.3.3 The HACC Program and health services. (Material in this section is mainly based on the interviews with service providers).

We conducted 23 interviews with HACC service providers (either the manager or senior staff), which revealed that many HACC service providers have extensive contact with Tasmanian health services. While some service providers perceive their clients as people with disabilities and locate themselves in the specialist disability services network, others see their client group as predominantly or partially people with chronic illnesses requiring long or short term assistance to live at home. These service providers have extensive contact with both the acute and primary health care services, as discussed below.

There are two main forms of linkage between HACC and the health care system. Firstly, there are strong organisational linkages. As shown previously, the three THOs are major providers of HACC services including community nursing, allied health care, personal care, domestic assistance, day centres, home maintenance services and case management. In the areas of community nursing and allied health care, HACC is essentially one source of funding for services that not only contribute to HACC objectives but also extend beyond HACC's remit. As a consequence, the distinction between HACC-funded and DHHS-funded community nursing and allied health care is somewhat blurred.

The other linkage is that HACC services receive many referrals from the health services, especially GPs and hospitals. Many referrals are channeled through the Accesspoint, but many non-government HACC agencies also report that health services are a major or significant source of direct client referrals.

The Accesspoint receives many referrals from nurses involved in discharging patients from hospital as well as from GPs wanting home-based care or support for their patients. Many comments were made concerning the quality of the referral processes. The Accesspoint stated it often receives referrals for services to commence immediately, when in reality, depending upon the service requested and location of the client, clients may be placed on wait lists for some service types. Further planning around when services are required would allow the Accesspoint to put services in place in a more timely manner and provide the opportunity to liaise with referrers to identify alternatives where services are unavailable.

There was also a perception that GP referrals varied widely in quality. While GPs and practice nurses who knew their patients were often able to provide an adequate medical and social history, this was less likely to be the case with locums or sessional GPs. Most commonly, referrals from health services were for nursing and wound care, as well as domestic assistance and personal care.

The roles that HACC services are playing in the health care system are diverse, although often not made explicit. The role most commonly mentioned was provision of community care during recovery after discharge from hospital, with the Accesspoint seen as a particularly important linking mechanism in this regard. Hospitals have certain responsibilities for immediate, post-acute medical services and there has

been extensive consideration and some experimentation concerning the respective roles of hospitals and HACC services in post-acute care. In our interviews, three service providers and one manager expressed the view that the HACC Program should provide short-term assistance, post-hospital discharge specifically aimed at re-enablement. They considered this post-acute care would also ensure that discharge is successful, avoiding readmission and further burden on a more expensive health system.

The other commonly mentioned role for HACC was the long-term care and support of people living at home with chronic illness. This included people with multiple chronic illnesses living in disadvantaged circumstances who do not qualify for the NDIS, but who nevertheless need ongoing assistance to live independently. Often this group of HACC clients are referred from GPs.

A third role for HACC agencies is in prevention of hospital admission by providing assistance to individuals with chronic illness who are at risk of hospital admission to learn how to live independently and self-manage their health condition. HACC funding has been used for services included in hospital avoidance programs aiming to address increasing dependency. HACC Programs were criticised by five service providers for encouraging dependency through long-term provision of services without review of client circumstances. Further development of the preventative role of HACC services is dependent, it was argued, on adoption of goals, processes and culture emphasising wellness and independence.

The roles that HACC plays, and potentially can play, in achieving the goals of Tasmanian health services can also be examined in terms of the different HACC service types. In addition to the service types already discussed, HACC-funded transport services have an important role in accessing GPs, hospitals and other health services. The proposed reorganisation of Tasmanian health services is likely to result in some patients needing to travel longer distances to receive specialised assistance, and HACC-funded community transport services may have new roles to play as a consequence.

HACC has also played an important role in case management of clients with complex needs and circumstances. Improved case management of patients receiving services at home is a central requirement of a reformed primary health care system. Case management is another example of a HACC-funded service that has potentially important roles to play in Tasmania's unified health service.

Finally, HACC-funded services continue to have an important role in providing health services for clients of Specialist Disability Services and the NDIS. Disability packages in general do not include health services, as these are viewed as mainstream services that should be made available to people with disabilities on the same basis as any other member of the population. The primary health care services that the HACC Program partially provides, namely community nursing and allied health care, will continue to be used by those who are deemed eligible for specialist disability services.

3.3.4 Implications for the HACC Program

Developments in health services policy seem likely to expand the potential role of HACC-funded services, subject to some necessary adjustments to the HACC Program itself.

The Tasmanian HACC Program is already deeply engaged with Tasmanian health services, particularly with respect to provision of post-acute support services in the home and long-term support for people living in the community with complex, chronic health conditions. As will be shown in later chapters:

- 56.6 per cent of HACC clients accessed at least one health service (e.g. hospital, emergency, nursing, or outpatients) during the July 2013-June 2014 period (Table 63).
- 72.9 per cent of HACC clients reported an illness/injury/surgery since July 2013 and 41.7 per cent of these clients required additional support in the home provided by an organisation, nurse or health worker (Table 97 and Table 101).

The three most common support services required due to the health condition during this period were: help with the housework, nursing care, and personal care (Table 103).

The importance of HACC's role in Tasmanian health services was emphasised in the Green and White Papers setting out the Tasmanian Government's aspirations for a reorganised Tasmanian health service. In addition, services funded under the HACC Program have the potential to contribute to a strengthened primary health care system by:

- preventing unnecessary admissions to hospital by timely provision of support and assisting individuals to self-manage their chronic health conditions
- case managing individuals with complex health conditions
- improving access to health services via community transport services
- providing the community support required to enable people to receive 'hospital-type' services in the community

In order to realise this potential, the HACC Program would need to:

- define its role in terms of health as well as disability objectives
- further develop close working relations with other primary health services and hospitals
- develop a culture centred on wellness and the re-enablement of clients.

3.4 MENTAL HEALTH

One important aspect of the relationship of the HACC Program with Tasmanian health services is the connection with mental health services and people with mental health issues.

Relations between HACC and mental health services in Tasmania have received less attention than relations with disability and general health services, although later chapters will show that mental health services are the third most common sources of referrals to the Tasmanian HACC Program, accounting for 15.6% of all referrals (Table 70). In this section the main themes of national and Tasmanian mental health policy are briefly reviewed; the experiences of HACC service providers with the sector are described; and the implications and possibilities for the HACC Program outlined.

3.4.1 National mental health policy

A paradigm shift in Australian mental health policy occurred in the 1990s with the closure of many psychiatric institutions and the discharging of many patients into community settings. Since then, there has been a strong emphasis on avoiding lengthy stays in hospital settings where possible and strengthening community-based services that focus on prevention, early intervention, coordinated care and recovery.

These policy emphases have been articulated since 1992 in National Mental Health Strategy documents endorsed by the Australian Government, and State and Territory Governments. The 1992 Strategy was re-endorsed and updated in 1998 and 2003 and the Fourth National Mental Health Plan was released in 2009 (Australian Government 2009b).

As part of the National Health Reforms of 2011, COAG agreed to reform of the mental health system as part of the wider health reform package, and the Australian Government committed additional funds to mental health for the 2011-2016 period in the 2011-12 budget. At a COAG meeting in December 2012, all Australian, State and Territory Governments endorsed *The Roadmap for Mental Health Reform, 2012-2022*, a document setting out a vision and strategic priorities for mental health policy and services for the forthcoming decade (COAG 2012b).

The Roadmap identified six priorities for reform of mental health services, including '*improving access to high quality services and supports*' (COAG 2012b: 24-26). Specific community care programs such as HACC were not named, but the document emphasised the importance of clinical and non-clinical services working together to provide support wherever and whenever it is needed. It stated that there is evidence that provision of suitable support can minimise the negative effects of some mental illnesses, improve the likelihood of lasting recovery and help people maintain social and economic participation during episodes of mental ill-health.

As well as setting out broad directions for mental health policy and services, the Australian Government since 2006-2007 has directly delivered community mental health services through the Targeted Community Care (Mental Health) Program (Australian Government 2012). This program comprises three sets of activities:

1. Personal Helpers and Mentors (PHaMs) provide practical assistance to people aged 16 years and over with severe mental illness to help them achieve personal goals, develop better relationships and manage everyday tasks.
2. Mental Health Respite: Carer Support provides a range of flexible respite and family support options for carers of people with severe mental illness.
3. Family Mental Health Support Services provide early intervention support to assist vulnerable families with children and young people who are at risk of, or affected by, mental illness (Australian Government 2012; 8).

These programs were evaluated in 2011 (Courage Partners 2011). Amongst other findings, the evaluation reported that these community care services were not well known by State and Territory Governments and were poorly integrated with other community care services provided by the community sector and government agencies. There also continued to be poor connections between traditional clinically-based services and community support services. In particular, more work was required in developing a whole-of-government approach to mental health (Courage Partners 2011: 6-8).

The implementation of the NDIS will include psychiatric disability, which will impact national mental health policy and mental health services.

3.4.2 Tasmanian mental health policy

Mental Health Services in Tasmania are delivered by the relevant Tasmanian Health Organisation while Alcohol and Drug Services and Forensic Health Services are delivered on a state-wide basis from the THO South.

The Mental Health, Alcohol and Drug Directorate works collaboratively with THOs and other key stakeholders to implement national and state strategic direction for the delivery of mental health, alcohol and drug and forensic health services.

Mental Health Services are delivered to people with a severe mental health disorder through community teams and inpatient services, and community organisations are involved in delivering support services to those with moderate to severe mental disorders. The Adult Community Mental Health Service is responsible for assessment, treatment, support and education services to people between 18 and 65 and these services are provided on a regional basis across the State. Mental Health Services are subject to the *Mental Health Act 2013* which came into operation in February 2014.

The broad changes in mental health policy at the national level that have occurred over the past 25 years have been mirrored in Tasmania, which has been a full participant in the various National Mental Health Plans dating back to 1992 (Tasmania DHHS 2006: 7). Services are based on a Recovery Model providing '*holistic treatment and care within an active ... partnership between the consumer, carer and the necessary support agencies*' (Tasmania DHHS 2006: 9). There is a strong emphasis on working closely with the broader health and welfare sector and on facilitating access to mainstream services (Tasmania DHHS 2006: 10-11). Mental Health Services are concerned with mental health promotion, prevention of mental ill-health and early intervention, as well as treatment and continuing care. This broad approach requires a whole of government approach and there is a strong commitment to coordination and collaboration with other government and non-government agencies and sectors, especially those in health and community services (Tasmania DHHS 2009).

The Tasmanian Government is committed to developing a new, long term plan for mental health services and in 2014 initiated the Rethink Mental Health Project. This Project aims to provide an independent analysis of Tasmanian public, private and community sector delivered mental health services. It will map

existing services, identify service gaps and make recommendations for system reform and new strategic investment. The project is being led by the Mental Health Council of Tasmania and the Mental Health, Alcohol and Drugs Directorate. The consultation phase of the project recently concluded and work is continuing on the development of the new mental health plan (Tasmania DHHS 2015c).

3.4.3 Implications for the HACC Program. (Much of the material in this section is based on the interviews with service providers).

A common theme arising from our stakeholder interviews was that people with mental health issues were a growing part of the HACC Program client group and there are particular issues associated with providing services to this group.

Several service providers emphasised the vulnerability of many clients with mental health issues and the complexity of providing support services to them. They reported that these clients were sometimes people living in insecure housing or unstable family situations, and that there had been an increase in the number of clients living in squalid circumstances. Clients with mental health issues often had other chronic illnesses that compounded their problems. Often these clients required higher levels of services than permitted under HACC guidelines.

Other providers spoke of the inadequate support available for clients with mental health issues who were exiting hospital or receiving treatment in the community, and the negative impact of this on client outcomes. Often these clients required social support services that were not available. No examples were provided on the type of social support to which service providers were referring. One service provider indicated that a lot of discharges from residential or rehab fail because clients need services such as social support. The view was also expressed that people with mental health issues were prone to falling through the gaps between services. Often they were unable to gain access to Specialist Disability Services, who tended to see mental health services as the responsible agency. This might continue to be a problem under the NDIS if clients were unable to demonstrate that their psychiatric disability was both significant and permanent.

The episodic nature of mental health problems also made it difficult to provide timely services. This was a source of difficulty in relations with community mental health services. Sometimes, by the time community care services were made available, the client no longer needed the service. Developing the right combination of clinical and support services sometimes presented problems. On occasions, clients simply needed some help around the house and social support rather than clinical services, but working out what was most appropriate in any particular case was a challenge. Sometimes there were eligibility issues with clients who could clearly benefit from HACC services, but who did not have functional limitations as such.

These comments seem to suggest that the needs of HACC clients with mental health issues require further investigation and that linkages between HACC and Mental Health Services may need to be deepened. In previous sections we saw that mental health policy emphasises the importance of links with mainstream community services and a whole of government approach. The evidence from the interviews conducted with service providers for this report is that these linkages may require closer attention.

3.5 SUMMARY AND IMPLICATIONS

This chapter has examined the complex policy and service environment of the Tasmanian HACC Program at a time when it has the need and opportunity to strike out in new directions. It also provides discussion based on feedback from interviews.

The Tasmanian HACC Program carries the legacy of almost three decades, during which time its framework of goals and services was set at the national level. However, the moment of release from these constraints was accompanied by unprecedented turbulence in the policy environment.

The Tasmanian HACC Program is considering the implications of the most comprehensive expansion of specialist disability services in the nation's history. The NDIS will expand both eligibility for disability support

and provide services on the basis of reasonable and necessary need, abandoning the rationed system of service delivery.

Contemporaneously, Tasmanian health services are undergoing an extensive reform process that is drawing attention to the importance of a more effective primary health care system. Although it has received little formal attention in this reform process, the Tasmanian HACC Program is faced with new opportunities for deployment of its resources and capabilities. According to stakeholder interviews, the suite of community care services that the HACC Program can provide appear well suited to such roles as:

- reducing hospital admissions
- facilitating return to home in the post-acute phase of treatment
- contributing to the long-term care of people living with chronic illness
- assisting patients to access health services
- managing the care of people with complex health conditions and social circumstances.

There appears to also be potential to extend and expand these roles to encompass those with mental as well as physical health issues.

To better understand the Tasmanian HACC Program client group and how they might use HACC services moving forward, we need to know more about their relationship to other current and prospective programs. Chief among our concerns are the following issues related to service linkages and the distinct role of HACC:

- The extent to which current HACC clients are likely to be eligible or ineligible for the NDIS
- The extent to which HACC clients have chronic illnesses and require long-term support to live independently in the community
- The extent to which HACC clients access assistance to cope with short-term illness or injury (e.g. hospitalisation before or after an adverse health event)
- The role of HACC in facilitation and coordination services, e.g., providing transport assistance to access health services, case management, or service coordination

These issues are explored in the client group analysis in the subsequent chapters.

4 CLIENT PROFILE: DHHS ADMINISTRATIVE DATASETS ANALYSIS

FACTS UP FRONT

Demographic characteristics of HACC Program clients

- There were 5,178 HACC clients in 2013-14, which represents 1.7 per cent of the Tasmanian population aged 18-64 (Table 7).
- 73.5 per cent Tasmanian HACC clients are aged 45-64 and 50.0 per cent are aged 55-64 (Table 7).
- 60.0 per cent of clients of the Tasmanian HACC Program are women compared with 50.9 per cent of the Tasmanian population aged 18-64 (Table 8).
- 12.0 per cent of the Tasmanian HACC Program are people born overseas compared with 11.8 per cent of the Tasmanian population aged 18-64 (Table 10).
- 5.8 per cent of the Tasmanian HACC Program are Aboriginal or Torres Strait Islanders compared with 4.3 per cent of the Tasmanian population aged 18-49 (Table 14).
- 36.3 per cent of the Tasmanian HACC Program are from the Hobart region (SA4) compared with 43.7 per cent of the Tasmanian population aged 18-64 (Table 12).
- 26.4 per cent of the Tasmanian HACC Program are from the Launceston and North East region (SA4) compared with 27.6 per cent of the Tasmanian population aged 18-64 (Table 12).
- 8.1 per cent of the Tasmanian HACC Program are from the South East region (SA4) compared with 7.2 per cent of the Tasmanian population aged 18-64 (Table 12).
- 29.1 per cent of the Tasmanian HACC Program are from the West and North West region (SA4) compared with 21.5 per cent of the Tasmanian population aged 18-64 (Table 12).
- 17.8 per cent of the Tasmanian HACC Program are public housing tenants compared with 6.1 per cent of the Tasmanian population aged 18-64 (Table 16).
- 48.8 per cent of the Tasmanian HACC Program are home owners or purchasers compared with 70.4 per cent of the Tasmanian population aged 18-64 (Table 16).
- 33.6 per cent of the Tasmanian HACC Program live alone compared with 10.9 per cent of the Tasmanian population aged 18-64 (Table 17).
- In 2013-14 there were 424 clients aged 0-17 which is 7.6 per cent of all clients aged 0-64 (Table 73).

Referrals to the HACC Program

- 26.9 per cent of Tasmanian HACC clients in 2013-14 were referred from the health services (hospitals, GPs, community nurses and other health facilities) (Table 20).
- 20.5 per cent of Tasmanian HACC clients in 2013-14 were referred from psychiatric/mental health services or facilities (Table 20).
- 21.4 per cent of Tasmanian HACC clients in 2013-14 were referred from palliative care facilities or hospices (Table 20).
- 16.8 per cent of Tasmanian HACC clients in 2013-14 were referred from Specialist Disability Services (Table 20).

Use of HACC service types

- Excluding 'assessment', the most widely used service types in 2013-14 were: client care coordination (32.7 per cent of all HACC clients); domestic assistance (30.0 per cent); transport (24.6 per cent); nursing care received at home or at a centre (22.2 per cent) and allied health care received at home or at a centre (14.6 per cent) (Table 28).
- 41.6 per cent of all HACC clients in 2013-14 used only 1 HACC service type; 21.9 per cent used 2 service types and 36.5 per cent used 3 or more service types (Table 28).

78.9 per cent of all HACC clients in 2013-14 received services from 1 HACC MDS reporting outlet; 14.7 per cent received services from 2 HACC MDS reporting outlets; and 6.4 per cent received services from 3 or more HACC MDS reporting outlets (Table 29).

Duration of involvement with the HACC Program

- 86.3 per cent of HACC clients in 2013-14 were continuing clients on 30 June 2014 (Table 30).
- 9.4 per cent of HACC clients in 2013-14 were clients for a period of one month (31 days) or less, and of these 66.5 per cent were non-continuing clients (Table 30).
- 14.5 per cent of HACC clients in 2013-14 were clients for a period of more than one month (32 days) and less than six months (182 days), and of these 25.3 per cent were non-continuing clients (Table 30).
- 71.5 per cent of HACC clients in 2013-14 were clients for a period of more than six months (183 days) and of these 3.0 per cent were non-continuing clients (Table 30).
- 60 per cent of HACC clients are long-term (longer than six months) clients and 13.6 per cent are short-term continuing clients (Table 32).

For all activity limitations (except mobility), long-term HACC clients were more likely to have an activity limitation than short-term users (Table 33).

6.8 per cent of long-term clients have no activity limitations and have been a client for one year or longer. Taking the missing data into account, a projected 29.7 to 42.5 per cent of long-term clients have no activity limitations and review processes of HACC MDS reporting outlets may need to be explored further (Table 34).

- The probability of exit from HACC services is highest in the first three months of service entry (0.111) and reduces approximately ten-fold in the second quarter (0.015).
- The probability of exit from HACC services remains low and stable in each quarter for those clients that are still receiving services one year after entry (0.001) (Table 39 and Figure 2).

Comparison with Disability Services program clients

- 41.2 per cent of adult Disability Services clients are aged 45-64 compared with 73.5 per cent of adult HACC clients (Table 40 and Table 7).
- 43.4 per cent of adult Disability Services clients are women compared with 60.0 per cent of adult HACC clients (Table 41 and Table 8).

57.8 per cent of adult Disability Services clients live in private dwellings in the community compared with 81.2 per cent of adult HACC clients (Table 48).

- 14.5 per cent of adult Disability Services clients live alone compared with 33.6 per cent of adult HACC clients (Table 49 and Table 17).
- 47.1 per cent of adult Disability Services clients have a carer compared with 26.1 per cent of adult HACC clients (Table 50).

- 83.7 per cent of adult Disability Services clients receive the DSP compared with 54.5 per cent of adult HACC clients (Table 51).

54.0 per cent of adult Disability Services clients have an intellectual disability compared with 9.8 per cent of HACC clients who identify their health condition as intellectual disability (Table 52 and Table 84).

Use of public health services by HACC Program clients

- 31.8 per cent of adult HACC clients were admitted into hospital in 2013-14, including 18.1 per cent who had multiple admissions (Table 64).
- 31.1 per cent of adult HACC clients visited hospital emergency departments in 2013-14, including 17.0 per cent who had multiple visits (Table 64).
- 45.0 per cent of adult HACC clients visited hospital-based health services in 2013-14, including 36.9 per cent who had multiple visits (Table 64).
- 17.6 per cent of adult HACC clients received the services of a community nurse in 2013-14, including 16.2 per cent who received multiple services (Table 64).
- 56.6 per cent of adult HACC clients received at least one public health service (hospital, emergency department, hospital-based services and community nursing) in 2013-14 (Table 63).

This chapter contributes to the development of a comprehensive client profile of the Tasmanian HACC Program using secondary data sources.

Data were extracted from the existing data sets for people who were clients of the Tasmanian HACC Program during the period 1 July 2013 to 30 June 2014. The administrative data sets from which the data were accessed are discussed in detail in the [technical report](#). We used:

1. The *HACC Minimum Data Set (MDS)* - a national data set that records data on the activities and services provided to clients of the HACC Program from all states and territories
2. The *Specialist Disability Services National Minimum Data Set (DS NMDS)* - an annual collation of nationally comparable data on services provided under the National Disability Agreement
3. *Health Central Data* - data collected through Health Central from DHHS's Patient Information and Administration Management System (the iPM) and the Emergency Department Information Systems (EDIS).

4.1 DEMOGRAPHIC PROFILE OF HACC CLIENTS

This chapter provides statistics on the distributions of age, sex, ethnicity, language, location, Indigenous status, source of income and living arrangements of Tasmanian HACC clients in 2013-14, compared (where possible) with the Tasmanian population aged 18-64 or the nearest comparable age range in 2011.

If the characteristics of HACC clients differ in significant ways from other members of the Tasmanian population, it may be reasonable to infer that these differences form part of the explanation for HACC service use.

The HACC MDS collected by service providers includes data on the personal details of all clients of the HACC Program including:

- name
- date of birth
- sex
- country of birth
- main language spoken at home

- Aboriginal/Torres Strait Islander status.
- living arrangements
- residential setting
- government pension/benefit status
- DVA card status
- Australian State/Territory identifier
- suburb/town/locality
- postcode
- functional status.

Information is also collected concerning the existence of a carer and, if present, the carer's personal details, relationship to client, and residency status.

This list reflects the administrative and service delivery requirements of the program. Some other important demographic variables such as income, employment status and educational attainment are not collected. Nevertheless, the list of client data items collected through the HACC MDS is sufficiently broad to present a statistical overview of the HACC client population.

Many of the data items (variables) in this component of the HACC MDS have a high rate of data completion. For the sample of 18-64 year old HACC clients in 2013-14, there is complete data on age, sex and country of birth; less than 1.0 per cent of the data missing for geographic location and living arrangements; and 2.7 per cent of the data missing for language spoken at home.

Levels of missing data for other items are somewhat higher, including Indigenous status (7.6 per cent missing), residential setting (12.3 per cent missing) and pension status (27.6 per cent missing). The percentages of missing data for these three data items are substantial. Nevertheless, there is sufficient data overall on most variables to provide a valuable demographic profile of the HACC client population.

To identify differences in the demographic profiles of the Tasmanian HACC population and the overall population of Tasmania aged 18-64, we made a comparison of summary characteristics for both populations. This was achieved by using 2011 Census data compiled by the Australian Bureau of Statistics (ABS) for describing the profile of the Tasmania population aged 18-64.

Where possible, this data was obtained from the Community Profile data available for Tasmania on the ABS website (ABS 2012a; ABS 2012b). Where this source does not provide comparable statistics, the 5 per cent Unit Record File of the 2011 Census was used. It is important to note that HACC MDS data on the HACC Program has been reported for 2013-14 and Census data on the Tasmanian population is from 2011, two years earlier. In some tables, data categories from the HACC MDS have been combined to present summary in more meaningful ways, as explained in the text or in the notes to tables.

4.1.1 Age and sex

Table 7 shows the age distribution of the adult Tasmanian HACC population compared with that of the Tasmanian population aged 18-64 years. The HACC client population in 2013-14 had a much older profile, with a much higher proportion of HACC clients in the age groups 55-59 and 60-64 than in the Tasmanian population and a much lower proportion in all age ranges from 18-39. 50 per cent of all HACC clients in 2013-14 were between 55 and 64 years of age. The likelihood of being a HACC client increases with age. In all age groups up to age 39, less than one person in 100 in the Tasmanian population is a HACC client. In the population aged 55-59, 3.1 persons in 100 are HACC clients and in the age group 60-64, 4.7 persons in 100 for the Tasmanian population are HACC clients.

The percentages of men and women who are HACC clients is shown in Table 8. While women slightly outnumber men in the Tasmanian population (50.9 per cent), they strongly outnumber men amongst HACC clients, accounting for 60.0 per cent of the HACC client population aged 18-64. In the Tasmanian population aged 18-64, 1.4 men per 100 are HACC clients compared with 2.0 women per 100.

Table 9, which combines age and sex data for the HACC and Tasmanian populations, shows that women have a slightly older age distribution than men amongst HACC clients. Both men and women are under-represented in the HACC population when compared with men and women in age groups from 18-49, and both are over-represented in older age groups. In summary, age, especially age over 55, is strongly associated with increased likelihood of being a HACC client and this association is greater for women.

Table 7 Distribution of adults by age groups for Tasmanian HACC clients, 2013-14 and the Tasmanian population aged 18-64, 2011

Age groups	HACC clients aged 18-64		Tasmanian population aged 18-64		HACC clients in overall population
	No.	%	No.	%	%
18-19	78	1.5	12,499	4.2	0.6
20-24	177	3.4	29,575	9.8	0.6
25-29	181	3.5	28,074	9.3	0.6
30-34	208	4.0	27,210	9.1	0.8
35-39	289	5.6	30,908	10.3	0.9
40-44	446	8.6	33,947	11.3	1.3
45-49	511	9.9	35,030	11.7	1.5
50-54	704	13.6	36,528	12.2	1.9
55-59	1,059	20.5	34,090	11.3	3.1
60-64	1,525	29.5	32,731	10.9	4.7
Total	5,178	100.0	300,592	100.0	1.7

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive; ABS 2011 Community Profile data for Tasmania.

Note: Excludes HACC clients aged under 18.

Table 8 Sex of Tasmanian HACC clients, 2013-14 and the Tasmanian population, 2011, aged 18-64

Sex	HACC clients aged 18-64		Tasmanian population aged 18-64		HACC clients in overall population
	No.	%	No.	%	%
Male	2,080	40.0	146,974	49.1	1.4
Female	3,098	60.0	153,618	50.9	2.0
Total	5,178	100.0	300,592	100.0	1.7

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive; ABS 2011 Community Profile data for Tasmania.

Note: Excludes HACC clients aged under 18.

Table 9 Age and sex distribution of Tasmanian HACC clients, 2013-14 and the Tasmanian population, 2011, aged 18-64

Age groups	Tasmanian HACC clients				Tasmanian Population			
	Males		Females		Males		Females	
	No.	%	No.	%	No.	%	No.	%
18-19	40	1.9	38	1.2	6,405	4.4	6,094	4.0
20-24	97	4.7	80	2.6	14,925	10.2	14,650	9.5
25-29	86	4.1	95	3.1	13,691	9.3	14,383	9.4
30-34	88	4.2	120	3.9	13,057	8.9	14,153	9.2
35-39	112	5.4	177	5.7	14,792	10.1	16,116	10.5
40-44	187	9.0	259	8.4	16,331	11.1	17,616	11.5
45-49	197	9.5	314	10.1	17,084	11.6	17,946	11.7
50-54	298	14.3	406	13.1	17,747	12.1	18,781	12.2
55-59	417	20.1	642	20.7	16,703	11.4	17,387	11.3
60-64	558	26.8	967	31.2	16,239	11.0	16,492	10.7
Total	2,080	100.0	3,098	100.0	146,974	100.0	153,618	100.0

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive; ABS 2011 Community Profile data for Tasmania.

Note: HACC clients exclude those aged under 18.

4.1.2 Ethnicity and language

Table 10 and Table 11 provide data on the country of birth and language spoken at home of Tasmanian HACC clients and comparative data for the Tasmanian population aged 18-64.

Reflecting the Tasmanian population as a whole, HACC clients are predominantly born in Australia and are English-speaking; 7 per cent of HACC clients are born in non-English speaking countries compared with 5.8 per cent for the Tasmanian population aged 15-64 (Table 10).

Table 11 indicates that only 0.8 per cent of HACC clients speak a language other than English at home compared with 4.6 per cent of the comparable Tasmanian population.

This considerable under-representation of persons speaking a language other than English at home (Table 11) appears inconsistent with the slight over-representation amongst HACC clients of persons born in non-English countries (Table 10).

No clear conclusion can be drawn about engagement of the HACC Program with non-English speaking Tasmanians from this data. However, we note that issues were raised around ethnicity in some of our stakeholder interviews:

- It was seen to be hard to reach first generation migrant groups who seem distrustful of services and often held the view they look after their own and thus were reluctant to accept help.
- Staff did not seem adequately trained to provide support in environments of cultural diversity and language barriers, or have an understanding of foreign diseases and wounds
- Hiring a culturally diverse workforce is difficult when a proportion of existing clients appear resistant to diversity in the workforce.

Table 10 Country of birth of Tasmanian HACC clients, 2013-14 and the Tasmanian population, 2011, aged 15-64⁵

Country of birth	HACC clients aged 18-64		Tasmanian population aged 15-64	
	No.	%	No.	%
<i>Australia</i>	4,559	88.0	268,477	83.7
<i>Other – English speaking</i>	258	5.0	19,343	6.0
<i>Other – non-English speaking</i>	361	7.0	18,468	5.8
<i>Not known/ missing</i>	-	-	14,489	4.5
Total	5,178	100.0	320,777	100.00

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive; ABS 2011 Community Profile data for Tasmania.

Note: 'Other - English speaking' comprises Canada, England, Ireland, New Zealand, Northern Ireland, Scotland, South Africa and Wales. Tasmanian population data is from 15-64 as only available from Community Profile in 5 year cohorts.

Table 11 Language spoken at home of Tasmanian HACC clients, 2013-14 and the Tasmanian population, 2011, aged 15-64⁶

Language spoken at home	HACC clients aged 18-64		Tasmanian population aged 15-64	
	No.	%	No.	%
<i>English</i>	4,994	96.4	294,416	92.2
<i>Other language</i>	43	0.8	14,619	4.6
<i>Not known/ missing</i>	141	2.7	10,390	3.3
Total	5,178	100.0	319,425	100.0

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive; the population estimates are based on the 5 per cent unit record file of the 2011 Census.

Note: Tasmanian population data is from 15-64 as only analysed in 5 year cohorts.

4.1.3 Geographic location

The geographic location of HACC clients in the HACC MDS is recorded as postcode and as suburb/town/locality, with postcode data being 99.9 per cent complete. This data makes it possible to examine whether geography is associated with the likelihood of being a HACC client. Two main measures of geography are used: the Statistical Area Level 4 (SA4) of the ABS and the ABS Remoteness structure.

Table 12 shows the geographic distribution of Tasmanian HACC clients using the ABS Statistical Area 4 (SA4) boundaries. This is the level of statistical boundaries immediately below state and territory boundaries. SA4 boundaries in turn comprise a number of SA3 areas, and so on down to the smallest area in the ABS's statistical area structure, SA1. Tasmania is divided into four SA4 areas: Hobart; Launceston and North East; South East (surrounding Hobart SA4); and West and North West.

We used ABS Community profile data to calculate the population aged 18-64 in each of these four areas. The ABS publishes Correspondence Tables matching postcodes with SA4 areas (ABS 2013d). These were used to determine the proportion of HACC clients in each of the four Tasmanian SA4 areas.

⁵ In the final report, data for the 18-64 population will be extracted from the 5% unit record file of the 2011 Census so that Tasmanian population data is directly comparable with HACC adult client data.

⁶ As per footnote 1.

Table 13 shows the geographic distribution of HACC clients using the ABS Remoteness Area boundaries. Remoteness Areas are based on the Accessibility/Remoteness Index of Australia (ARIA+) developed in 2000. ARIA+ measures the remoteness of a point based on the physical road distance to the nearest Urban Centre (ABS 2013d). There are five categories of remoteness areas:

1. major cities (no Tasmanian city meets the criteria to be included in this category)
2. inner regional (the urban areas of Hobart, Launceston and Devonport)
3. outer regional (predominantly comprised of Burnie)
4. remote (the West coast plus a small area around Bicheno on the East Coast)
5. very remote (the Islands off the North coast of Tasmania).

We used ABS Community profile data to calculate the population aged 18-64 in each of these types of Remoteness Areas in Tasmania. The ABS also publishes Correspondence Tables matching postcodes with Remoteness Areas (ABS 2013e). These were used to determine the proportion of HACC clients in each of the Tasmanian Remoteness Areas. Maps showing the geographic boundaries for Table 12 and Table 13 are publicly available (ABS 2013d).

Taken together, Table 12 and Table 13 show that the geographic distribution of HACC clients is similar to that of the Tasmanian population as a whole, with a tendency to over-representation in the non-urban areas of the state. Table 12 shows that, relative to the Tasmanian population aged 18-64, HACC clients are:

- somewhat under-represented in the greater Hobart area
- slightly under-represented in Launceston and the North East
- slightly over-represented in the South East
- somewhat over-represented in the West and North West.

Table 13 shows that HACC clients are somewhat under-represented in inner regional areas; and somewhat over-represented in outer regional and remote areas.

Table 12 Geographic location of Tasmanian HACC clients, 2013-14 and the Tasmanian population, 2011, aged 18-64, ABS Statistical Areas Level 4

Statistical Area 4	HACC clients aged 18-64		Tasmanian population aged 18-64	
	No.	%	No.	%
<i>Hobart</i>	<i>1,878</i>	<i>36.3</i>	<i>131,048</i>	<i>43.7</i>
<i>Launceston and North East</i>	<i>1,365</i>	<i>26.4</i>	<i>82,657</i>	<i>27.6</i>
<i>South East</i>	<i>418</i>	<i>8.1</i>	<i>21,613</i>	<i>7.2</i>
<i>West and North West</i>	<i>1,506</i>	<i>29.1</i>	<i>64,343</i>	<i>21.5</i>
<i>Not known/ missing</i>	<i>11</i>	<i>0.2</i>	<i>-</i>	<i>-</i>
Total	5,178	100.0	299,661	100.0

Sources: Extraction of postcode data from HACC MDS for Tasmania for July 2013-June 2014 inclusive; ABS 2011 Community Profile data for Tasmanian Statistical Areas 4.

Notes: ABS data is based on place of usual residence. Migratory-offshore-shipping and no usual address are not included.

Table 13 Geographic location of Tasmanian HACC clients, 2013-14 and the Tasmanian population, 2011, aged 18-64, ABS Remoteness Areas

Remoteness Areas	HACC clients aged 18-64		Tasmanian population aged 18-64	
	No.	%	No.	%
<i>Inner regional</i>	3,194	61.7	199,074	66.4
<i>Outer regional</i>	1,834	35.4	94,165	31.4
<i>Remote</i>	121	2.3	4,949	1.7
<i>Very remote</i>	18	0.4	1,471	0.5
<i>Not known/ missing</i>	11	0.2	-	-
Total	5,178	100.0	299,659	100.0

Sources: Extraction of postcode data from HACC MDS for Tasmania for July 2013-June 2014 inclusive; ABS 2011 Community Profile data for Tasmanian Remoteness Areas 4.

Notes: ABS data is based on place of usual residence. Migratory-offshore-shipping and no usual address are not included.

4.1.4 Aboriginal or Torres Strait Islander people

Table 14 shows the number and proportion of HACC clients aged 18 or over identified as having Aboriginal or Torres Strait Islander status compared with the equivalent Tasmanian population aged 18-49.

Aboriginal or Torres Strait Islander people aged 50 and over are eligible for the Commonwealth Government's Home Care program rather than HACC. The table shows that those identifying as Indigenous people are slightly over-represented in the HACC population aged 18-49 years. However, this over-representation needs to be viewed in the context of the higher proportion of Indigenous people requiring assistance with core activities.

Table 15 presents data from the 2011 Census showing that 6.0 per cent of Aboriginal or Torres Strait Islander people aged 15-54 require assistance with core activities compared with 3.0 per cent for the overall Tasmanian population. By combining data in Table 14 and Table 15, we calculated that 17.4 per cent of Aboriginal or Torres Strait Islander people requiring assistance with core activities (628) are HACC clients (109). This compares with the 26.3 per cent of all Tasmanians requiring assistance with core activities (7,532) who are HACC clients in the age range 15-54 (1,890). The extent to which this under-representation is offset by the number and proportion of Aboriginal or Torres Strait Islander people receiving assistance from the Specialist Disability Services program has not been investigated.

Table 14 Indigenous status of Tasmanian HACC clients 2013-14 and the Tasmanian population, 2011, aged 18-49

Indigenous status	HACC clients aged 18-49		Tasmanian population aged 18-49	
	No.	%	No.	%
<i>Aboriginal or Torres Strait Islander</i>	109	5.8	8,128	4.3
<i>Non- Aboriginal or Torres Strait Islander</i>	1,637	86.6	181,462	95.7
<i>Not known/ missing</i>	144	7.6	-	-
Total	1,890	100.0	189,590	100.0

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive; the population data for Tasmania are from ABS 2011 Census Indigenous and Torres Strait Islander Peoples (Indigenous) Profile for Tasmania (ASB 2012c).

Notes: ABS data is based on place of usual residence. Migratory-offshore-shipping and no usual address are not included.

Table 15 Aboriginal or Torres Strait Islander people in Tasmania aged 15-54 requiring assistance with core activities, 2011

	Indigenous persons in Tasmania, aged 15-54		All persons in Tasmania, aged 15-54	
	No.	%	No.	%
<i>Has need for assistance</i>	628	6.0	7,532	3.0
<i>Does not have need for assistance</i>	9,486	91.1	235,611	92.8
<i>Need for assistance not stated</i>	304	2.9	10,812	4.3
Total	10,416	100.0	253,955	100.0

Sources: ABS 2011 Census Indigenous and Torres Strait Islander Peoples (Indigenous) Profile for Tasmania (ASB 2012c); ABS 2011 Census Community Profile for Tasmania (ABS 2012a).

Notes: ABS data is based on place of usual residence. Migratory-offshore-shipping and no usual address are not included. The age range 15-54 is the closest available from the Community Profile data to the age range 18-49 of adult HACC clients.

4.1.5 Housing tenure

The HACC MDS data item on residential setting provides information concerning the main types of accommodation of HACC clients during the period that they were receiving services. The data categories are a mix of tenure and dwelling types.

In Table 16, these categories have been grouped into three tenure categories: owned/purchasing; private renting and public renting. This data is compared with data from the ABS 2011 Census Community Profile for all private dwellings in Tasmania. Two main points can be drawn from Table 16:

1. *Home owners/purchasers are strongly under-represented amongst HACC clients.* While 70.4 per cent of private dwellings in Tasmania are owner-occupied or under purchase by the occupier, only 48.8 per cent of HACC clients fall within this tenure group.
2. *Public housing tenants are strongly over-represented amongst HACC clients.* Public housing comprises 6.1 per cent of all private dwellings in Tasmania, but 17.8 per cent of HACC clients are public housing tenants. Public housing in Tasmania is strongly targeted in terms of both income and special need (including disability), and the relatively high proportion of HACC clients in this form of tenure reflects their low income and special needs.

The 7.2 per cent of HACC clients in other forms of accommodation mainly comprise those living in non-private accommodation including supported housing (3.9 per cent), boarding houses (0.3 per cent), emergency housing (0.2 per cent) and other forms of housing. A very small number (0.2 per cent) are living in public places or temporary shelters.

Table 16 Housing tenure of Tasmanian HACC clients 2013-14 and the tenure status of private dwellings in Tasmania, 2011

Housing tenure	HACC clients aged 18-64		Private dwellings, Tasmania	
	No.	%	No.	%
Owned/purchasing	2,526	48.8	135,691	70.4
Private renting	720	13.9	39,189	20.3
Public renting	923	17.8	11,768	6.1
Other	373	7.2	1,494	0.8
Not known/ missing	636	12.3	4,684	2.4
Total	5,178	100.0	192,826	100.0

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive; the population data for Tasmania are from ABS 2011 Census Community Profile data for Tasmania.

4.1.6 Living arrangements

Table 17 presents data on the living arrangements of HACC clients in Tasmania compared with the living arrangements of the whole population. The data reveals that approximately one-third of all HACC clients live alone and that HACC clients are more than three times as likely to be living alone as Tasmanians aged 15-64.

Conversely, a far smaller proportion of HACC clients live with other family members than do 15-64 year olds in the general Tasmanian population. A slightly higher proportion of HACC clients live with non-family members than is the case in the population as a whole. This suggests that absence of family support may be one factor leading to use of HACC services.

Table 18 shows the extent to which the living arrangements of Tasmanian HACC clients differ between men and women. While the differences are not great, the living arrangements of Tasmanian HACC clients are not independent of sex.⁷ More females, compared to males, live with family, whereas, more males, compared to females, live alone (or live with others).

The HACC MDS also records whether or not a client has a carer, i.e., a person who provides regular and sustained assistance to the client in managing his or her life on an informal or unpaid basis. In 2013-14, 22.1 per cent of clients indicated the presence of a carer, and of these 72.7 per cent were co-resident with the carer. 66.1 per cent of carers were the spouse or partner of the client, and in almost all other cases they were related to the client, most commonly a parent (13.9 per cent).

Table 17 Living arrangements of Tasmanian HACC clients 2013-14 compared with living arrangements of the Tasmanian population, 2011

Living arrangements	HACC clients aged 18-64		Persons aged 15-64 in Tasmanian occupied private dwellings	
	No.	%	No.	%
<i>Lives alone</i>	1,742	33.6	32,518	10.9
<i>Lives with family</i>	2,670	51.6	241,935	80.9
<i>Lives with others</i>	461	8.9	15,646	5.2
<i>Not known/missing</i>	305	5.9	-	-
<i>Other</i>	-	-	8,950	3.0
Total	5,178	100.0	299,049	100.0

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive; the population data for Tasmania are from ABS 2011 Census Community Profile data for Tasmania (Relationship in household by age by sex).

Notes: ABS data is based on place of usual residence. The age range 15-64 is the closest available from the Community Profile data to the age range 18-64 of adult HACC clients.

⁷ The probability associated with the Pearson chi-square statistic of 33.05 is less than 0.001 indicating there is a strong relationship between living arrangements and sex.

Table 18 Living arrangements and sex distribution of Tasmanian HACC clients 2013-14

	HACC clients aged 18-64			
	Males		Females	
Living arrangements	No.	%	No.	%
<i>Lives alone</i>	755	36.3	987	31.9
<i>Lives with family</i>	975	46.9	1,695	54.7
<i>Lives with others</i>	220	10.6	241	7.8
<i>Not known/missing</i>	130	6.2	175	5.6
Total	5,178	100.0	299,049	100.0

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

4.1.7 Main pension or benefit

The main item in the HACC MDS relating to socio-economic status records which Commonwealth Government pension or benefit, if any, is received by the client. This data is shown in Table 19.

The table shows that 54.1 per cent of HACC clients receive the Disability Support Pension (DSP) and a further 12.0 per cent receive some other form of pension or benefit. Data is missing on this item for 27.6 per cent of HACC clients and it is likely that the actual proportion reliant on a public pension or benefit is considerably higher. In June 2011, there were 27,759 recipients of the DSP in Tasmania, 9.3 per cent of the population aged 18-64 (Australian Government 2012). Hence, adult HACC clients are at least five times more likely to be DSP recipients than other Tasmanians within the HACC age range.

Table 19 Pension status of Tasmanian HACC clients, 2013-14

Pension status	HACC clients aged 18-64		
	No.	%	% not including missing data
<i>Aged pension</i>	215	4.2	5.7
<i>DVA pension</i>	16	0.3	0.4
<i>Disability support pension</i>	2,801	54.1	74.7
<i>Carer payment</i>	147	2.8	3.9
<i>Unemployment related benefit</i>	63	1.2	1.7
<i>Other pension or benefit</i>	179	3.5	4.8
<i>No pension or benefit</i>	328	6.3	8.8
<i>Not known/missing</i>	1,429	27.6	-
Total	5,178	100.0	100.0 (3749)

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

4.2 PATHWAYS INTO HACC

4.2.1 Significance and quality of data

The HACC MDS includes a mandatory data item called Source of Referral which refers to '*the individual or organisation that referred the person to the service*' (AIHW 2012: 230-31). The item is collected to provide an understanding of the pathways that HACC clients follow on their way to receiving a service. The other

stated purpose of the item is to understand the pattern of interactions between the HACC Program and other services.

There are 23 categories of individual or organisational types in the Source of Referral classification system. The information is collected at the beginning of each service episode, i.e. the period of time during which the client or their carer receives HACC-funded assistance from a service. As a client can have several service episodes - if they receive services from more than one provider or if they cease and then resume a service - multiple sources of referral are possible for an individual client.

Data on referral pathways can be used to infer the reason for use of HACC services. While no information is collected in the HACC MDS on reasons for referral, some aspects of the circumstances of a client can be reasonably inferred from referral pathways data. For example, referral from a mental health, palliative care or disability service provider indicates that a HACC user has been a client of these services and has a problem or issue associated with mental health, end of life and/or disability respectively. Other categories are broader and less informative. However, referral from a GP or hospital is at the least an indication of a health-related issue or problem.

4.2.2 Sources of referral

The data on source of referral into HACC for 2013-14 is presented in Table 20. As HACC clients can have more than one service episode within a given time period, the number of referral sources is likely to exceed the number of clients. This was found to be the case in the 2013-14 data. Of the 5,178 HACC clients:

- 366 (7.1 per cent) had no source of referral data (i.e. the data was missing)
- 3,618 (69.9 per cent) had one source of referral noted
- 1,194 (23.1 per cent) had two or more sources noted.

Table 20 presents the proportions of referral sources in terms both of total number of clients and of total number of referrals. A client can also have more than one referral from the same provider or type of provider. To avoid double counting, each type of provider is counted once only for each client in Table 20.

In order to present the data clearly, the 23 categories available in the HACC MDS have been reduced to 11 categories in Table 20, and the HACC MDS codes included under each new category are shown in the table.

The first distinction to note in Table 20 is that between referrals from individuals and referrals from organisations. 25.3 per cent of referrals were from individuals (including self-referrals) and the remainder were from organisations. The four main sources of organisational referral were:

1. Palliative Care Services
2. Mental Health Services
3. Specialist Disability Services
4. Health Services.

Palliative Care Services, including hospices, accounted for 16.3 per cent of all referrals and 21.4 per cent of HACC clients were referred from this service type. Similar proportions (15.6 per cent of all referrals and 20.5 per cent of HACC clients) were referred from Mental Health Services, including psychiatric hospitals. A somewhat smaller proportion was referred from Specialist Disability Services (12.8 per cent of all referrals and 16.8 per cent of HACC clients). Health Services include GPs and other medical practitioners, hospitals, community nurses and other health/medical services.

Collectively, these services represented 20.7 per cent of referrals, and 26.9 per cent of all HACC clients were referred from these health providers and organisations. GPs and other medical practitioners accounted for more than half of health services' referrals. Other HACC services were involved in 4.0 per cent of referrals; 5.2 per cent of all clients were referred from HACC services.

Table 20 Source of referral to HACC services, HACC clients 2013-14

Source	No.	% of HACC clients aged 18-64	% of all referrals (see note)	Codes from HACC User Guide
<i>Self</i>	1,182	22.8	17.4	1
<i>Family, friend or neighbour</i>	537	10.4	7.9	2
<i>GP or other medical practitioner</i>	720	13.9	10.6	3
<i>Public or private hospital</i>	404	7.8	6.0	4, 5
<i>Psychiatric/mental health service or facility</i>	1,062	20.5	15.6	6
<i>Community nursing</i>	38	0.7	0.6	8
<i>Other health/medical service or facility</i>	235	4.5	3.5	7, 9, 10, 1, 1 14
<i>Palliative care facility or hospice</i>	1,107	21.4	16.3	15
<i>Specialist disability Services</i>	868	16.8	12.8	13, 96
<i>Other HACC service</i>	269	5.2	4.0	12, 97
<i>Not stated</i>	366	7.1	5.4	99
<i>Total number of referrals</i>	6,788	-	100.0	
<i>Total number of clients</i>	5,178	-		

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Note: Referral data is collected by service episode and is converted in this table to referrals per client. Of the 5 178 clients in the sample, 366 (7.1%) have no source of referral data; 3 618 (69.9 per cent) have one source of referral noted; and 1 194 (23.1 per cent) have 2 or more sources noted. Clients are counted once only for each source of referral. Numbers exceed 100 per cent as some clients are referred from more than one source. HACC User Guide codes showing 0 were 16, 17, 18, 19, 20, 21, 22, 23, and 98.

4.3 FUNCTIONAL STATUS

In addition to the demographic data discussed in the previous section, the HACC MDS contains information on the functional status of HACC clients, or '*the extent to which the person is able to perform selected activities of daily living; and whether they have memory or behaviour problems*' (AIHW 2012).

This data is collected at the beginning of a service episode based on information from the client and other sources and may be altered if the client's status changes. The assessment takes the form of a series of questions such as '*Can you do your housework?*' There are twelve questions of this type, and two further questions about memory and behavioural problems. The data is used by some service providers as an assessment and screening tool, although providers are permitted to use additional assessment tools at their discretion.

Functional status data is a potentially valuable source of information on the reasons that people use HACC services and on the different types of HACC clients. Data of this kind can indicate whether a person has functional limitations across a wide range of functions or whether their limitations are restricted to just one or a small number of functions.

Some functional limitations data relate to specific tasks (such as shopping, managing money) whereas other data relates to areas of core functioning such as self-care, communication and mobility. Functional status data sometimes also includes levels of functional limitation which can be used to distinguish amongst different types of HACC clients.

The HACC MDS has a number of significant limitations with respect to understanding functional status:

- no data is collected on the health conditions and impairments leading to the functional limitations of the client

- the assessments of functional limitations are undertaken by a large number of service providers at different times and in different contexts. The HACC MDS User Guide provides broad guidelines for the assessment of functional status (AIHW 2012: 32-36), but there is no way of knowing to what extent a uniform standard is actually applied across all assessments
- not all HACC MDS questions are recorded in exactly the same way
- the HACC MDS functional status data contains a high level of missing data which limits the capacity to generalise about all clients from the data that is available.

These limitations must be considered when interpreting the summary statistics presented below. Additional information on how functional status data has been used in this analysis and caveats with respect to data quality are provided in the technical report at [Appendix I](#).

4.3.1 Levels of activity limitations

Table 21 summarises the data on the functional status of HACC clients for all 14 activities covered in the HACC MDS, including 7 ABS-defined core activities (shown in italics). The data is presented inclusive of missing data, i.e., no assumption is made that missing data reflects the pattern of available data. Percentages relate to all HACC clients (5,178). The data is inclusive of all clients with complete and partial data on functional status, and response categories have been aggregated to provide a total for all with activity limitations.

There is considerable variation in the incidence of activity limitation amongst the functional status items (see Column 3). The items with the highest proportion of activity limitation are:

- housework (49.2 per cent of HACC clients)
- behavioural problems (41.8 per cent)
- shopping (40.2 per cent).

The items with the lowest proportion of activity limitation are:

- eating (9.2 per cent)
- toileting (10.2 per cent)
- communication (11.0 per cent).

Those items defined by the ABS as core activity limitations have markedly lower rates of activity limitation than other items. The range for core activity limitations is from 22.5 per cent (bathing and showering) to 9.2 per cent (eating) with a mean across the six items of 13.7 per cent. This contrasts with the non-core items which range from 49.2 per cent (housework) to 20.3 per cent (medication) with a mean across the eight items of 34.1 per cent

There is a similar pattern to the data on extreme activity limitation, i.e. those indicating that they are completely unable to do the activity. Across all items, the highest level of extreme activity limitation is for:

- housework (14.1 per cent)
- shopping (11.9 per cent)
- transport (11.3 per cent).

The lowest levels are for:

- communication (2.5 per cent)
- getting out of bed and moving around (3.6 per cent)
- eating (4.1 per cent).

Extreme activity limitations are lowest among the items defined by the ABS as core activities. The range for core activities is 6.8 per cent (bathing and showering) to 2.5 per cent (communication) with a mean of 4.5 per cent. For the non-core items, the range is 14.1 per cent (housework) to 6.5 per cent (medication) with a mean of 9.9 per cent.

Interpretation of the data in Table 21 is limited by the high level of missing data. However, a number of tentative conclusions can be drawn. Firstly, persons with a severe or profound core activity limitation at the

time of using HACC services are in a minority (ranging from 9.2 to 22.5 per cent across the six core activities). A far higher proportion of HACC clients have activity limitations around specific tasks such as housework (49.2 per cent), shopping (40.2 per cent) and transport (37.9 per cent).

Secondly, the marked differences in level of activity limitation between non-core and core activities suggests that there is a large group of HACC clients who are not incapacitated in terms of the core activities of self-care, communication and mobility, but who nevertheless require assistance with a range of daily tasks such as shopping, housework and transport (29.1 per cent, see Table 25). If we include the missing data, this figure drops to 15.8 per cent of clients who do not have core activity limitations but nevertheless indicated that they have other activity limitations.

Table 21 Activity limitation on all functional status items - HACC clients, 2013-14

		'Completely unable to do'	'Can do with help' (or 'sometimes')	All with activity limitation	'Can do without help'	Total responses	Missing/ not stated	All HACC clients, 18-64
<i>Housework</i>	No.	732	1,816	2,548	727	3,275	1,903	5,178
	%	14.1	35.1	49.2	14.0	63.2	36.8	100.0
<i>Transport</i>	No.	584	1,379	1,963	1,330	3,293	1,885	5,178
	%	11.3	26.6	37.9	25.7	63.6	36.4	100.0
<i>Shopping</i>	No.	617	1,466	2,083	1,205	3,288	1,890	5,178
	%	11.9	28.3	40.2	23.3	63.5	36.5	100.0
<i>Medication</i>	No.	337	713	1,050	2,253	3,303	1,875	5,178
	%	6.5	13.8	20.3	43.5	63.8	36.2	100.0
<i>Money</i>	No.	403	670	1,073	2,230	3,303	1,875	5,178
	%	7.8	12.9	20.7	43.1	63.8	36.2	100.0
<i>Walking</i>	No.	392	868	1,260	2,039	3,299	1,879	5,178
	%	7.6	16.7	24.3	39.4	63.7	36.3	100.0
<i>Bathing and showering</i>	No.	351	812	1,163	1,954	3,117	2,061	5,178
	%	6.8	15.7	22.5	37.7	60.2	39.8	100.0
<i>Communication</i>	No.	129	441	570	2,715	3,285	1,893	5,178
	%	2.5	8.5	11.0	52.4	63.4	36.6	100.0
<i>Dressing</i>	No.	281	600	881	2,023	2,904	2,274	5,178
	%	5.4	11.6	17.0	39.1	56.1	43.9	100.0
<i>Eating</i>	No.	210	264	474	2,415	2,889	2,289	5,178
	%	4.1	5.1	9.2	46.6	55.8	44.2	100.0
<i>Toileting</i>	No.	243	282	525	2,369	2,894	2,284	5,178
	%	4.7	5.5	10.2	45.7	55.9	44.1	100.0
<i>Getting out of bed/ moving around</i>	No.	188	455	643	2,467	3,110	2,068	5,178
	%	3.6	8.8	12.4	47.6	60.0	40.0	100.0
<i>Memory problems or confusion</i>	No.	1,981	-	1,981	1,256	3,237	1,941	5,178
	%	38.3	-	38.3	24.3	62.5	37.5	100.0
<i>Behavioural problems</i>	No.	2,165	-	2,165	1,083	3,248	1,930	5,178
	%	41.8	-	41.8	20.9	62.7	37.3	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Notes: The category 'All with activity limitation' is the aggregate of the two previous columns, except for memory and communication problems which are a simple yes/no category. Column 2 is 'Can do, with help' for all items except communication, dressing, eating, toileting and getting out of bed which are 'Can do, sometimes'. *Items defined as 'core activities' by the ABS are shown in italics.*

4.3.2 Multiple activity restrictions

Another approach to analysing the functional status data in the HACC MDS is to examine multiple activity restrictions, i.e. the number of functional status items on which each client recorded an activity restriction.

Multiple activity restrictions is in some respect a misleading measure. The ABS's approach in the SDAC is to define a person as having a core activity restriction on the basis of inability to do just one core activity.

However, cumulative activity restriction can be used to indicate complexity of need and this is the rationale for using this approach in the context of HACC clients.

Table 22 shows the number of activity limitations for those HACC clients for whom we have data on all 12 functional status items. There are 2,802 such clients, comprising 54.1 per cent of all HACC clients in 2013-14. More than half of those HACC clients for whom data is available have five or fewer activity restrictions (67.8 per cent). At the other end of the spectrum, 16.6 per cent of HACC clients (464) for whom data is available have more than 8 activity limitations. A total of 357 clients (12.7 per cent) for whom data is available were receiving HACC services even though they were assessed as having no activity limitations at all.

It makes sense that most HACC clients have multiple functional limitations given the close links amongst certain items (for example, those relating to self-care) and the dependence of some items on others (e.g. mobility limitations and ability to shop or do housework). The proportion (16.6 per cent) of clients with more than eight activity limitations suggests that a minority of HACC clients have highly complex needs requiring a range of HACC and other support services.

Table 22 Total number of activity limitations - HACC clients 2013-14 with complete data on all 12 functional status items

Number of activity limitations	HACC clients for whom we have data on all 12 functional status items		
	No.	%	Cumulative %
0	357	12.7	12.7
1	363	13.0	25.7
2	291	10.4	36.1
3	327	11.7	47.8
4	337	12.0	59.8
5	225	8.0	67.8
6	187	6.7	74.5
7	135	4.8	79.3
8	116	4.1	83.4
9	100	3.6	87.0
10	167	6.0	93.0
11	85	3.0	96.0
12	112	4.0	100.0
Total HACC clients with complete data - functional status	2,802	100.0	
Total HACC clients aged 18-64	5,178		

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Note: Includes the 2,802 HACC clients for whom we have data on all 12 functional status items. Client identified as having 'activity restrictions' when they answer an item with 'completely unable to do' or 'can do with some help'.

4.3.3 Types of activity restrictions

In the previous section, particular attention was paid to those functional status items identified by the ABS in the SDAC as core activities relating to self-care, mobility and communication.

Table 23 presents the total number of core activity limitations identified amongst those HACC clients for whom there is complete data on all 12 functional status items. The distribution of the number of limitations

differs from that in Table 22 in that a high proportion of those with core activity limitations have only one or two such limitations.

Of particular significance are the 1,173 HACC clients for whom we have complete data on core activity limitations but who were recorded as having no core activity limitations at all. This group - 41.9 per cent of those with complete core activity data - are HACC clients requiring assistance with non-core activities despite the fact that they do not have limitations in the areas of self-care, mobility or communication.

To explore this further, Table 24 presents the total number of domestic activity limitations identified amongst those HACC clients for whom there is complete data on all 12 functional status items. A large proportion of the clients who did not have a core activity limitation have a domestic limitation (29.1 per cent).

Table 25 further illustrates that there are very few HACC clients who have only a core limitation (1.9 per cent) and more than half (56.2 per cent) have both a core and domestic limitation. Table 25 presents the relative size of this and other groups⁸ for those clients for whom data is available, as well as examining the constellation of activity limitations associated with particular activities such as shopping or housework.

Table 23 Total number of core activity limitations - HACC clients 2013-14 with complete data on all 12 functional status items

Total number of core activity limitations	HACC aged 18-64 clients for whom we have data on all 12 functional status items		
	No.	%	Cumulative %
0	1,173	41.9	41.9
1	570	20.3	62.2
2	277	9.9	72.1
3	203	7.2	79.3
4	125	4.5	83.8
5	210	7.5	91.3
6	122	4.4	95.7
7	122	4.4	100.0
Total HACC clients with complete data on all 12 functional status items	2,802	100.0	
Total HACC clients aged 18-64	5,178		

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Note: Includes the 2,802 HACC clients for whom we have data on all 12 functional status items. 'Activity restrictions' includes clients answering 'completely unable to do' and 'can do with some help'.

⁸ By dividing activities into core and non-core activities (following the ABS) we can identify four groups: those with both core and non-core activity limitations; those with core activity limitations only; those with non-core activities only; and those without core or non-core activity limitations.

Table 24 Total number of domestic activity limitations, HACC clients 2013-14 with complete data on all 12 functional status items

Total number of domestic activity limitations	HACC aged 18-64 clients for whom we have data on all 12 functional status items		
	No.	%	Cumulative %
0	410	14.6	14.6
1	444	15.9	30.5
2	365	13.0	43.5
3	710	25.3	68.8
4	295	10.5	79.4
5	578	20.6	100.0
Total HACC clients with complete data on all 12 functional status items	2,802	100.0	
Total HACC clients aged 18-64	5,178		

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Note: Includes the 2 802 HACC clients for whom we have data on all 12 functional status items. 'Activity restrictions' includes clients answering 'completely unable to do' and 'can do with some help'.

Table 25 Relationship of core and domestic activity limitations

Core activity limitation		Domestic activity limitation	
		No	Yes
	No	357 (12.7%)	816 (29.1%)
	Yes	53 (1.9%)	1,576 (56.2%)

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

4.3.4 HACC clients with profound and severe core activity limitations

One sub-group of HACC clients in 2013-14 are those for whom we have complete information (all seven items) on functional limitations on core activities. A total of 2,819 (54.4 per cent) of clients fall within this sub-group.

This group can be used to estimate the number and proportion of HACC clients who would meet ABS definitions of profound, severe, and moderate activity limitations. This is an important link to make as it enables us to describe HACC clients in terms that are widely used to measure the incidence of disability in the community, which in turn is linked to the population coverage of the NDIS.

We identified the 2,819 (54.4 per cent) clients for whom we have complete data on functional limitations on core activities.⁹ Following the ABS classification, the seven core activities were divided into the three groups:

1. self-care (bathing, dressing, toileting, eating)
2. communication (communication)
3. mobility (walking, getting out of bed).

Within each of these groups, we identified all clients who have at least one core activity that they are completely unable to do. According to the ABS definition, this is the number classified as having profound activity limitations from each group. In order to exclude overlaps amongst the three groups, we also

⁹ For 1,818 (35.1 per cent) clients there is no information on functional limitations on core activities. For 541 clients (10.5 per cent) there is data on 106 items.

identified all clients who have at least one core activity amongst the seven activities that they are completely unable to do. This is the overall number of clients having *profound activity limitations*.

For each of the three groups of core activities, we then identified all clients who have at least one core activity that they can only do with help. This is the number of clients classified as having severe activity limitations from each group. In order to exclude overlaps amongst the three groups, we also identified all clients who have at least one core activity amongst the seven activities that they can only do with help. This is the overall number of clients having *severe activity limitations*.¹⁰

The estimate for severe needs to subtract the number with severe who have previously been counted as profound. The numbers currently are inflated for severe as many who are severe have already been counted as 'profound'. The results are shown in Table 26.

Overall, 19.0 per cent of HACC clients in the sample were found to have a profound activity limitation as defined by the ABS. A further 39.3 per cent were found to have a severe activity limitation. It is important to bear in mind that this data is based on a sample comprising 2,819 (54.4 per cent of all HACC clients in 2013-14).

If we calculate the proportions based on the total HACC sample, the proportion of clients who have a profound activity limitation is 10.3 per cent and 21.4 per cent have a severe activity limitation. These proportions are similar to the Tasmanian population where 7 per cent of the population have a profound activity limitation and 18 per cent have a severe activity limitation.

Table 26 HACC clients (aged 18-64) 2013-2014: profound and severe core activity limitations

	Self-care (4 items)		Communication (1 item)		Mobility (2 items)		Overall (7 items)	
	No.	%	No.	%	No.	%	No.	%
<i>Profound</i>	353	12.5	113	4.0	393	13.9	535	19.0
<i>Severe</i>	783	27.8	362	12.8	844	29.9	1,109	39.3
<i>Other</i>	1,683	59.7	2,344	83.2	1,582	56.1	1,175	41.7
<i>Total with data</i>	2,819	100.0	2,819	100.0	2,819	100.0	2,819	100.0
<i>Missing data</i>	2,359		2,359		2,359		2,359	
Total all HACC	5,178		5,178		5,178		5,178	

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based on the 2,819 clients who have complete data on the seven core limitations.

4.4 USE OF HACC SERVICES

4.4.1 Significance and quality of data

A further approach to understanding the needs and circumstances that result in people using HACC services is to examine their pattern of use of HACC services. The types and number of services that clients use provides some indication of the nature and intensity of their needs.

The overall period of time that people use HACC services is a particularly significant indication of the nature of HACC usage. If a high proportion of HACC clients have used HACC services consistently over a period of several years, this suggests that HACC is providing ongoing assistance to a relatively stable clientele requiring regular assistance to deal with long-term activity limitations. If, on the other hand, a high proportion of HACC users are short-term clients of six months or less, this suggests that many HACC

¹⁰ This methodology should be read in conjunction with the ABS definitions of profound, severe and moderate activity limitations. See AIHW 2009: 31-33 and this report, section 1.3.

clients are using HACC services to deal with activity limitations that are of relatively short-term duration and/or episodic in nature. When the temporal pattern of usage is established, further analysis can reveal the characteristics of long and short-term users.

HACC MDS data on usage of HACC services takes a number of forms. As previously mentioned, the basic unit of service usage in the HACC MDS is the service episode, a defined period of time during which the client and/or their carer receives HACC-funded assistance (AIHW 2012: 7). Data included in the service episode includes source of referral, date of referral in and exit from HACC services, and main reason for cessation of services. Information is also recorded concerning the type and amount of assistance received by a client. Assistance is categorised into 21 service types, and the objectives and activities associated with each service type is detailed (AIHW 2012: 197-215). The amount of assistance provided within a reporting period is measured in terms of quantity, cost or hours, whichever is appropriate to the service type.

Because of the ways in which this data is recorded in the HACC MDS, we have used considerably complex computations to derive duration variables from existing data items for the measures required. For example, calculating how long a person has been a HACC client requires aggregating data from all service episodes associated with that client. Missing data from service episodes (such as date of referral) complicates these calculations. The methods used to produce data and any limitations inherent in these methods are discussed throughout this report.

The summary data presented in this section is of three kinds:

1. Overall pattern of usage of HACC services
2. Length of time of use of HACC services
3. Characteristics of long and short-term users of HACC services.

4.4.2 Overall pattern of service use

Table 27 shows the number and proportion of clients using the main service types. Table 28 and Table 29 show the number of different service types and HACC MDS reporting outlets used by each client.

The service types shown in Table 27 comprise direct and indirect services. Indirect services are those concerned with management of the needs of a client and include assessment, case management and client care coordination. A high proportion of HACC clients received indirect services during 2013-14:

- 43.0 per cent (2,224) of clients during 2013-14 received assessment and screening
- 9.4 per cent (486) were case managed
- 32.7 per cent (1,691) received client care coordination.

Assessment and screening processes involve assessment for eligibility, support needs and service response and priority allocation of clients. If it is assumed that most of those receiving assessment and screening are clients who are new to the HACC service or returning after a significant period of non-use of service, this provides a clear indication that around 40.0 per cent of HACC clients in 2013-14 were using HACC services or a HACC service type for the first time. Analysis of data showing service types provided by HACC MDS reporting outlets, shows that 40 HACC MDS reporting outlets undertook client assessments in 2013-14. Many reporting outlets undertook less than 10 assessments, but 16 reporting outlets undertook 50 or more assessments.

Client care coordination was provided to almost one third of HACC clients. This is the process of coordinating activities to facilitate access to more than one HACC service if required by the client's circumstances. Twenty HACC MDS reporting outlets delivered this service in 2013-14, but the bulk of client care coordination was provided by 10 major reporting outlets.

It can be assumed that clients requiring care coordination have somewhat complex needs or service responses requiring review of their circumstances or responses to complex situations. This is especially the case for the almost 10 per cent of clients receiving case management. Case management is designed especially for clients with 'chronic, ongoing or complex conditions or situations' and for people with 'a range

of interacting physical/medical, social and emotional needs' (AIHW 2012: 208). It may also play a role in the coordination of multiple services by one client. It involves assessment, care planning, monitoring and coordination of services. Twelve HACC MDS reporting outlets were formally involved in case management during 2013-14, but almost all case management was delivered through six reporting outlets. The extent of provision of case management, and to a lesser extent care coordination, reflects the complex circumstances of at least 10 per cent of HACC clients. However, the number and proportion of other clients with complex needs who could benefit from case management cannot be assessed using HACC MDS data.

The most commonly used direct service was domestic assistance which was accessed by 30.0 per cent of clients. Other widely used service types were:

- transport (24.6 per cent)
- nursing care in the home or at a centre (22.2 per cent)
- allied health care (14.6 per cent)
- personal care (12.0 per cent)
- social support (11.3 per cent)
- home maintenance (11.2 per cent).

All other services were used by less than 10 per cent of HACC clients.

This overall pattern of service provision gives us some sense of the needs and circumstances underpinning service usage. For example, personal care involves provision of assistance with daily self-care tasks such as bathing, dressing, toileting and feeding. The 12.0 per cent of clients requiring this service are likely to have profound or severe activity limitations in the area of self-care and possibly other areas. By contrast, the 24.6 per cent of HACC clients who are users of transport services are likely to be a more diverse group in terms of nature and severity of activity limitations. Further analysis detailing the client profile of the top four service types is provided in section 4.4.5.

Table 27 Service types used by HACC clients, 2013-14

Service type	No.	% of all clients aged 18-64 using the service type
<i>Assessment including screening (client)</i>	2,224	43.0
<i>Client care coordination</i>	1,691	32.7
<i>Domestic assistance</i>	1,551	30.0
<i>Transport</i>	1,275	24.6
<i>Nursing care received at home or at centre</i>	1,148	22.2
<i>Allied health care received at home or at centre</i>	756	14.6
<i>Personal care</i>	620	12.0
<i>Social support</i>	586	11.3
<i>Home maintenance</i>	581	11.2
<i>Meals received at home or at centre</i>	501	9.7
<i>Case management</i>	486	9.4
<i>Counselling/support, information and advocacy</i>	378	7.3
<i>Centre-based day care</i>	316	6.1
<i>Respite care</i>	200	3.9
<i>Home modification</i>	17	0.3
<i>Formal linen services</i>	10	0.2
<i>Other food service</i>	1	0.0
<i>Equipment</i>	0	0.0
Total clients	5,178	-

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Note: Many clients use more than one service type, hence percentages do not add up to 100.0.

Table 28 Number of service types used, HACC clients 2013-14

Number of service types used	No.	%
0	4	0.1
1	2,152	41.6
2	1,135	21.9
3	806	15.6
4	506	9.8
5 or more	575	11.1
Total	5,178	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Table 29 Number and proportion of HACC service providers used, HACC clients 2013-14

Number of service providers	No.	%
1	4,087	78.9
2	760	14.7
3	239	4.6
4	68	1.3
5 or more	24	0.5
Total	5,178	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

4.4.3 How long HACC clients use services

The duration of time that a client uses HACC services is important evidence for the circumstances in which a person is using HACC services. A person using HACC services over a period of several years can be considered likely to have core activity limitations that provide a permanent impediment to independent living. However, we should be mindful that there may be clients in the long-term group who do not have any activity limitation and continue to receive services due to poor reviews by HACC MDS reporting outlets. Further analyses in this section will explore this further. By contrast, a person who uses HACC services for a short time period of six months or less is most likely to have a condition that is non-permanent involving time-limited activity limitations. While there are many factors that might blur this distinction, it can be hypothesised that the characteristics of long and short-term users will differ.

The first step in exploring this relationship is to determine the length of time that people have used HACC services. The HACC MDS provides information relating to all service episodes for a particular client, i.e. the records of all clients of HACC in 2013-14 will contain all episodes of HACC services received by that client since the commencement of the HACC MDS. At least one of those records must refer to the 2013-14 year for the client to be included in the sample of 2013-14 clients. Each service episode record is expected to include a date of entry into and date of exit from a service episode. However, both date of entry and date of exit are not always recorded. In some cases date of entry is omitted by the organisation providing the service; this does not preclude a client's record being accepted into the HACC MDS. The same omission can occur for date of exit. However, more commonly, no exit date is recorded for a continuing HACC client. Information from the HACC data manager in DHHS confirmed that the majority of missing exit data occurs because the client has not exited from the service.

These factors make the process of determining the length of time that people use HACC services somewhat complex, particularly when missing data occurs. We created a variable that combined the service episode records for each client (between one and 17 records per client) to measure total length of HACC service provision data.

It was possible to compute the length of time that services were received for 4,345 of the 5,178 clients, i.e. 83.9 per cent of clients. This required the assumption that the client was a continuing client on 30 June 2014 if any service episode record for the client did not contain an exit date. This may have resulted in the number of clients classified as continuing being higher than is actually the case. The summary statistics from analyses of these data is shown in Table 30 to Table 32.

Table 30 shows the length of time since commencing as a HACC client for those in the data set, 2013-14. Clients were divided into those continuing as HACC clients as of 30 June 2014 and those who were non-continuing, i.e. they completed the receipt of services as HACC clients during 2013-14. Continuing clients, by far the larger group, include 36.4 per cent of all HACC clients who have been clients for more than two years and a further 30.5 per cent who have been clients for over six months and up to one year. These are continuing clients who have been HACC clients for a considerable period of time and it might be expected that many of them have ongoing or long-term activity limitations (especially those who have been clients for

more than two years). It is more difficult to speculate about the 15.5 per cent of continuing clients who have been HACC clients for up to six months. Some may have short-term activity limitations but others may be at the beginning of a long career as a HACC client.

Non-continuing clients, those who ceased being HACC clients during 2013-14, are heavily clustered in the short-term categories. The 51.2 per cent who were HACC clients for less than one month were likely those receiving a one-off or very short-term service to deal with a particular event or problem. They might also include persons who were assessed and deemed not suitable or not a priority for HACC services and were on a waiting list (302 persons received an assessment service only in 2013-14). Only 10 per cent of non-continuing clients had been HACC clients for more than six months. These were long-term clients who happened to finish their time as HACC clients during 2013-14.

When continuing and non-continuing HACC clients are combined, the proportions falling into particular sub-groups can be readily identified. Longer term clients, whether continuing or not, comprise 32.6 per cent (more than two years) or 60.1 per cent (more than six months) of all HACC clients (including the 16.1 per cent for whom data is missing). We might expect these clients to tend to have long-term core activity limitations. Short-term clients of six months service duration or less, who comprise 23.9 per cent of all HACC clients, will include some who are commencing long periods as continuing HACC clients. This group will have similar characteristics as long-term users. Others will be short-term clients receiving assistance to deal with a particular event. 324 clients are non-continuing and were clients for less than one month. They have probably received a one-off service or have been assessed as ineligible or placed back on a waiting list due to priority rating.

Table 30 Length of time since starting services as a HACC client - HACC clients 2013-14

	Continuing with services		Non-continuing		All	
	No.	%	No.	%	No.	%
<i>Up to one month (0-31 days)</i>	145	3.2	324	51.2	487	9.4
<i>Up to 3 months (32-93 days)</i>	227	5.0	140	22.1	367	7.1
<i>Up to 6 months (94-182 days)</i>	333	7.3	50	7.9	383	7.4
<i>Up to 1 year (183-365 days)</i>	772	17.0	24	3.8	796	15.4
<i>Up to 2 years (366-730 days)</i>	615	13.5	11	1.7	626	12.1
<i>Up to 5 years (731-1826 days)</i>	1,034	22.8	20	3.2	1,054	20.4
<i>Up to 10 years (1827-3652 days)</i>	479	10.5	7	1.1	486	9.4
<i>More than 10 years (3653+ days)</i>	143	3.1	1	0.2	144	2.8
<i>Total with data</i>	3,748	82.5	595	94.0	4,343	83.9
<i>Missing data</i>	797	17.5	38	6.0	835	16.1
<i>Total all HACC clients aged 18-64</i>	4,545	100.0	633	100.0	5,178	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Table 31 Date of first use of a HACC service - HACC clients 2013-14

Year	No.	%	Cum %
2000-2004	138	2.7	2.7
2005	45	0.9	3.6
2006	54	1.0	4.6
2007	112	2.2	6.8
2008	107	2.1	8.9
2009	261	5.0	13.9
2010	240	4.6	18.5
2011	531	10.3	28.8
2012	420	8.1	36.9
2013	1,493	28.8	65.7
2014	914	17.7	83.4
Total	4,315	83.4	-
Missing data	863	16.6	100.0
All HACC clients aged 18-64	5,178	100.0	-

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Note: Missing data includes 30 clients whose recorded start date preceded the commencement of the HACC MDS

4.4.4 Relationship between service use and time as client

Table 32 presents length of time as a HACC client in terms of year of first use of HACC services. 28.8 per cent of clients commenced as HACC users up to and including 2011, two years prior to the 2013-14 year. As we saw in Table 30, most of this group are continuing, long-term clients who are likely to be found to have core activity limitations and an ongoing need for HACC services. The remaining 54.5 per cent of clients (there are also 16.6 per cent with missing data) who commenced as HACC clients between 2012 and 2014 are a more mixed group.

Based on Table 30, we know that about 20 per cent of these are non-continuing clients who have received a very short-term or one-off service in response to a particular problem or event, or in some cases no more than an assessment. The majority group of continuing clients amongst these relatively recent clients are likely to be a mix of potentially longer term clients with core activity limitations and a need for ongoing HACC services and clients whose short-term activity limitations mean that they will only need HACC services for a short time. More complex analysis will be required to determine the proportions of this group who fit into these two categories.

In order to test the proposition that long-term users of HACC services are more likely to have ongoing or long-term activity limitations, the sample of 2013-14 HACC clients for whom data was available on length of time as a HACC client was divided into three groups (Table 32):

1. Short-term clients (up to six months) who were not continuing as HACC clients on 30 June 2014
2. Short-term clients (up to six months) who were continuing as HACC clients on 30 June 2014
3. Long-term clients (more than six months).

Six months is used in the ABS's definition of a long-term health condition and the ABS defines a disabling condition as 'a disease, disorder or event that leads to an impairment or restriction that has lasted or is likely to last for at least six months' (AIHW 2009: 32). By using six months as the cut-off for a long-term HACC client our approach conforms to these ABS definitions.

Table 33 examines the differences between long and short-term users of HACC services in terms of activity limitations. The sample comprises the 2,780 HACC clients for whom we have data on all 14 functional status items less 471 of these clients who do not have data on when they first entered HACC services. This results in a sample of 2,309 clients.

Those with activity limitations are defined as those who answered No (completely unable to do), Yes, with help, and/or Yes, sometimes to questions about their ability to undertake various activities. The table compares long and short-term clients in terms of core activities, other activities and problems of memory and behavior (clients are assessed as having/not having these problems). We used a chi-squared test of association to determine whether there was a statistically significant relationship between activity limitation and length of time as a HACC client. P-values computed from these tests for each activity limitation are reported in Table 33.

Table 33 shows that in terms of the core activity limitations, long-term users of HACC services were considerably more likely to have activity limitations than short-term users, including short-term continuing and non-continuing. The relationship between activity limitation and length of time as a HACC client was statistically significant on all items except mobility. The same was found for non-core activity limitations. For all non-core activities with the exception of transport and shopping, long-term users were more likely to have activity limitations than short-term users. These relationships were found to be statistically significant, with the exception of transport and shopping. On the memory and behavior items there was a wide divergence between long-term HACC users who were likely to have these problems, and short-term non-continuing users who were not.

While Table 33 is interesting, it does not provide insight into clients who have no activity limitation and whether they are long- or short-term users. To investigate this further, Table 34 explores the length of time as a client by the activity limitation, specifically focusing on long-term clients.

This table shows that 6.8 per cent of long-term clients have no activity limitation. All of these 211 clients have been clients for one year or more and 54.0 per cent have been clients for two years or more. Of further interest is that 42.3 per cent of long-term clients have missing activity limitation information.

We know from the linked administrative data that 54.2 to 84.3 per cent of missing data may be explained by HACC MDS reporting outlets not documenting information for clients with no activity limitation. We can project that between 29.7 (924) and 42.5 (1,320) per cent of long-term clients have no activity limitation. This is an interesting finding, and may point to HACC MDS reporting outlets review processes and perhaps an area that could be explored further by the HACC Program.

Table 32 Long and short-term users of HACC services, HACC clients 2013-14

Client type	No.	%	Cum. %
<i>Short-term (up to six months) – not continuing</i>	532	10.3	10.3
<i>Short-term (up to six months) – continuing</i>	705	13.6	23.9
<i>Long-term (over six months)</i>	3,106	60.0	83.9
<i>Missing data</i>	835	16.1	100.0
<i>Total</i>	4,343	83.9	-
All HACC clients aged 18-64	5,178	100.0	

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Table 33 Activity limitations of long and short-term users of HACC services, 2013-14

Activity limitation	Short-term not continuing		Short-term continuing		Long-term		p-value
	No.	%	No.	%	No.	%	
<i>Core activities</i>							
<i>Walking</i>	62	28.2	102	33.3	742	41.6	<0.001
<i>Bathing and showering</i>	67	30.4	87	28.4	657	36.8	<0.01
<i>Communication</i>	21	9.5	33	10.8	310	17.4	<0.001
<i>Dressing</i>	52	23.6	65	21.2	526	29.5	<0.01
<i>Eating</i>	19	8.6	26	8.5	310	17.4	<0.001
<i>Toileting</i>	24	10.9	28	9.1	334	18.7	<0.05
<i>Getting out of bed/moving around</i>	34	15.4	46	15.0	357	20.0	0.117
<i>Other activities</i>							
<i>Housework</i>	135	61.4	219	71.6	1,368	76.7	<0.001
<i>Transport</i>	135	61.4	174	56.9	1,067	59.8	0.527
<i>Shopping</i>	130	59.1	186	60.8	1,110	62.2	0.615
<i>Medication</i>	47	21.4	74	24.2	615	34.5	<0.001
<i>Money</i>	50	22.8	65	21.2	624	35.0	<0.001
<i>Other issues</i>							
<i>Memory/confusion</i>	44	20.0	219	71.6	1,082	60.7	<0.001
<i>Behaviour</i>	41	18.6	232	75.8	1,181	66.2	<0.001

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Note: Sample comprises the 2,780 HACC clients for whom we have data on all 14 functional status items minus 471 of these clients who do not have data on when they first entered HACC services. This results in a sample size of 2,309 clients.

Table 34 Long and short-term users of HACC services by activity limitation category, HACC clients 2013-14

	Domestic		Core activities		Both core and domestic		No activity limitation		Missing data		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Short-term (up to six months) – not continuing</i>	70	13.2	3	0.6	86	16.2	61	11.5	312	58.6	532	100.0
<i>Short-term (up to six months) – continuing</i>	107	15.2	6	0.9	149	21.1	45	6.4	398	56.5	705	100.0
<i>Long-term (over six months)</i>	510	16.4	38	1.2	1,032	33.2	211	6.8	1,315	42.3	3,106	100.0
<i>Missing data</i>	129	15.4	6	0.7	309	37.0	40	4.8	351	42.0	835	100.0
All HACC clients aged 18-64	816	15.8	53	1.0	1,576	30.4	357	6.9	2,376	45.9	5,178	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

4.4.5 Client profiles for the top 4 service types

To further explore the needs and circumstances that result in people using the HACC services, we have provided a profile of clients using the top four service types:

1. domestic assistance
2. transport
3. nursing
4. allied health.

More specifically we will examine certain demographic characteristics, length of time as a HACC client, as well as the category of activity limitations they fall in. This work complements the sub-group analysis in chapter 5 and Table 71 presents a breakdown for all service types by sub-groups.

As shown in Table 35:

- a higher proportion (69.9 per cent) of females use domestic assistance as compared to other service types, with men more likely to use nursing services
- almost half (49.9 per cent) of domestic assistance and 40.9 percent of transport clients live alone, compared to a quarter of clients using nursing or allied health services.

Table 37 shows that transport and nursing service types have the highest proportion of clients with no data on activity limitation, and nursing and allied health have the highest proportion of clients with no activity limitations. As shown in Table 38, a much higher proportion of nursing clients are short-term clients.

Table 35 Sex of clients using the top four service types, HACC clients 2013-14

Sex	Domestic Assistance		Transport		Nursing		Allied Health	
	No.	%	No.	%	No.	%	No.	%
Male	471	30.4	521	40.9	543	47.3	329	43.5
Female	1,080	69.6	754	59.1	605	52.7	427	56.5
Total	1,551	100.0	1,275	100.0	1,148	100.0	756	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Table 36 Living arrangements of clients using the top four service types, HACC clients 2013-14

Living arrangement	Domestic Assistance		Transport		Nursing		Allied Health	
	No.	%	No.	%	No.	%	No.	%
Lives alone	774	49.9	509	39.92	304	26.48	185	24.47
Lives with family	666	42.94	590	46.27	581	50.61	448	59.26
Lives with others	73	4.71	107	8.39	143	12.46	66	8.73
Missing data	38	2.45	69	5.41	120	10.45	57	7.54
Total	1,551	100	1,275	100	1,148	100	756	100

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Table 37 Activity limitations of clients using the top four service types, HACC clients 2013-14

Activity limitation	Domestic Assistance		Transport		Nursing		Allied Health	
	No.	%	No.	%	No.	%	No.	%
Domestic activity limitations only	414	26.69	195	15.29	189	16.46	82	10.85
Core activity limitations only	5	0.32	16	1.25	7	0.61	17	2.25
Both core and domestic	636	41.01	397	31.14	376	32.75	373	49.34
No activity limitations	23	1.48	67	5.25	112	9.76	64	8.47
Missing data	473	30.5	600	47.06	464	40.42	220	29.1
Total	1,551	100	1,275	100	1,148	100	756	100

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Table 38 Long and short-term clients using the top four service types, HACC clients 2013-14

Length of time client	Domestic Assistance		Transport		Nursing		Allied Health	
	No.	%	No.	%	No.	%	No.	%
<i>Short-term (up to six months) – not continuing</i>	28	1.81	5	0.39	383	33.36	40	5.29
<i>Short-term (up to six months) –continuing</i>	158	10.19	186	14.59	128	11.15	128	16.93
<i>Long-term (over six months)</i>	1,119	72.15	1,049	82.27	578	50.35	440	58.2
<i>Missing data</i>	246	15.86	35	2.75	59	5.14	148	19.58
Total	1,551	100	1,275	100	1,148	100	756	100

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

4.4.6 Future use of HACC services: life table analysis

The analysis above is necessarily incomplete because it is not possible to know the length of time that the 13.6 per cent of HACC clients, classified to the short-term but continuing category in Table 39, will continue to require HACC services beyond July 2014.

An alternative way to analyse duration data of this type, specifically the length of time that a person receives HACC services, is to use a *survival analysis* approach. This analysis technique is also known as *event history analysis* in applications to social science data where the question of interest is of the form: how likely is it that a person will exit from a social circumstance after a given period of time?

In this report, the social circumstance is receipt of HACC services. This approach acknowledges that the data for some people (13.6 per cent) will be censored; that is, the exit from service date has not been observed because the event of interest has not yet occurred. An *event history analysis* is able to use this censored information to estimate the probability that a person is likely to exit from being a HACC client after a specified period of time. This provides additional information for understanding the use of HACC services for differing lengths of time, in addition to the findings reported in the previous section.

A life table provides the format for reporting summary statistics produced from an event history analysis of the time taken to exit from the receipt of HACC services. In this analysis, one time period is defined as three months or one quarter of a year. Therefore, in alignment with the duration categories in Table 39, a person who has received HACC services for two quarters or less is considered a short-term client, and a person who has received HACC services for more than two quarters is considered a long-term client.

Table 39 is a life table showing summary statistics for the service duration of the 4,340 HACC clients with an entry date, recorded as receiving services in the year from July 2013 – June 2014. The first column shows the length of time in receipt of HACC services. The first data row of the table summarises data for HACC clients who were in the dataset for up to three months (up to one quarter); the second row corresponds to HACC clients who were in the dataset for three or more months but less than six months, (up to two quarters), and so on.

The second column shows the number of clients who were receiving HACC services in the corresponding duration period (measured in quarters) following their entry into the dataset. At the end of each quarter, clients are removed from the table as a result of both exiting from HACC services and censoring.

Censoring occurs for clients who were still receiving HACC services in June 2014 so that their date of exit, and hence duration on HACC services is unknown. For example, the second column in Table 39 shows that 4,340 received HACC services. The third column shows that 481 clients (11.08 per cent) exited from HACC services within three months. The fourth column shows the probability of exiting HACC service within the corresponding quarter since entry, given that the client was receiving services in the previous quarter. This is defined as the hazard of exiting from HACC services.

In addition to the 481 clients who ceased receiving services within three months, 372 clients were censored, therefore, the number of clients receiving services between 3 and 6 months is reduced to 3,487. After 3 months since entry to HACC services, and before six months, a further 51 clients exit HACC services, and a further 333 clients are censored. The probability of exiting HACC services after three months but before six months duration is 0.0146. The interpretation of the fifth row of the table is that 2,307 clients remain in HACC services after four quarters or one year but only three of these people exit before the fifth quarter. A similar pattern occurs for the remaining rows of the table in which five or less clients exit from HACC services within each additional quarter since date of entry up to more than ten years.

Table 39 A life table for the HACC MDS, summary duration data for the 4,340 HACC clients with an entry date, recorded as receiving services in the year from July 2013 – June 2014 (table has been truncated to 27 quarters or 9 years)

Number of quarters from HACC service entry date	Clients in service at beginning of quarter	Clients exiting service in quarter	Hazard: Probability of exiting service in quarter	Standard error of hazard
0-1	4340	481	0.1108	0.0051
1-2	3487	51	0.0146	0.0020
2-3	3103	17	0.0055	0.0013
3-4	2736	7	0.0026	0.0010
4-5	2307	3	0.0013	0.0008
5-6	2073	3	0.0014	0.0008
6-7	1912	2	0.0010	0.0007
7-8	1802	3	0.0017	0.0010
8-9	1681	5	0.0030	0.0013
9-10	1590	3	0.0019	0.0011
10-11	1502	2	0.0013	0.0009
11-12	1435	1	0.0007	0.0007
12-13	1328	4	0.0030	0.0015
13-14	1111	1	0.0009	0.0009
14-15	976	2	0.0020	0.0014
15-16	927	0	0.0000	.
16-17	864	0	0.0000	.
17-18	807	1	0.0012	0.0012
18-19	740	0	0.0000	.
19-20	695	1	0.0014	0.0014
20-21	627	1	0.0016	0.0016
21-22	518	0	0.0000	.
22-23	478	1	0.0021	0.0021
23-24	454	1	0.0022	0.0022
24-25	420	1	0.0024	0.0024
25-26	395	1	0.0025	0.0025
26-27	373	0	0.0000	.

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

The pattern in the probability of exit from HACC services after a particular period of time is more easily observed using graphs of the probability (or hazard) against the number of quarters to occurrence of exit from HACC service. This helps to identify time periods in which the likelihood of exit from HACC services is particularly high or low.

Figure 2 shows a graph of the probability of exiting by duration of HACC services. This figure shows sharp drop in the probability of exiting after about two quarters (six months) then remains low and constant for nine years following entry to HACC services, demonstrating that the conditional probability of exiting is high in the first two quarters following entry and then remains low in subsequent quarters. In other words, if a client needs short-term services they will likely cease using the services within six months. If a client needs services longer than six months, it is highly likely that they will remain a long-term client.

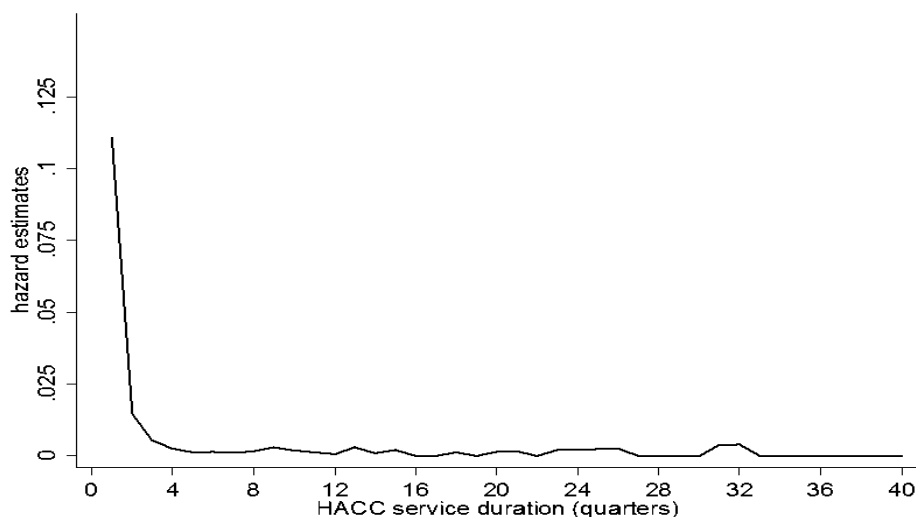


Figure 2 Probability of exiting HACC services - by duration since entry to receiving services

Figure 3 shows a graph of the unadjusted probability of exiting by duration of HACC service, separately for DS/HACC users and HACC only users. This figure shows that the probability of exiting is higher for HACC only users within the first quarter following entry. In other words, HACC clients who also use Specialist Disability Services are less likely to exit from HACC services after six months, or more likely to require HACC services for a longer period of time than clients who only use HACC services.

Table 32 shows that at least 60.0 per cent of HACC clients are long-term users of HACC services, at least 10.3 per cent of clients are short-term users of HACC services and that the duration of use of HACC services is unknown for 29.7 per cent of clients. The life table analysis presented in this section provides additional information on the likelihood of exit from HACC services at intervals of length of time from first entry date. The main findings are:

- The probability of exit from HACC services is highest within three months of service entry (0.111)
- The probability of exit from HACC services reduces approximately ten-fold in the second quarter, that is, between three months but less than six months from service entry (0.015).
- The probability of exit from HACC services remains low and stable in each quarter for those clients that are still receiving services four quarters, or one year following entry (0.001).
- HACC clients who also use Specialist Disability Services are more likely to require HACC services for a longer period of time than clients who only use HACC services.

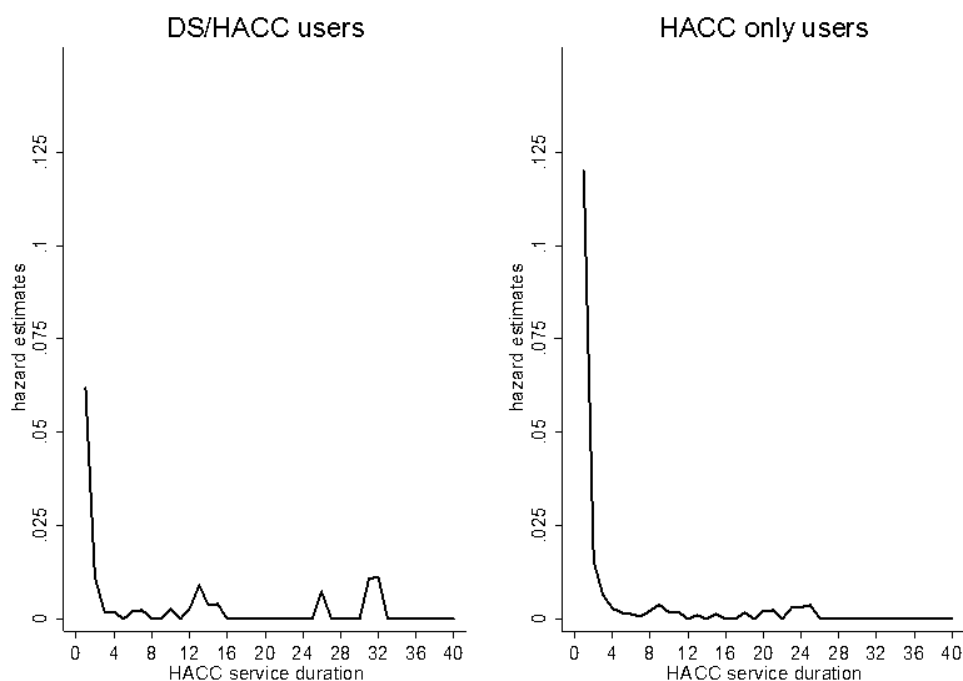


Figure 3 Probability of exiting HACC services - by duration since receiving entry to HACC services and disability client type

4.5 HACC CLIENTS WHO USE SPECIALIST DISABILITY SERVICES

There are 6,455 users of Specialist Disability Services (during 2013-14) in the disability data received from DHHS. DHHS provided the SLK code for a client if they were one of the 5,178 HACC clients aged 18-64 that from the 2013-2014 period (i.e., if the SLK is blank it is because it is not a match with one of the 5,178 HACC clients). There were 785 Specialist Disability Services clients who were also HACC clients during that period.

To be consistent with the HACC data extraction, the data is restricted to Specialist Disability Service users aged 18-49 for Indigenous and ages 18-64 for non-Indigenous. Once this adjustment is made, the data reduces to 2,070 DS clients who only use specialist disability services and 2,855 clients in scope. Using this figure, the proportion of all DS clients who are also HACC clients is 27.5 per cent.

4.5.1 Comparing client groups

We compared the demographic characteristics of three sub-groups to identify the proportion of HACC clients who have a permanent disability. These groups were:

1. clients who use only Specialist Disability Services
2. clients who use both Specialist Disability Services and HACC services
3. clients who only use HACC services.

The results show that approximately half (49.6 per cent) of the HACC clients using Specialist Disability Services are below the age of 45, which is about 10 per cent lower than the corresponding age group for Specialist Disability Services only clients (58.8 per cent).

However, this proportion drops significantly for HACC only clients, where 22.5 per cent of the clients are below the age of 45 (Table 40). These results suggest that the HACC Program attracts a large proportion of older clients that do not have permanent disabilities.

Comparisons made based on gender show an inverse relationship between the Specialist Disability Services clients and HACC client groups, with a higher proportion of males (54.6 per cent) being Specialist Disability Services users as compared to a higher proportion (60.0 per cent) of females using HACC services. The results seem to suggest that this is almost certainly a function of age differences as younger users of the HACC client group tend to be male (Table 41).

Table 42 through to Table 45 compare the country of birth, language spoken at home, and geographic location across the sub-groups. These data do not reveal any significant differences on these characteristics. There were slight variations in the proportion of Aboriginal or Torres Strait Islander people across the sub-groups, with Specialist Disability Services showing a higher proportion of Aboriginal or Torres Strait Islander people as compared to the HACC Program (Table 46).

A comparison of the living environment, showed that HACC clients who do not use Specialist Disability Services are more likely to own their home while clients that use both Specialist Disability Services and HACC services are more likely to be public renters (Table 47). There is a large proportion of clients who use Specialist Disability Services and HACC services who indicated other (19.4 per cent) which may be because they reside formal group homes.

Table 48 provides support for this rationale, in that 34.7 per cent of Specialist Disability Services only clients reside in group homes, hostels, supported residential services/facilities as compared to only 2.0 per cent of HACC only clients.

The results from Table 49 add further support, in that a comparably lower proportion of Specialist Disability Services only clients live alone (14.5 per cent) as compared to HACC only clients (34.6 per cent). A higher proportion of clients who only use Specialist Disability Services have a carer (47.1 per cent) as compared to HACC only clients (22.4 per cent). The results from Table 51 show that a higher proportion of Specialist Disability Services only clients receive a disability support pension as compared to HACC only clients.

Table 40 Age groups of HACC only, Specialist Disability Services only and joint HACC/ Specialist Disability Services clients, 2013-14

Age groups	DS only clients		DS/HACC clients		HACC only clients		All HACC clients	
	No.	%	No.	%	No.	%	No.	%
18-19	119	5.8	32	4.1	46	1.1	78	1.5
20-24	315	15.2	72	9.2	105	2.4	177	3.4
25-29	194	9.4	59	7.5	122	2.8	181	3.5
30-34	199	9.6	59	7.5	149	3.4	208	4.0
35-39	181	8.7	67	8.5	222	5.1	289	5.6
40-44	209	10.1	100	12.7	346	7.9	446	8.6
45-49	205	9.9	90	11.5	421	9.6	511	9.9
50-54	243	11.7	109	13.9	595	13.5	704	13.6
55-59	232	11.2	117	14.9	942	21.4	1,059	20.5
60-64	173	8.4	80	10.2	1,445	32.9	1,525	29.5
Total	2,070	100.0	785	100.0	4,393	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS and DS NMDS for Tasmania for July 2013-June 2014 inclusive.

Note: When demographic details are available in both datasets, HACC MDS data was used in the first instance.

Table 41 Sex of HACC and Specialist Disability Services clients, 2013-14

Sex	DS only clients		DS/HACC clients		HACC only clients		All HACC clients	
	No.	%	No.	%	No.	%	No.	%
Male	1,172	56.6	386	49.2	1,694	38.6	2,080	40.0
Female	898	43.4	399	50.8	2,699	61.4	3,098	60.0
Total	2,070	100.0	785	100.0	4,393	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS and DS NMDS for Tasmania for July 2013-June 2014 inclusive.

Table 42 Country of birth of HACC and Specialist Disability Services clients, 2013-14

Country of birth	DS only clients		DS/HACC clients		HACC only clients		All HACC clients	
	No.	%	No.	%	No.	%	No.	%
Australia	1,902	91.9	739	94.1	3,829	87.2	4,568	88.2
Other – English speaking	33	1.6	18	2.3	240	5.5	258	5.0
Other – non-English speaking	39	1.9	14	1.8	164	3.7	178	3.4
Not known/missing	96	4.6	14	1.8	160	3.6	174	3.4
Total	2,070	100.0	785	100.0	4,393	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS and DS NMDS for Tasmania for July 2013-June 2014 inclusive.

Table 43 Language spoken at home of HACC and Specialist Disability Services clients, 2013-14

Language spoken at home	DS/HACC clients		HACC only clients		All HACC clients	
	No.	%	No.	%	No.	%
English	770	98.1	4,242	96.6	5,012	96.8
Other language	3	0.4	35	0.8	38	0.7
Not known/missing	12	1.5	116	2.6	128	2.5
Total	785	100.0	4,393	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Note: No corresponding variable for 'DS only users'.

Table 44 Geographic location of HACC and Specialist Disability Services clients, 2013-14 (ABS Statistical Area 4)

Statistical Area 4	DS only clients		DS/HACC clients		HACC only clients		All HACC clients	
	No.	%	No.	%	No.	%	No.	%
Hobart	845	40.8	260	33.1	1,618	36.8	1,878	36.3
Launceston and North East	578	27.9	242	30.8	1,123	25.6	1,365	26.4
South East	99	4.8	37	4.7	381	8.7	418	8.1
West and North West	446	21.6	245	31.2	1,261	28.7	1,506	29.1
Not known/missing	102	4.9	1	0.1	10	0.2	11	0.2
Total	2,070	100.0	785	100.0	4,393	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS and DS NMDS for Tasmania for July 2013-June 2014 inclusive.

Table 45 Geographic location of HACC and Specialist Disability Services clients, 2013-14 (ABS Remoteness Index)

Remoteness Areas	DS only clients		DS/HACC clients		HACC only clients		All HACC clients	
	No.	%	No.	%	No.	%	No.	%
<i>Inner regional</i>	1,508	72.9	522	66.5	2,672	60.8	3,194	61.7
<i>Outer regional</i>	454	21.9	250	31.9	1,584	36.1	1,834	35.4
<i>Remote</i>	4	0.2	10	1.3	111	2.5	121	2.3
<i>Very remote</i>	2	0.1	2	0.3	16	0.4	18	0.4
<i>Not known/missing</i>	102	4.9	1	0.1	10	0.2	11	0.2
Total	2,070	100.0	785	100.0	4,393	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS and DS NMDS for Tasmania for July 2013-June 2014 inclusive.

Table 46 Indigenous status of HACC and Specialist Disability Services clients, 2013-14

Indigenous status	DS only clients		DS/HACC clients		HACC only clients		All HACC clients	
	No.	%	No.	%	No.	%	No.	%
<i>Aboriginal or Torres Strait Islander</i>	55	2.7	23	2.9	94	2.1	117	2.3
<i>Non – Aboriginal or Torres Strait Islander</i>	1,859	89.8	711	90.6	3,960	90.1	4,671	90.2
<i>Not known/missing</i>	156	7.5	51	6.5	339	7.7	390	7.5
Total	2,070	100.0	785	100.0	4,393	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS and DS NMDS for Tasmania for July 2013-June 2014 inclusive.

Table 47 Housing tenure of HACC only and joint HACC/ Specialist Disability Services clients, 2013-14

Housing tenure	DS/HACC clients		HACC only clients		All HACC clients	
	No.	%	No.	%	No.	%
<i>Owner/purchasing</i>	322	41.0	2,198	50.0	2,520	48.7
<i>Private rental</i>	86	11.0	668	15.2	754	14.6
<i>Public rental</i>	152	19.4	776	17.7	928	17.9
<i>Other</i>	152	19.4	215	4.9	367	7.1
<i>Not known/missing</i>	73	9.3	536	12.2	609	11.8
Total	785	100.0	4,393	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Note: No corresponding variable for 'DS only users'.

Table 48 Residential setting of HACC and Specialist Disability Services clients, 2013-14

Residential setting	DS only clients		DS/HACC clients		HACC only clients		All HACC clients	
	No.	%	No.	%	No.	%	No.	%
Private dwelling	1,196	57.8	560 (580)	71.3 (73.9)	3,642	82.9	4,202	81.2
Supported living facility/ supported accommodation facility	719	34.7	114 (164)	14.5 (20.9)	86	2.0	200	3.9
Boarding house	5	0.2	3 (2)	0.4 (0.3)	12	0.3	15	0.3
Other	54	2.6	35 (53)	4.5 (6.8)	117	2.7	152	2.9
Not known/ missing	96	4.6	73 (25)	9.3 (3.2)	536	12.2	609	11.8
Total	2,070	100.0	785 (785)	100.0	4,393	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS and DS NMDS for Tasmania for July 2013-June 2014 inclusive.

Notes: Different categories of residential setting are used in DS NMDS and HACC MDS. Categories have been combined to create comparable information. The number of DS/HACC users differs somewhat between the HACC MDS and the DS NMDS. Hence, both figures are given (DS in brackets).

Table 49 Living arrangements of HACC and Specialist Disability Services clients, 2013-14

Living arrangements	DS only clients		DS/HACC clients		HACC only clients		All HACC clients	
	No.	%	No.	%	No.	%	No.	%
Lives alone	300	14.5	221	28.2	1,521	34.6	1,742	33.6
Lives with family	886	42.8	392	49.9	2,278	51.9	2,670	51.6
Lives with others	788	38.1	147	18.7	314	7.2	461	8.9
Not known/missing	96	4.6	25	3.2	280	6.4	305	5.9
Total	2,070	100.0	785	100.0	4,393	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS and DS NMDS for Tasmania for July 2013-June 2014 inclusive.

Table 50 Presence of carer of HACC and Specialist Disability Services clients, 2013-14

Carer present	DS only clients		DS/HACC clients		HACC only clients		All HACC clients	
	No.	%	No.	%	No.	%	No.	%
Yes	975	47.1	371 (470)	47.3 (59.9)	982	22.4	1353	26.1
No	999	48.3	391 (315)	49.8 (40.1)	3,213	73.1	3604	69.6
Not known	96	4.6	23	2.9	198	4.5	221	4.3
Total	2,070	100.0	785 (785)	100.0 (100.0)	4,393	100.0	5178	100.0

Sources: Extraction of data from HACC MDS and DS NMDS for Tasmania for July 2013-June 2014 inclusive. Notes: The number of DS/HACC users differs somewhat between the HACC MDS and the DS NMDS. Hence, both figures are given (DS in brackets).

Table 51 Pension status of HACC and Specialist Disability Services clients, 2013-14

Pension status	DS only clients		DS/HACC clients		HACC only clients		All HACC clients	
	No.	%	No.	%	No.	%	No.	%
<i>Disability support pension</i>	1,733	83.7	575 (693)	73.3 (88.3)	2,245	51.1	2,820	54.5
<i>Other pension or benefit</i>	50	2.4	27 (20)	3.4 (2.6)	593	13.5	620	12.0
<i>No pension or benefit</i>	189	9.2	18 (189)	2.3 (24.0)	312	7.1	330	6.4
<i>Not known/missing</i>	98	4.7	165 (25)	21.0 (3.2)	1,243	28.3	1,408	27.2
Total	2,070	100.0	785 (785)	100.0 (100.0)	4,393	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS and DS NMDS for Tasmania for July 2013-June 2014 inclusive.

Notes: Different categories of pension status are used in DS NMDS and HACC MDS. Categories have been combined to create comparable information. The number of DS/HACC users differs somewhat between the HACC MDS and the DS NMDS. Hence, both figures are given (DS in brackets).

4.5.2 Joint HACC and Specialist Disability Services clients

Using the Specialist Disability Services data to profile the HACC clients who use Specialist Disability Services, the analysis focused on three aspects: primary disability group, support needs and individual funding status. The results showed that a higher proportion of joint HACC and Specialist Disability Services clients had Physical disability (19.9 per cent) as compared to Specialist Disability Services only clients (9.5 per cent). The main support needs (Table 54) of joint HACC and Specialist Disability Services clients were in the life areas domestic life (92.1 per cent) and working (88.0 per cent). A higher proportion of joint HACC and Specialist Disability Services clients receive individualised funding (Table 55).

Table 52 Primary disability group of joint Specialist Disability Services/HACC and Specialist Disability Services only clients, 2013-14

Disability group	DS only clients		DS/HACC clients		All DS clients	
	No.	%	No.	%	No.	%
<i>Intellectual (including Down syndrome)</i>	1,117	54.0	325	41.4	1,442	50.5
<i>Specific learning/Attention Deficit Disorder (other than Intellectual)</i>	27	1.3	4	0.5	31	1.1
<i>Autism (including Asperger's syndrome and Pervasive Developmental Delay)</i>	135	6.5	36	4.6	171	6.0
<i>Physical</i>	197	9.5	156	19.9	353	12.4
<i>Acquired brain injury</i>	242	11.7	106	13.5	348	12.2
<i>Neurological (including epilepsy and Alzheimer's disease)</i>	219	10.6	108	13.8	327	11.5
<i>Deafblind (dual sensory)</i>	1	0.1	1	0.1	2	0.1
<i>Vision</i>	7	0.3	12	1.5	19	0.7
<i>Hearing</i>	4	0.2	4	0.5	8	0.3
<i>Speech</i>	0	0.0	1	0.1	1	0.0
<i>Psychiatric</i>	25	1.2	7	0.9	32	1.1
<i>Developmental delay</i>	0	0.0	0	0.0	0	0.0
<i>Not known/missing</i>	96	4.6	25	3.18	121	4.2
Total	2,070	100.0	785	100.0	2,855	100.0

Source: Extraction of data from DS NMDS for Tasmania for July 2013-June 2014 inclusive.

Table 53 Other significant disability groups of joint Specialist Disability Services/HACC and Specialist Disability Services only clients, 2013-14

Disability group	DS only clients		DS/HACC clients		All DS clients	
	No.	%	No.	%	No.	%
<i>Intellectual (including Down syndrome)</i>	187	9.0	95	12.1	282	9.9
<i>Specific learning/Attention Deficit Disorder (other than Intellectual)</i>	66	3.2	12	1.5	78	2.7
<i>Autism (including Asperger's syndrome and Pervasive Developmental Delay)</i>	149	7.2	39	5.0	188	6.6
<i>Physical</i>	355	17.2	192	24.5	547	19.2
<i>Acquired brain injury</i>	35	1.7	15	1.9	50	1.8
<i>Neurological (including epilepsy and Alzheimer's disease)</i>	245	11.8	117	14.9	362	12.7
<i>Deafblind (dual sensory)</i>	8	0.4	5	0.6	13	0.5
<i>Vision</i>	117	5.7	54	6.9	171	6.0
<i>Hearing</i>	68	3.29	22	2.8	90	3.2
<i>Speech</i>	336	16.2	128	16.3	464	16.3
<i>Psychiatric</i>	200	9.7	67	8.5	267	9.4
<i>Developmental delay</i>	0	0.0	0	0.0	0	0.0
Total	2,070	100.0	785	100.0	2,855	100.0

Source: Extraction of data from DS NMDS for Tasmania for July 2013-June 2014 inclusive.

Note: Multiple options may be chosen for co-existing disability group(s) hence percentages do not add up to 100.

Table 54 Support needs of joint Specialist Disability Services/HACC clients, 2013-14

Life area	Always needs help		Sometimes needs help		Uses aids or equipment		Doesn't need help		Not applicable		Missing		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Self-care</i>	230	29.3	343	43.7	43	5.5	144	18.3	0	0.0	25	3.2	785	100.0
<i>Mobility</i>	194	24.7	296	37.7	82	10.5	188	24.0	0	0.0	25	3.2	785	100.0
<i>Communication</i>	129	16.4	300	38.2	29	3.7	302	38.5	0	0.0	25	3.2	785	100.0
<i>Interpersonal interactions</i>	154	19.6	368	46.9	29	3.7	209	26.6	0	0.0	25	3.2	785	100.0
<i>Learning</i>	189	24.1	393	50.1	33	4.2	145	18.5	0	0.0	25	3.2	785	100.0
<i>Education</i>	248	31.6	319	40.6	35	4.5	158	20.1	0	0.0	25	3.2	785	100.0
<i>Community (civic) and economic life</i>	235	29.9	356	45.4	42	5.4	127	16.2	0	0.0	25	3.2	785	100.0
<i>Domestic life</i>	317	40.4	390	49.7	16	2.0	37	4.7	0	0.0	25	3.2	785	100.0
<i>Working</i>	442	56.3	230	29.3	19	2.4	69	8.8	0	0.0	25	3.2	785	100.0

Source: Extraction of data from DS NMDS for Tasmania for July 2013-June 2014 inclusive.

Note: Based on a total of 785 DS/HACC users

Table 55 Individual funding status of joint Specialist Disability Services/HACC and Specialist Disability Services only clients, 2013-14

Receiving individualised funding	DS only clients		DS/HACC clients		All DS clients	
	No.	%	No.	%	No.	%
Yes	654	31.6	348	44.3	1,002	35.1
No	1,311	63.3	407	51.9	1,718	60.2
Not known/missing	105	5.1	30	3.8	135	4.7
Total	2,070	100.0	785	100.0	2,855	100.0

Source: Extraction of data from DS NMDS for Tasmania for July 2013-June 2014 inclusive.

4.5.3 Comparing joint HACC/DS and HACC only clients

In this section comparisons are made between the HACC clients who use Specialist Disability Services and those clients who do not. The comparisons focus on three aspects:

1. source of referral
2. service type used
3. length of time as a HACC client.

The two sub-groups seem to differ with regards to the most prevalent referral source. Palliative care and Specialist disability service were most used by Specialist Disability Service users, while self and Psychiatric/mental health service or facility referral sources were most used by HACC only clients (Table 56).

The HACC clients that use Specialist Disability Services seem to differ from other HACC users in the types of services they use, with more clients using personal care, centre-based day care, respite care, and transport as compared to HACC only clients (Table 57). There is also a noticeable difference in the proportion of clients who use HACC services for less than one year, 25.9 per cent of HACC only clients have been a HACC client for less than one year, while comparatively 13.1 per cent of HACC clients who use Specialist Disability Services have used HACC services for less than one year (Table 58).

Table 56 Source of referral of joint Specialist Disability Services/HACC and HACC only clients, 2013-14

Source	HACC only clients			DS/HACC clients			All HACC clients		
	No.	% of HACC only clients	% of all HACC only referrals	No.	% of DS/HACC clients	% of all DS/HACC referrals	No.	% of DS/HACC clients	% of all HACC referrals
<i>Self</i>	1,041	23.7	18.6	141	18.0	11.8	1,182	22.8	17.4
<i>Family, friend or neighbour</i>	396	9.0	7.1	141	18.0	11.8	537	10.4	7.9
<i>GP or other medical practitioner</i>	611	13.9	10.9	109	13.9	9.1	720	13.9	10.6
<i>Public or private hospital</i>	324	7.4	5.8	80	10.2	6.7	404	7.8	6.0
<i>Psychiatric/mental health service or facility</i>	978	22.3	17.5	84	10.7	7.0	1,062	20.5	15.6
<i>Community nursing</i>	30	0.7	0.5	8	1.0	0.7	38	0.7	0.6
<i>Other health/medical service or facility</i>	214	4.9	3.8	21	2.7	1.8	235	4.5	3.5
<i>Palliative care facility or hospice</i>	817	18.6	14.6	290	36.9	24.2	1,107	21.4	16.3
<i>Disability service</i>	658	15.0	11.8	210	26.8	17.5	868	16.8	12.8
<i>Other HACC service</i>	223	5.1	4.0	46	5.9	3.8	269	5.2	4.0
<i>Not known/missing</i>	299	6.8	5.3	67	8.5	5.6	366	7.1	5.4
<i>Total number of referrals</i>	5,591	-	100.0	1,197	-	100.0	6,788	-	100.0
Total number of clients	4,393	100.0	-	785	100.0	-	5,178	-	-

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Note: Referral data is collected by service episode and is converted in this table to referrals per client. Of the 4393 clients in the HACC only users sample, 299 (6.8%) have no source of referral data; 3183 (72.5%) have one source of referral noted; and 911 (20.7%) have 2 or more sources noted. Of the 785 clients in the DS/HACC users sample, 67 (8.5%) have no source of referral data; 435 (55.4%) have one source of referral noted; and 283 (36.1%) have 2 or more sources noted. Clients are counted once only for each source of referral. Numbers exceed 100% as some clients are referred from more than one source. HACC User Guide codes showing 0 were 16, 17, 18, 19, 20, 21, 22, 23, and 98.

Table 57 Service types used for joint Specialist Disability Services/HACC and HACC only clients, 2013-14

Service type	HACC only clients		DS/HACC clients		All HACC clients	
	No.	%	No.	%	No.	%
<i>Domestic assistance</i>	1364	31.0	187	23.8	1,551	30.0
<i>Social support</i>	472	10.7	114	14.5	586	11.3
<i>Nursing care received at home or at centre</i>	989	22.5	159	20.3	1,148	22.2
<i>Allied health care received at home or at centre</i>	632	14.4	124	15.8	756	14.6
<i>Personal care</i>	452	10.3	168	21.4	620	12.0
<i>Centre-based day care</i>	218	5.0	98	12.5	316	6.1
<i>Other food service</i>	1	0.0	0	0.0	1	0.0
<i>Respite care</i>	97	2.2	103	13.1	200	3.9
<i>Assessment including screening (client)</i>	1,874	42.7	350	44.6	2,224	43.0
<i>Case management</i>	396	9.0	90	11.5	486	9.4
<i>Client care coordination</i>	1,342	30.5	349	44.5	1,691	32.7
<i>Home maintenance</i>	493	11.2	88	11.2	581	11.2
<i>Counselling/support, information and advocacy</i>	318	7.2	60	7.6	378	7.3
<i>Home modification</i>	14	0.3	3	0.4	17	0.3
<i>Meals received at home or at centre</i>	385	8.8	116	14.8	501	9.7
<i>Formal linen services</i>	6	0.1	4	0.5	10	0.2
<i>Transport</i>	984	22.4	291	37.1	1,275	24.6
<i>Equipment</i>	0	0.0	0	0.0	0	0.0
<i>Total clients</i>	4,393	100.0	785	100.0	5,178	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Note: Many clients use more than one service type hence percentages do not add up to 100.0.

Table 58 Length of time since commencing as a HACC client of joint Specialist Disability Services/HACC and HACC only clients, 2013-14

	HACC only users		DS/HACC users		All	
	No.	%	No.	%	No.	%
<i>Up to one month (0-31 days)</i>	443	10.1	44	5.6	487	9.4
<i>Up to 3 months (32-93 days)</i>	346	7.9	21	2.7	367	7.1
<i>Up to 6 months (94-182 days)</i>	345	7.9	38	4.8	383	7.4
<i>Up to 1 year (183-365 days)</i>	706	16.1	90	11.5	796	15.4
<i>Up to 2 years (366-730 days)</i>	520	11.8	106	13.5	626	12.1
<i>Up to 5 years (731-1826 days)</i>	861	19.6	193	24.6	1,054	20.4
<i>Up to 10 years (1827-3652 days)</i>	344	7.8	142	18.1	486	9.4
<i>More than 10 years (3653+ days)</i>	84	1.9	60	7.6	144	2.8
<i>Total with data</i>	3,649	83.1	694	88.4	4,343	83.9
<i>Missing data</i>	744	16.9	91	11.6	835	16.1
<i>Total all HACC clients aged 18-64</i>	4,393	100.0	785	100.0	5,178	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

4.6 HEALTH CONDITIONS

It is important to determine the scope of health conditions that HACC clients may have, and which disabling health conditions are disabling outside of NDIS but will still require basic community care services from the HACC Program. More specifically, it is important to determine what proportion of HACC clients will be people with short-term health conditions requiring assistance to live independently prior to or subsequent to an episode of hospitalisation, or until their condition improves?

The sub-groups of clients may be:

- people requiring palliative care in the community
- people requiring post-acute care in the community
- people with chronic health conditions that may not meet the eligibility requirements of the NDIS who may require short or long-term support to remain at home
- people who require episodic care related to a specific or ongoing health condition (Tasmania DHHS 2013: 8).

In this section, profiling the HACC clients' health conditions is based on three secondary data sources: Hospital Admissions, Emergency Department, and Community Nursing 2013-14. Only HACC clients who accessed these health services, which ranged between 19.4 and 57.0 per cent of clients, are presented in the tables below. The *International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM)* was used to classify the presenting health conditions of the

Hospital Admissions and Emergency Department and where possible the Community Nursing data into 20 groups. ICD-10-AM is a derived version of the World Health Organization (WHO) ICD-10. The results show that the four most common diseases initiating an admission to hospital (Table 59) or an emergency department (Table 60) visit by the HACC client group (2013-14) are:

1. Injuries, poisons and other external causes
2. Diseases of the digestive system
3. Factors influencing health status and contact with health services not reported
4. Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified.

43.1 per cent of the HACC clients using community nursing services are referred because they require wound management or they have cancer (Neoplasms) (Table 61). On average during the 2013-14 period, the proportion of HACC clients' that use hospital admissions, emergency department, or nursing services for mental health issues ranged between 4.6 and 6.5 per cent.

Table 59 Principal diagnosis classified by ICD-10-AM, HACC clients 2013-14 who were admitted into hospital

Principal diagnosis	No.	%
<i>Z00-Z99 Factors influencing health status and contact with health services Not reported</i>	362	12.8
<i>S00-T98 Injury, poisoning and certain other consequences of external causes</i>	321	11.4
<i>K00-K93 Diseases of the digestive system</i>	272	9.6
<i>R00-R99 Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified</i>	269	9.5
<i>C00-D48 Neoplasms</i>	229	8.1
<i>M00-M99 Diseases of the musculoskeletal system and connective tissue</i>	192	6.8
<i>I00-I99 Diseases of the circulatory system</i>	163	5.8
<i>L00-L99 Diseases of the skin and subcutaneous tissue</i>	163	5.8
<i>J00-J99 Diseases of the respiratory system</i>	157	5.6
<i>N00-N99 Diseases of the genitourinary system</i>	144	5.1
<i>F00-F99 Mental and behaviour disorders</i>	130	4.6
<i>G00-G99 Disease of the nervous system</i>	123	4.4
<i>E00-E89 Endocrine, nutritional and metabolic diseases</i>	95	3.4
<i>A00-B99 Certain infectious and parasitic diseases</i>	81	2.9
<i>D50-D89 Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism</i>	49	1.7
<i>H00-H59 Diseases of the eye and adnexa</i>	31	1.1
<i>O00-O99 Pregnancy, childbirth and the puerperium</i>	30	1.1
<i>H60-H99 Diseases of the ear and mastoid process</i>	7	0.2
<i>Q00-Q99 Congenital malformations, deformations and chromosomal abnormalities</i>	5	0.2
Total	2,823	100.0

Source: Extraction of data from Hospital Admissions for Tasmania for July 2013-June 2014 inclusive.

Table 60 Principal diagnosis classified by ICD-10-AM, HACC clients 2013-14 who used Emergency Department services

Principal diagnosis	No.	%
<i>S00-T98 Injury, poisoning and certain other consequences of external causes</i>	495	16.8
<i>R00-R99 Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified</i>	460	15.6
<i>Z00-Z99 Factors influencing health status and contact with health services Not reported</i>	271	9.2
<i>K00-K93 Diseases of the digestive system</i>	222	7.5
<i>L00-L99 Diseases of the skin and subcutaneous tissue</i>	194	6.6
<i>A00-B99 Certain infectious and parasitic diseases</i>	189	6.4
<i>J00-J99 Diseases of the respiratory system</i>	186	6.3
<i>I00-I99 Diseases of the circulatory system</i>	171	5.8
<i>F00-F99 Mental and behaviour disorders</i>	167	5.7
<i>M00-M99 Diseases of the musculoskeletal system and connective tissue</i>	158	5.3
<i>G00-G99 Disease of the nervous system</i>	123	4.2
<i>N00-N99 Diseases of the genitourinary system</i>	122	4.1
<i>C00-D48 Neoplasms</i>	70	2.4
<i>E00-E89 Endocrine, nutritional and metabolic diseases</i>	62	2.1
<i>D50-D89 Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism</i>	27	0.9
<i>H00-H59 Diseases of the eye and adnexa</i>	17	0.6
<i>H60-H99 Diseases of the ear and mastoid process</i>	9	0.3
<i>O00-O99 Pregnancy, childbirth and the puerperium</i>	9	0.3
<i>Total</i>	2,952	100.0

Source: Extraction of data from Emergency Department Presentations for Tasmania for July 2013-June 2014 inclusive.

Table 61 Referral diagnosis, HACC clients 2013-14 who used Community nursing

Referral diagnosis	No.	%
Wound management & burns	285	28.4
C00-D48 Neoplasms	148	14.7
Amputation	85	8.5
F00-F99 Mental and behaviour disorders	65	6.5
Post op orthopaedic & non-orthopaedic	62	6.2
Physical disability/disabling impairment	57	5.7
E00-E89 Endocrine, nutritional and metabolic diseases	56	5.6
I00-I99 Diseases of the circulatory system	48	4.8
M00-M99 Diseases of the musculoskeletal system and connective tissue	42	4.2
G00-G99 Disease of the nervous system	35	3.5
Pain (extremity, back, neck etc)	34	3.4
S00-T98 Injury, poisoning and certain other consequences of external causes	25	2.5
Incontinence urinary or faecal	20	2.0
N00-N99 Diseases of the genitourinary system	11	1.1
Missing/not specified	8	0.8
No impairment	6	0.6
J00-J99 Diseases of the respiratory system	5	0.5
Diagnosis unclear	4	0.4
Remote isolated	4	0.4
Q00-Q99 Congenital malformations, deformations and chromosomal abnormalities	3	0.3
D50-D89 Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism	1	0.1
Financially disadvantaged	1	0.1
Total	1,005	100.0

Source: Extraction of data from Community Nursing for Tasmania for July 2013-June 2014 inclusive.

4.7 USE OF HEALTH SERVICES

In this section, the usage of health services by HACC clients during the 2013-14 period is reviewed using the following secondary data sources:

- Hospital Admissions
- Emergency Department
- Community Nursing
- Outpatients.

Table 62 shows that 31.1 to 45.0 per cent of HACC clients used services from the hospital. A lower proportion of clients use community nursing services (17.6 per cent), however, these figures do not include nursing services offered by non-government organisations. More than half (56.6 per cent) of all Tasmanian HACC clients have accessed at least one health service from these four sources over the 2013-14 period (Table 63). Table 64 shows how often HACC clients use the services from each of the four sources. As would be expected more than half of the HACC clients used community nursing (81.6 per cent) and other hospital based health (59.6 per cent) services more than four times in the 2013-14 period.

Table 62 HACC client 2013-14 access of each of the four health services

Health Service	No.	Mean	Min.	Max.
Frequency of hospital admissions	1,648	4.7	1	159
Frequency of emergency department	1,612	2.7	1	65
Frequency of community nursing	910	34.3	1	730
Frequency of outpatients	2,329	11.0	1	179
Frequency of community mental health	-	-	-	-

Source: Extraction of data from Hospital Admissions; Emergency Department Presentations; Community Nursing; and Non-admitted Patient Service Events for Tasmania for July 2013-June 2014 inclusive.

Table 63 HACC client 2013-14 access of at least one of the four health services

Client access of at least one of the four health services	No.	%
Did not access health services	2,245	43.4
Accessed at least 1 of the 4 health services	2,933	56.6
Total	5,178	100.0

Source: Extraction of data from Hospital Admissions; Emergency Department Presentations; Community Nursing; and Non-admitted Patient Service Events for Tasmania for July 2013-June 2014 inclusive.

Note: It is estimated that the proportion of clients not accessing health services does not take into account the 8.4 per cent of HACC clients that use nursing services from Non-government organisations.

Table 64 Frequency of use of health services by HACC clients 2013-14 by HACC client hospital admissions

Frequency of health service usage	Hospital admissions		Emergency department treatments		Community nursing		Other hospital based health services	
	No.	%	No.	%	No.	%	No.	%
0	3,530	68.2	3,566	68.9	4,268	82.4	2,849	55.0
1	711	13.7	734	14.2	70	1.4	419	8.1
2 to 3	536	10.4	528	10.2	97	1.9	522	10.1
4 or more	401	7.7	350	6.8	743	14.3	1388	26.8
Total	5,178	100.0	5,178	100.0	5,178	100.0	5,178	100.0

Source: Extraction of data from Hospital Admissions; Emergency Department Presentations; Community Nursing; and Non-admitted Patient Service Events for Tasmania for July 2013-June 2014 inclusive.

Note: It is estimated that 8.4 per cent of HACC clients use nursing services from Non-government organisations which is not reflected in the community nursing data which only pertains to THOs.

5 CLIENT PROFILE: SUB-GROUP ANALYSIS

FACTS UP FRONT

This chapter investigates ‘*Why clients currently need and use HACC services?*’ and highlights eight sub-groups that contribute to the understanding of the profile of HACC clients.

HACC clients aged 18-44

Results seem to suggest that as people age, they seem to need HACC services more, however, little is known about clients aged 18-44 years. For instance, would a high proportion of this group use specialist disability services?

- 26.6 per cent of HACC clients are aged 18-44 years (1,379)
- 28.2 per cent of this group use Specialist Disability Services

Clients living alone

The results so far have shown that the proportion of HACC clients living alone is three times higher than in the Tasmanian population. While living alone does not necessarily equate to social isolation or absence of family support, the finding does suggest that this group should be explored further. For instance, what services do they use and are they older (above age 50)?

- 33.6 per cent of HACC clients live alone (1,684)
- 72.9 per cent of HACC clients living alone are above the age of 50 (10 percentage points higher than the HACC population)
- HACC clients living alone are more likely to use domestic assistance, social support, and home maintenance and less likely to use nursing care and allied health care

Long-term clients (more than 2 years)

Long-term usage of HACC services provides important evidence of the circumstances leading to the use of HACC services. For instance, does a high proportion of this group use specialist disability services and have core activity limitations?

- 32.5 per cent of HACC clients could be classified as long-term (1,684)
- 40.2 per cent have a profound or severe activity limitation (23 percentage points higher than short-term users)
- 23.5 per cent use specialised disability services (14 percentage points higher than short-term users)

Short-term clients (up to 6 months, non-continuing)

Short-term use of HACC services provides important evidence of the circumstances leading to the use of HACC services. A person who uses HACC services for a short time period of six months or less is most likely to have a condition that is non-permanent involving time-limited activity limitations. For instance, would this group comprise a high proportion of hospital or emergency admissions and no activity limitations?

- 10.3 per cent of HACC clients are short-term (532)
- Short-term clients have a younger profile relative to the HACC client group, and 59.7 per cent of short-term users are referred by a psychiatric/mental health service or facility
- 11.5 per cent have no activity limitations (5 percentage points higher than long-term users)
- 60.3 per cent had at least one hospital admission during the 2013-14 period (32 percentage points higher than long-term users)
- 47.5 per cent of the HACC services used by short-term clients is for nursing care (38 percentage points higher than the HACC client group)

Clients with at least one hospital admission recorded

HACC's role in managing chronic illness and reducing demand on expensive hospital services needs to be explored. The findings should be complemented with the survey findings, which addresses some of the gaps.

- 31.8 per cent of HACC clients had at least one hospital admission recorded (1,648)
- The proportion of short-term clients using hospital admissions is double that of long-term clients who have had admissions in the same time period

Clients referred by mental health services

There has been increasing emphasis at national and state levels on the importance of community support and care in enabling people with acute and chronic mental health issues to live in the community. The HACC program needs to explore what proportion of HACC clients are people who have mental health issues requiring assistance (long or short term, episodic or continuous) to live independently at times of ill-health?

- 20.5 per cent of clients are referred by mental health services (1,062)
- 39.1 per cent have a profound or severe core activity limitation
- 42.4 per cent have been a client 6 months or less
- HACC clients who have been referred by a mental health service are more likely to use services like nursing care, personal care and case management as compared to other HACC clients

Clients referred from palliative care services

Community palliative care was identified as one of six primary health care activities that can be strengthened to keep people out of hospitals. A key question in this research is to determine what proportion of HACC clients are people requiring palliative care and what are the characteristics of this sub-group?

- 21.4 per cent of clients are referred from palliative care services (1,107)
- These clients are likely to be older, use disability services, have profound or severe core activity limitations, and be a client for longer than two years as compared to the HACC client group

Clients with profound or severe core activity limitation

The relationship between the HACC Program and the specialist disability services sector is one of the key factors impacting on future demand for the HACC Program and on the profile of current and future HACC clients. It is therefore important to determine the prevalence of HACC clients who have profound or severe core activity limitations and what proportion of these clients use specialist disability services? Further, it is important to understand which HACC services they currently use.

- 31.7 per cent of clients have profound or severe core activity limitations (1,644)
- 23.3 per cent use specialised disability services
- These clients are more likely to be older, be referred by a mental health service, palliative care service or, specialist disability service and be a long-term (longer than 2 years) client as compared to other HACC clients
- These clients are more likely to use domestic assistance, allied health, personal care, social support, centre based day care, and respite as compared to other HACC clients

This chapter investigates the broad underlying research question '*Why do clients currently need and use HACC services?*' In order to comprehensively answer this question, a number of aspects of clients' experiences, circumstances and personal characteristics need to be considered. Previous sections of this report have highlighted eight sub-groups that contribute to understanding the profile of HACC clients and warrant further investigation:

1. HACC clients aged 18-44
2. Clients living alone
3. Long-term clients (more than 2 years)
4. Short-term clients (Up to 6 months, non-continuing)
5. Clients with at least one hospital admission recorded
6. Clients referred by mental health services
7. Clients referred from palliative care services
8. Clients with profound or severe core activity limitation

These sub-groups are described in Table 65 and discussed in more detail in the subsequent sections.

Six client characteristics are compared across the eight sub-groups:

1. age
2. pathways into HACC
3. length of time as a client
4. use of Specialist Disability Services
5. severe disability
6. service type used (Table 66 to Table 71).

We use a series of interlinked statistical tables to explore trends relating to these client characteristics.

The characteristics of HACC clients under the age of 18 were out of scope for the purpose of this study; however we provide a brief summary at the end of this chapter, for completeness.

Table 65 Sub-groups of HACC clients

Sub-group	Operational definition	Number of clients	% of all HACC clients (5,178)	Reasons for interest
<i>HACC clients aged 18-44</i>	<i>Table 7</i>	<i>1,379</i>	<i>26.6</i>	<i>Does a high proportion of this group use specialist disability services?</i>
<i>Clients living alone</i>	<i>Table 17</i>	<i>1,742</i>	<i>33.6</i>	<i>What services do they use? Are they older (above age 50)?</i>
<i>Long-term clients (more than 2 years)</i>	<i>Table 30</i>	<i>1,684</i>	<i>32.5</i>	<i>Does a high proportion of this group use specialist disability services and have core activity limitations?</i>
<i>Short-term clients (Up to 6 months, non-continuing)</i>	<i>Table 30</i>	<i>532</i>	<i>10.3</i>	<i>Does this group comprise a high proportion of hospital or emergency admissions and no activity limitations?</i>
<i>Clients with at least one hospital admission recorded</i>	<i>Table 62</i>	<i>1,648</i>	<i>31.8</i>	<i>Are these clients' short-term users?</i>
<i>Clients referred by mental health services</i>	<i>Table 20</i>	<i>1,062</i>	<i>20.5</i>	<i>What are the characteristics of these clients and their specific needs? Does this group have a higher proportion of clients with no activity limitations?</i>
<i>Clients referred from palliative care services</i>	<i>Table 20</i>	<i>1,107</i>	<i>21.4</i>	<i>Are these short-term HACC users?</i>
<i>Clients with profound or severe core activity limitation</i>	<i>Table 26</i>	<i>1,644</i>	<i>31.7</i>	<i>Does this group comprise a high proportion of clients using specialist disability services? Which services do they use most?</i>

5.1 HACC CLIENTS AGED 18-44

The results in earlier sections have shown (Table 7) that clients aged 18-44 comprise a quarter of the HACC client group. The results seem to suggest as people age they tend to need the HACC services more (rising from 0.6 per cent 18-29 to 4.7 per cent for the 60-64 age group), however, we do not know a great deal about the group aged 18-44.

The findings from this sub-group support the premise that as people age they are more likely to use HACC services (50 per cent of this sub-group are aged 35-44, Table 66). While we anticipated that a large proportion of these clients would have lifelong disabilities, the figures were not as high as one might have anticipated, with only 28.2 per cent of this group using Specialist Disability Services as compared to 15.2 per cent of the HACC client group (Table 67).

Interesting to note is that a higher proportion of these clients are referred from palliative care facilities or hospices (21.3 per cent), which is five percentage points higher than the HACC client group (Table 70). There were no notable differences found for the length of time as a clients for this sub-group when compared to the HACC client group (Table 69).

Younger clients are less likely (by 4 percentage points) to have a profound or severe core activity limitation (Table 68). The results show (Table 71) that a higher proportion (4.2 per cent) of younger HACC clients (aged 18-44) use respite as compared to the other sub-groups and the HACC client group (1.6 per cent).

Further, younger clients use transport services more and domestic assistance less when compared with the HACC client group.

5.2 HACC CLIENTS LIVING ALONE

The findings have indicated that living alone is a factor associated with the use of HACC services. The proportion of HACC clients living alone is more than three times higher than for those living alone in the Tasmanian population (Table 17).

Living alone does not necessarily equate to social isolation or absence of family support, but this finding suggests that these may be factors resulting in the use of HACC services. We would also expect people with disabilities residing in private dwellings to be more likely to live alone as compared to those without disabilities and older clients to be living alone as compared to younger clients. It is important to examine this group more closely to unpack some of these propositions and determine the service needs of this sub-group.

The results show that clients living alone are more likely to be above the age of 45 and these results were 10 percentage points higher than the HACC client group (Table 66). HACC clients living alone, seem less likely to be clients of disability services, have profound or severe core activity limitations, and more likely to be a client for longer than 2 years as compared to the HACC client group more broadly (Table 69 to Table 68). They are also less likely to be referred to the HACC Program by family, friend or a neighbour or a Psychiatric/mental health service and more likely to refer themselves to the program. The service use of HACC clients living alone differs from the HACC client group, in that they are more likely to use domestic assistance, social support, and home maintenance and less likely to use nursing care and allied health care (Table 70 and Table 71).

5.3 LONG-TERM HACC CLIENTS (MORE THAN TWO YEARS)

Long-term usage of HACC services provides important evidence of the circumstances leading to the use of HACC services. A person using HACC services over a period of several years can be considered likely to have core activity limitations that provide a permanent impediment to independent living. While there are many factors that might blur this distinction including service provider review practices, it can be hypothesised that long-term HACC clients would have:

- a higher proportion of younger clients (45 years of age or younger)
- a higher level of core activity limitations (disability) than clients using HACC for short periods of time
- Disability Services
- been referred from a disability service.
- more serious health conditions that are permanent in nature.

Table 30 shows that 32.5 per cent of HACC clients in 2013-14 had been HACC clients for more than two years (inclusive of missing data).

Reviewing the personal characteristics of long-term users shows no significant differences between the age profiles of the long-term users compared to the HACC client group (Table 66) which indicates that there is no support for the claim that long-term clients would be younger (below 45 years).

The use of Specialist Disability Services and the level of profound or severe core activity limitations is higher (8 percentage points for each) than the HACC client group (Table 67 and Table 68) which support the hypothesis that this client group would have a higher proportion of core activity limitations and use specialised disability services as compared to short-term clients.

Similarly, reviewing the referral pathways, long-term users were found to be more likely to be referred by Specialist Disability Services, or palliative care facility or hospice (Table 70) as compared to short-term clients. Long-term users of HACC services were also found to be more likely to use the following services as compared to other HACC clients:

- domestic assistance
- transport

- personal care
- social support
- meals
- centre based day care
- respite (Table 71).

The statistical evidence was not sufficient to support or disprove the hypothesis regarding health conditions and so subsequent data was collected through the HACC Client Survey (see Table 84).

5.4 SHORT-TERM HACC CLIENTS

Short-term use of HACC services provides important evidence of the circumstances leading to the use of HACC services. A person who uses HACC services for a short time period of six months or less is most likely to have a condition that is non-permanent involving time-limited activity limitations. While there are many factors that might blur this distinction, it can be hypothesised that short-term HACC clients would:

- have an older age profile than other HACC clients because the injuries and illnesses giving rise to activity limitations are positively correlated with older age
- be characterised by high levels of activity limitation for domestic tasks (shopping, housekeeping) and to have lower levels of core activity limitations than other HACC clients, especially long-term clients
- be less likely to be users of Specialist Disability Services and less likely to become clients of the NDIS
- use hospital or medical services prior to or during the period of time that they were using HACC services
- be more likely to be referred from GPs, hospitals or other parts of the health services relative to other HACC clients.

For the analyses for short-term, we only included those clients who were defined as short-term (six months or less) and who were not at that point in time continuing.

Table 30 shows that 10.3 per cent of HACC clients in 2013-14 had been HACC clients for six months or less (inclusive of missing data). Contrary to what was hypothesised, short-term clients have a younger profile relative to the HACC client group. This sub-group has a higher proportion of clients in their 20's and between the ages of 35-39 (Table 66).

As hypothesised, the use of Specialist Disability Services and the level of profound or severe core activity limitations is lower (6 and 15 percentage points respectively) than the HACC client group and the proportion of clients with no activity limitation (11.5 per cent) is higher (Table 67 and Table 68).

Reviewing the referral pathways, 59.7 per cent of short-term users are referred by a psychiatric/mental health service or facility, which is 44 percentage points higher than the HACC client group. As expected, this sub-group were also less likely to be referred by a palliative care facility or hospice and disability service (Table 70).

As hypothesised, a high proportion of short-term clients have had at least one hospital admission during the 2013-14 period (Table 72). This was 32 percentage points higher than long-term users. Almost half (47.5 per cent) of the HACC services used by short-term clients is for nursing care, which is 38 percentage points higher than the HACC client group.

The use of case management is also noticeably higher than the HACC client group (Table 71).

5.5 HACC CLIENTS WHO WERE HOSPITAL INPATIENTS DURING 2013-14

As discussed earlier, the role the HACC Program will play in the management of chronic illness in the community and in reducing demand on expensive hospital services may be something that the program will

explore further. The evidence gathered for this section is aimed at assisting the HACC Program in its future decisions.

While the administrative data provides some insight into the profile characteristics of this group and use of services, to determine the extent to which HACC services are supporting individuals' pre and post hospital admissions will rely on the collection of new data from the clients through the survey. Using the Hospital admissions data linked with the HACC MDS data we determined that 31.8 per cent of the HACC client group have had at least one hospital admission in the financial year 2013-14 (Table 65) and that these clients are more likely to be short-term users of HACC services (Table 69).

The proportion of short-term clients using hospital admissions is double that of long-term clients who have had admissions in the same time period (Table 72). Examining the total hospital admissions made by the HACC clients in the 2013-14 period, 53.1 per cent have been HACC clients six months or longer (Table 72). Examining the age distribution of clients admitted to hospital compared to the HACC client group, we notice no significant differences (Table 66).

Table 67 shows that this group is less likely to use Specialist Disability Services than other HACC clients, however there are no differences between clients who are admitted to hospital and other HACC clients (Table 68).

Reviewing the referral pathways, clients admitted to hospital are more likely to be referred by a psychiatric/mental health service or facility and to some extent more public and private hospitals (Table 70).

HACC clients who have had a hospital admission are more likely to use nursing care as compared to other HACC clients (Table 71). It should be noted, that it is only through the HACC Client Survey, discussed in subsequent chapters, that we are able to isolate the services they use due to the hospitalisation.

5.6 HACC CLIENTS WHO USED COMMUNITY MENTAL HEALTH SERVICES

There has been increasing emphasis at national and state levels on the importance of community support and care in enabling people with acute and chronic mental health issues to live in the community (e.g., Tasmania DHHS 2009). This has included a strong emphasis on the need to support the carers of people with mental illness.

Generally speaking, people needing mental health services often need episodic rather than continuous care and HACC plays an important role in providing relatively short-term assistance to persons at times of personal stress and high need. A key question for the HACC Program is therefore

'What proportion of HACC clients are people who have mental health issues requiring assistance (long or short term, episodic or continuous) to live independently at times of ill-health?'

Examining the referral pathways into HACC revealed an unexpectedly high proportion of clients (20.5 per cent) who have been referred by mental health services (Table 20). This could indicate a future significant role of HACC may be in providing relatively short-term assistance to persons at times of personal stress and high need.

Important questions that the program may need answered are:

- 'What the estimated impact of the changes in mental health services will be on the need and demand for HACC services?'
- 'What are the personal characteristics and service needs of the clients within the HACC Program who have been referred by mental health services?'

Reviewing the personal characteristics of HACC clients referred via mental health services, shows a similar age profile to the HACC client group (Table 66). The clients are less likely to use Specialist Disability Services (7.9 per cent) but more likely to have profound or severe core activity limitations (39.1 per cent) (Table 67 and Table 68). It is likely that these 415 individuals referred to HACC by mental health services

that also have a profound or severe core activity limitation, which equates to 8.0 per cent of HACC clients could move to the NDIS.

However, this figure is conservative as there will be other clients who have a psychiatric disability that may have been referred through another pathway. A third of the clients referred through mental health services have only been using HACC services for up to three months, while a small proportion (16.7 per cent) have been clients longer than two years (Table 69). HACC clients who have been referred by a mental health service are more likely to use services like nursing care, personal care and case management as compared to other HACC clients (Table 71).

5.7 HACC CLIENTS REFERRED FROM PALLIATIVE CARE SERVICES

Palliative care services are by their very nature a time limited service, provided to clients at times of personal stress and high need. One of the key questions in this research is *'What proportion of HACC clients are people requiring palliative care in the community?'*

Community palliative care was identified as one of six primary health care activities that can be strengthened to keep people out of hospitals (Tasmania DHHS 2014c). The White Paper, published in March 2015, while discussing alternatives to hospital, made reference to the Tasmanian HACC Program as playing an important role in assisting people to remain in their own home and community. The findings reveal an unexpectedly high (21.4 per cent) proportion of referrals from palliative care services (Table 20).

Table 66 to Table 69 shows that clients who have been referred through palliative care services are more likely to be older, use disability services, have profound or severe core activity limitations, and be a client for longer than two years as compared to the HACC client group.

Clients who have been referred through palliative care services seem more likely to use the following services compared to other HACC clients:

- domestic assistance
- personal care
- home maintenance
- social support
- respite.

Interesting to note is that clients referred from palliative care services seem less likely to use services from nursing care as compared to other HACC clients which seem to suggest that the services HACC is providing is complementary to formal palliative care services (Table 71).

5.8 HACC CLIENTS WITH PROFOUND AND/OR SEVERE CORE ACTIVITY LIMITATIONS

The relationship between the HACC Program and the specialist disability services sector is one of the key factors impacting on future demand for the HACC Program and on the profile of current and future HACC clients. The key questions that need to be answered are:

- *Within the HACC population, what is the prevalence of people with a permanent, long-term disability (physical, intellectual, psychological) or chronic illness requiring ongoing assistance to live independently?*
- *What are the implications of the NDIS for the prevalence of this group in the HACC population, i.e. what proportion will and will not be eligible for the NDIS?*

As previously discussed, activity limitations can be thought of as the social consequences of impairments or disabilities (Bowling 2005: 3) and defined as people who cannot do a task or *'if they needed assistance, had difficulty, or used aids or equipment to do ... tasks'* (ABS 2011a: 11). While determining the prevalence

of chronic health conditions can only be explored using the HACC Client Survey data, the data from the HACC MDS can determine the proportion of HACC clients who may be eligible for the NDIS based on whether they are profoundly/severely disabled according to the ABS criteria.

Table 23 presented the variable created for this purpose. The analysis showed that 31.7 per cent of the HACC clients have a profound or severe core activity limitation (Table 65) and while it was anticipated that a high proportion of these clients would use specialised disability services, only 23.2 per cent currently do.

The findings showed that clients who have a profound or severe core activity limitation are more likely to be older, be referred by a mental health service, palliative care service or, specialist disability service and be a long-term (longer than 2 years) client as compared to other HACC clients (Table 66 to Table 70).

Clients with a profound or severe core activity limitation are more likely to use the following services: domestic assistance, allied health, personal care, social support, centre based day care, and respite as compared to other HACC clients (Table 71).

5.9 HACC CLIENTS AGED UNDER 18 YEARS

Obtaining informed consent from persons aged less than 18 to participate in the HACC Client Survey was beyond the scope of this study and HACC clients aged less than 18 years were excluded from the sampling frame which was all clients aged 18-64 who used at least one service in the 2013-14 year period. Throughout this chapter, the findings pertain to this group.

However, Tasmanian HACC clients include persons 0-17 years of age and for this purpose, this section summarised some key characteristics pertaining to this group:

As Table 74 shows, HACC clients aged 0-17 represent only a very small per cent (1.5%) of all Tasmanian HACC clients in 2013-14.

The findings from Table 75 show that males outnumber females which is different from the gender profile of Tasmanian HACC clients aged 18-64 where females strongly outnumber males (Table 8).

When an age gender comparison is conducted, Table 76 shows that a higher proportion of females are between the age of 0-4 and females outnumber males 2:1. In the tweens and early teens, the proportion of male clients jumps and is 13 percentage points higher than female in the same age group.

The proportion of Aboriginal or Torres Strait Islander people is slightly higher in HACC clients aged 0-17 as compared to HACC clients aged 18-64 (Table 77 and Table 14).

The living arrangement for clients 0-17 was explored and the results as presented in Table 78 and Table 79 seems to indicate that the proportion of clients who live alone is higher in the 0-17 as compared to clients aged 18-64 (see Table 17), however, when you breakdown the living arrangements by age categories, most of those clients recorded as living alone are aged between 0-4.

Table 80 shows that a higher number of the HACC clients aged 0-17 are renting from public housing.

In Table 81, there is a high number of clients receiving aged pension as compared to the 18-64 HACC client group (Table 19). The table shows that the majority of the clients receiving the aged pension are in the age group 0-4.

Table 82 and Table 83 shows that while the majority of HACC clients aged 0-17 have carers, a high proportion (75 per cent) of those aged 0-4 do not have a carer. These findings call into question the reliability of the HACC MDS data in the recording of birth information.

Throughout the HACC Client Survey sampling process, the researchers came across numerous instances where the year of birth was recorded incorrectly, which results in more than one unique SLKs to be generated for the same individual. Going forward, DHHS may want to consider auditing the HACC MDS to check the quality of data entered by the service providers.

Table 66 Age distribution of sub-groups of HACC clients 2013-14

Age groups	HACC clients aged 18-44		Clients living alone		Long-term client (over 2 years)		Short-term clients		Clients admitted to hospital		Clients referred from mental health services		Clients referred from palliative care services		Profound or severe core activity limitation		All HACC clients	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
18-19	78	5.7	4	0.2	19	1.1	9	1.7	17	1.0	10	0.9	29	2.6	34	2.1	78	1.5
20-24	177	12.8	16	0.9	52	3.1	31	5.8	44	2.7	34	3.2	43	3.9	56	3.4	177	3.4
25-29	181	13.1	36	2.1	50	3.0	29	5.5	53	3.2	32	3.0	57	5.1	38	2.3	181	3.5
30-34	208	15.1	43	2.5	63	3.7	24	4.5	74	4.5	34	3.2	51	4.6	54	3.3	208	4.0
35-39	289	21.0	76	4.4	91	5.4	41	7.7	93	5.6	44	4.1	77	7.0	74	4.5	289	5.6
40-44	446	32.3	126	7.2	150	8.9	52	9.8	144	8.7	78	7.3	110	9.9	125	7.6	446	8.6
45-49	-	-	172	9.9	170	10.1	39	7.3	171	10.4	76	7.2	122	11.0	169	10.3	511	9.9
50-54	-	-	262	15.0	238	14.1	79	14.8	225	13.7	136	12.8	139	12.6	212	12.9	704	13.6
55-59	-	-	412	23.7	365	21.7	108	20.3	376	22.8	227	21.4	215	19.4	355	21.6	1,059	20.5
60-64	-	-	595	34.2	486	28.9	120	22.6	451	27.4	391	36.8	264	23.8	527	32.1	1,525	29.5
<i>Total</i>	<i>1,379</i>	<i>100.0</i>	<i>1,742</i>	<i>100.0</i>	<i>1,684</i>	<i>100.0</i>	<i>532</i>	<i>100.0</i>	<i>1,648</i>	<i>100.0</i>	<i>1,062</i>	<i>100.0</i>	<i>1,107</i>	<i>100.0</i>	<i>1,644</i>	<i>100.0</i>	<i>5,178</i>	<i>100.0</i>

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Table 67 Whether or not a client of Specialist Disability Services by sub-groups of HACC clients 2013-14

Client of Specialist Disability Services	HACC clients aged 18-44		Clients living alone		Long-term client (over 2 years)		Short-term clients		Clients admitted to hospital		Clients referred from mental health services		Clients referred from palliative care services		Profound or severe core activity limitation		All HACC clients	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Client of Specialist Disability Services	389	28.2	221	12.7	395	23.5	50	9.4	209	12.7	84	7.9	290	26.2	382	23.2	785	15.2
Not a client of Specialist Disability Services	990	71.8	1,521	87.3	1,289	76.5	482	90.6	1,439	87.3	978	92.1	817	73.8	1,262	76.8	4,393	84.8
Total	1,379	100.0	1,742	100.0	1,684	100.0	532	100.0	1,648	100.0	1,062	100.0	1,107	100.0	1,644	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS and DS NMDS for Tasmania for July 2013-June 2014 inclusive.

Table 68 Whether or not a client with profound or severe core activity limitations by sub-groups of HACC clients 2013-14

Profound or core activity limitations	HACC clients aged 18-44		Clients living alone		Long-term client (over 2 years)		Short-term clients		Clients admitted to hospital		Clients referred from mental health services		Clients referred from palliative care services		Profound or severe core activity limitation		All HACC clients	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Has profound or severe core activity limitation	381	27.6	481	27.6	677	40.2	89	16.7	526	31.9	417	39.3	399	36.0	-	-	1,644	31.7
Domestic/non-core limitation	309	22.4	495	28.4	414	24.6	134	25.2	380	23.1	264	24.9	246	22.2	-	-	1,175	22.7
Missing data	689	50.0	766	44.0	593	35.2	309	58.1	742	45.0	381	35.9	462	41.7	-	-	2,359	45.6
Total	1,379	100.0	1,742	100.0	1,684	100.0	532	100.0	1,648	100.0	1,062	100.0	1,107	100.0	-	-	5,178	100.0

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Table 69 Length of time as a client by sub-groups of HACC clients 2013-14

Length of time as a HACC client	HACC clients aged 18-44		Clients living alone		Long-term client (over 2 years)		Short-term clients		Clients admitted to hospital		Clients referred from mental health services		Clients referred from palliative care services		Profound or severe core activity limitation		All HACC clients	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Up to one month (0-31 days)</i>	174	12.6	79	4.5	-	-	-	-	262	15.9	241	22.7	40	3.6	79	4.8	487	9.4
<i>Up to 3 months (32-93 days)</i>	107	7.8	108	6.2	-	-	-	-	180	10.9	122	11.5	37	3.3	85	5.2	367	7.1
<i>Up to 6 months (94-182 days)</i>	105	7.6	124	7.1	-	-	-	-	146	8.9	87	8.2	47	4.2	81	4.9	383	7.4
<i>Up to 1 year (183-365 days)</i>	209	15.2	267	15.3	-	-	-	-	311	18.9	159	15.0	204	18.4	189	11.5	796	15.4
<i>Up to 2 years (366-730 days)</i>	147	10.7	246	14.1	-	-	-	-	194	11.8	105	9.9	159	14.4	213	13.0	626	12.1
<i>Up to 5 years (731-1826 days)</i>	235	17.0	454	26.1	-	-	-	-	256	15.5	121	11.4	299	27.0	397	24.1	1,054	20.4
<i>Up to 10 years (1827-3652 days)</i>	146	10.6	194	11.1	-	-	-	-	91	5.5	41	3.9	131	11.8	210	12.8	486	9.4
<i>More than 10 years (3653+ days)</i>	44	3.2	42	2.4	-	-	-	-	23	1.4	15	1.4	31	2.8	70	4.3	144	2.8
<i>Total with data</i>	1,167	84.6	1,514	86.9	-	-	-	-	1,463	88.8	891	83.9	948	85.6	1,324	80.5	4,343	83.9
<i>Missing data</i>	212	15.4	228	13.1	-	-	-	-	185	11.2	171	16.1	159	14.4	320	19.5	835	16.1
Total	1,379	100.0	1,742	100.0	-	-	-	-	1,648	100.0	1,062	100.0	1,107	100.0	1,644	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Table 70 Referral pathways into HACC by sub-groups of HACC clients 2013-14

Referral pathway	HACC clients aged 18-44		Clients living alone		Long-term client (over 2 years)		Short-term clients		Clients admitted to hospital		Clients referred from mental health services		Clients referred from palliative care services		Profound or severe core activity limitation		All HACC clients	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Self</i>	253	14.7	526	21.3	549	21.6	39	7.1	297	13.0	-	-	-	-	356	14.2	1,182	17.4
<i>Family, friend or neighbour</i>	184	10.7	164	6.6	239	9.4	10	1.8	127	5.6	-	-	-	-	210	8.4	537	7.9
<i>GP or other medical practitioner</i>	126	7.3	253	10.3	244	9.6	49	8.9	251	11.0	-	-	-	-	308	12.3	720	10.6
<i>Public or private hospital</i>	65	3.8	156	6.3	175	6.9	24	4.4	146	6.4	-	-	-	-	194	7.8	402	5.9
<i>Psychiatric/mental health service or facility</i>	232	13.5	315	12.8	177	7.0	327	59.7	618	27.1	-	-	-	-	417	16.7	1,062	15.6
<i>Community nursing</i>	12	0.7	13	0.5	17	0.7	1	0.2	12	0.5	-	-	-	-	18	0.7	38	0.6
<i>Other health/medical service or facility</i>	52	3.0	77	3.1	51	2.0	20	3.6	103	4.5	-	-	-	-	74	3.0	235	3.5
<i>Palliative care facility or hospice</i>	367	21.3	430	17.4	461	18.2	31	5.7	298	13.1	-	-	-	-	399	15.9	1,107	16.3
<i>Specialist Disability Services</i>	241	14.0	335	13.6	373	14.7	32	5.8	258	11.3	-	-	-	-	341	13.6	868	12.8
<i>Other HACC service</i>	62	3.6	85	3.4	97	3.8	4	0.7	90	3.9	-	-	-	-	119	4.8	269	4.0
<i>Not stated</i>	128	7.4	113	4.6	156	6.1	11	2.0	83	3.6	-	-	-	-	66	2.6	366	5.4
Total	1,722	100.0	2,467	100.0	2,539	100.0	548	100.0	2,283	100.0	-	-	-	-	2,502	100.0	6,786	100.0

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Note: Referral data is collected by service episode and is converted in this table to referrals per client. Of the 5,178 clients in the sample, 366 (7.1 per cent) have no source of referral data; 3,618 (69.9 per cent) have one source of referral noted; and 1,194 (23.1 per cent) have 2 or more sources noted. Clients are counted once only for each source of referral. Numbers exceed 100% as some clients are referred from more than one source.

Table 71 HACC service types used by sub-groups of HACC clients 2013-14

HACC service types used	HACC clients aged 18-44		Clients living alone		Long-term client (over 2 years)		Short-term clients		Clients admitted to hospital		Clients referred from mental health services		Clients referred from palliative care services		Profound or severe core activity limitation		All HACC clients	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Assessment</i>	525	17.5	897	19.1	720	15.3	123	15.3	722	17.4	536	18.8	614	17.2	814	16.6	2,224	18.1
<i>Client care coordination</i>	437	14.6	670	14.3	527	11.2	34	4.2	510	12.3	343	12.1	619	17.4	623	12.7	1,691	13.7
<i>Domestic assistance</i>	258	8.6	774	16.5	718	15.3	28	3.5	491	11.9	327	11.5	499	14.0	646	13.2	1,551	12.6
<i>Transport</i>	377	12.6	509	10.8	620	13.2	5	0.6	395	9.5	128	4.5	358	10.1	419	8.6	1,275	10.4
<i>Nursing care</i>	293	9.8	304	6.5	297	6.3	383	47.5	672	16.2	648	22.8	128	3.6	387	7.9	1,148	9.3
<i>Allied health care</i>	172	5.7	185	3.9	186	4.0	40	5.0	271	6.5	181	6.4	143	4.0	393	8.0	756	6.1
<i>Personal care</i>	145	4.8	237	5.0	299	6.4	23	2.9	209	5.0	173	6.1	232	6.5	378	7.7	620	5.0
<i>Social support</i>	132	4.4	287	6.1	267	5.7	6	0.7	157	3.8	78	2.7	198	5.6	252	5.1	586	4.8
<i>Home maintenance</i>	100	3.3	265	5.6	226	4.8	61	7.6	205	5.0	125	4.4	214	6.0	220	4.5	581	4.7
<i>Meals</i>	103	3.4	205	4.4	254	5.4	8	1.0	112	2.7	69	2.4	163	4.6	193	3.9	501	4.1
<i>Case management</i>	147	4.9	181	3.9	154	3.3	82	10.2	223	5.4	197	6.9	146	4.1	187	3.8	486	3.9
<i>Counselling</i>	106	3.5	109	2.3	139	3.0	12	1.5	85	2.1	12	0.4	63	1.8	93	1.9	378	3.1
<i>Centre based daycare</i>	79	2.6	62	1.3	180	3.8	1	0.1	57	1.4	15	0.5	100	2.8	156	3.2	316	2.6
<i>Respite</i>	127	4.2	11	0.2	108	2.3	0	0.0	30	0.7	13	0.5	83	2.3	133	2.7	200	1.6
Total	3,001	100.0	4,696	100.0	4,695	100.0	806	100.0	4139	100.0	2,845	100.0	3,560	100.0	4,894	100.0	12,313	100.0

Sources: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive.

Note: Includes the 14 most commonly used service types. Clients may have used a number of these service types during the 2013/14 period.

Table 72 Hospital admission by length of time as a HACC client 2013-14

	Short not continuing		Short continuing		Long (6+ months)		Missing		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
<i>No hospital admission</i>	211	39.7	438	62.1	2,231	71.8	650	77.8	3,530	68.2
<i>At least 1 hospital admission</i>	321	60.3	267	37.9	875	28.2	185	22.2	1,648	31.8
Total	532	100.0	705	100.0	3,106	100.0	835	100.0	5,178	100.0

Sources: Extraction of data from HACC MDS for Tasmania and Hospital Admissions for Tasmania for July 2013-June 2014 inclusive.

Table 73 Age groups of Tasmanian HACC clients, 2013-14, aged 0-17

Age	No.	%
0-4	92	21.7
5-9	96	22.6
10-14	137	32.3
15-17	99	23.4
Total	424	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 74 Age groups of Tasmanian HACC clients, 2013-14

Age	No.	%
0-4	92	0.3
5-9	96	0.3
10-14	137	0.5
15-17	99	0.3
15-19	78	0.3
20-24	179	0.6
25-29	181	0.6
30-34	210	0.7
35-39	290	1.0
40-44	446	1.6
45-49	511	1.8
50-54	747	2.6
55-59	1,101	3.9
60-64	1,581	5.6
65+	22,682	79.8
Total	28,430	100

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 75 Sex of Tasmanian HACC clients, 2013-14, aged 0-17

Sex	No.	%
Male	234	55.2
Female	190	44.8
Total	424	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 76 Age and sex distribution of Tasmanian HACC clients, 2013-14, aged 0-17

Age groups	Males		Females	
	No.	%	No.	%
0-4	35	15.0	57	30.0
5-9	55	23.5	41	21.6
10-14	90	38.5	47	24.7
15-17	54	23.1	45	23.7
Total	234	100.0	190	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 77 Indigenous status of Tasmanian HACC clients, 2013-14, aged 0-17

Indigenous status	No.	%
Aboriginal or Torres Strait Islander	25	5.8
Non- Aboriginal or Torres Strait Islander	3373	88.0
Not known/ missing	26	6.1
Total	424	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 78 Living arrangements of Tasmanian HACC clients, 2013-14, aged 0-17

Living arrangements	No.	%
Lives alone	59	13.9
Lives with family	335	79.0
Lives with others	12	2.8
Not known/missing	18	4.3
Other	-	-
Total	424	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 79 Living arrangements and age distribution of Tasmanian HACC clients, 2013-14, aged 0-17

Living Arrangements	Age group				
	0-4	5-9	10-14	15-17	Total
<i>Lives alone</i>	54	2	3	0	59
	91.5	3.4	5.1	0.0	100.0
	58.7	2.1	2.2	0.0	13.9
<i>Lives with family</i>	38	87	125	85	335
	11.3	26.0	37.3	25.4	100.0
	41.3	90.6	91.2	85.9	79.0
<i>Lives with others</i>	0	2	4	6	12
	0.0	16.7	33.3	50.0	100.0
	0.0	2.1	2.9	6.1	2.8
<i>Not stated/inadequate</i>	0	5	5	8	18
	0.0	27.8	27.8	44.4	100.0
	0.0	5.2	3.7	8.1	4.3
Total	92	96	137	99	424
	21.7	22.6	32.3	23.4	100.0
	100.0	100.0	100.0	100.0	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 80 Housing tenure of Tasmanian HACC clients, 2013-14, aged 0-17

Housing tenure	No.	%
<i>Owned/purchasing - Private res</i>	237	55.9
<i>Private rental - Private res</i>	72	17.0
<i>Public rental - Private res</i>	53	12.5
<i>Retirement village- Independent Living</i>	2	0.5
<i>Supported accommodation or supported living facility</i>	2	0.5
<i>Public place/temporary shelter</i>	1	0.2
<i>Other</i>	10	2.4
<i>Not stated/inadequately described</i>	47	11.1
Total	424	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 81 Pension status and age distribution of Tasmanian HACC clients, 2013-14, aged 0-17

Pension Arrangements	Age group				
	0-4	5-9	10-14	15-17	Total
<i>Aged pension</i>	53	4	1	0	58
	91.4	6.9	1.7	0.0	100.0
	57.6	4.2	0.7	0.0	13.7
<i>DVA pension</i>	5	0	0	0	5
	100.0	0.0	0.0	0.0	100.0
	5.4	0.0	0.0	0.0	1.2
<i>Disability support pension</i>	9	6	9	15	39
	23.1	15.4	23.1	38.5	100.0
	9.8	6.3	6.6	15.2	9.2
<i>Carer payment</i>	1	25	37	23	86
	1.2	29.1	43.0	26.7	100.0
	1.1	26.0	27.0	23.2	20.3
<i>Unemployment related</i>	0	0	0	1	1
	0.0	0.0	0.0	100.0	100.0
	0.0	0.0	0.0	1.0	0.2
<i>Other Government pension</i>	2	6	6	5	19
	10.5	31.6	31.6	26.3	100.0
	2.2	6.3	4.4	5.1	4.5
<i>No government pension</i>	12	43	68	34	157
	7.6	27.4	43.3	21.7	100.0
	13.0	44.8	49.6	34.3	37.0
<i>Not stated/inadequate</i>	10	12	16	21	59
	17.0	20.3	27.1	35.6	100.0
	10.9	12.5	11.7	21.2	13.9
Total	92	96	137	99	424
	21.7	22.6	32.3	23.4	100.0
	100.0	100.0	100.0	100.0	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 82 Existence of carer of Tasmanian HACC clients, 2013-14, aged 0-17

	No.	%
<i>Has a carer</i>	298	70.3
<i>Has no carer</i>	116	27.4
<i>Not stated/missing</i>	10	2.3
Total	424	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 83 Existence of carer and age distribution of Tasmanian HACC clients, 2013-14, aged 0-17

Age group	Carer			
	Has a carer	No carer	Not stated	Total
0-4	22	69	1	92
	23.9	75.0	1.1	100.0
	7.4	59.5	10.0	21.7
5-9	86	8	2	96
	89.6	8.3	2.1	100.0
	28.9	6.9	20.0	22.6
10-14	122	12	3	137
	89.1	8.8	2.2	100.0
	40.9	10.3	30.0	32.3
15-17	68	27	4	99
	68.7	27.3	4.0	100.0
	22.8	23.3	40.0	23.4
Total	298	116	10	424
	70.3	27.4	2.4	100.0
	100.0	100.0	100.0	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

6 CLIENT PROFILE: CLIENT SURVEY ANALYSIS

FACTS UP FRONT

- The custom HACC Client Survey designed for this project addresses gaps in what is known about the HACC Program client group.
- There were 389 survey respondents from a representative sample of the Tasmanian HACC population.
- Of these, 311 respondents consented to having their survey data linked to administrative records to tell the most complete story about the HACC client experience.

Health conditions, disabling conditions and functional dependencies giving rise to the use of HACC services

- 97.9 per cent of HACC clients reported that they had one or more chronic health conditions or disabilities.
- The most common health conditions and disabilities reported (Table 84) were:
 - physical disability (52.4 per cent)
 - joint, bone, muscle disease (48.3 per cent)
 - mental health problem (35.7 per cent)
 - respiratory disease or difficulty breathing (28.5 per cent)
 - neurological condition (24.2 per cent)
 - digestive disorder (22.4 per cent)
 - sensory disability (20.8 per cent)
 - diabetes (20.3 per cent)
 - heart failure (12.3 per cent)
 - cancer (11.8 per cent)
 - acquired brain injury (9.8 per cent)
 - intellectual disability (9.8 per cent)
 - stroke (9.0 per cent).
- 67.5 per cent of HACC clients reported that the duration of their health condition was 10 years or longer (Table 88).
- 40.6 per cent of HACC clients reported they expect their health condition to get worse (Table 91).
- The most common disabilities were (Table 92):
 - chronic pain or discomfort (65.6 per cent)
 - limited use of arms, fingers, feet or legs (60.7 per cent)
 - breathing difficulties or shortness of breath (35.7 per cent)
 - mental health problem (31.9 per cent).

Short-term health circumstances giving rise to the use of HACC services

- 72.9 per cent of all HACC clients (Table 97) and 100 per cent of short-term clients (Table 98) have had an illness, injury or surgery in the 18 month period prior to the survey.
- 41.9 per cent of HACC clients had surgery during this period (Table 96).
- 41.7 per cent of HACC clients received help or change in help from an organisation, nurse or health worker due to the illness, injury, or surgery (Table 100 and Table 101).
- 54.2 per cent of HACC clients have had at least one overnight stay in hospital in the 18 month period prior to the survey (Table 104) and a higher proportion (47.5 per cent) of long-term users

have had an overnight stay in hospital during this period (Table 105).

- 46.0 per cent of HACC clients who had an overnight stay in hospital, received help or change in help from an organisation, nurse or health worker following their hospital admission (Table 110 and Table 111).

Referral pathways into HACC for HACC service users

- The circumstances that triggered the use of HACC services were (Table 113):
 - long-term health condition or disability (67.1 per cent)
 - an illness (29.6 per cent)
 - surgery (24.9 per cent)
 - an injury (18.0 per cent)
 - a mental health problem (4.9 per cent).

The top three referral pathways were (Table 114):

- your doctor (37.8 per cent)
- someone from a community organisation (31.4 per cent)
- a nurse or another person working in the hospital (28.0 per cent).

Pattern of past, current and anticipated future use of HACC services

- 93.9 per cent of HACC clients continue to receive HACC services because they still have the health condition or disability that triggered their use of the services. 1.4 per cent of HACC clients continue to receive services even though they have recovered from their health condition or disability (Table 117).
- There were five service types that did not meet the needs of at least 10 per cent or more of HACC clients and these were (Table 121):
 - counselling and support (15.4 per cent)
 - client care coordination (12.9 per cent)
 - case management (12.5 per cent)
 - home maintenance (12.5 per cent)
 - Nursing (10.0 per cent)
- HACC clients use the following services on a as needed basis (Table 123):
 - counselling and support (54.5 per cent)
 - transport (51.1 per cent)
 - Nursing (40.0 per cent)
- HACC clients use the following services on a regular basis (Table 123):
 - centre-based daycare (100 per cent)
 - domestic care (97.0 per cent)
 - meals (92.9 per cent)
 - social support (90.5 per cent)
- 80 per cent or more of HACC clients expect to use the following services for the rest of their lives (Table 124):
 - home maintenance (90.5 per cent)
 - client care coordination (86.7 per cent)
 - personal care (84.0 per cent)
 - domestic assistance (83.8 per cent)

30 per cent or more of HACC clients indicated they needed more of the following services (Table 125):

- home maintenance (46.9 per cent)
- domestic assistance (33.8 per cent)
- counselling and support (33.3 per cent)
- centre-based daycare (30.8 per cent)

Service gaps identified by clients were (Table 126):

- Computer education
- Cooking in the home
- Services for pets
- Flexibility of services (e.g. payment options, responding to emergencies)

Personal support available to HACC service users

- 61.4 per cent of HACC clients receive help with everyday activities and tasks from family, friends and neighbours (Table 128).

Personal characteristics of HACC service users giving rise to the use of HACC services

- 10.5 of HACC clients are in the workforce, with short-term not continuing clients (13.3 per cent) more likely to be working than long-term clients (8.9 per cent) (Table 131 and Table 132).
- 33.9 per cent of HACC clients have qualifications beyond year 12 (Table 133) and short-term not continuing clients were more likely to have a qualification beyond grade 12 (46.7 per cent) (Table 134)
- 12.1 per cent of HACC clients have a household income above \$40,000 per annum (Table 135). 40.0 per cent of short-term not continuing clients have a household income above \$40,000 per annum (Table 136).
- 32.7 per cent of HACC clients reported their health as good, very good or excellent (Table 139).
- 49.6 per cent of HACC clients reported their quality of life as good or very good (Table 141).

Overlap of use of other services of HACC clients

- 33.2 per cent of HACC clients visited a GP more than 20 times in the 18 months prior to the survey (Table 143).
- 59.9 per cent of HACC clients are unsure of whether they would be eligible for the NDIS, with only 11.8 per cent indicating that they thought that they would be eligible (Table 146).

In order to profile the Tasmanian HACC client group, numerous DHHS data sources were investigated and linked using a subset of clients aged 18-64 from the financial year period 2013-14.

However, the data extrapolated from these sources could not be used to answer all the research questions. We designed the HACC Client Survey to obtain information pertaining to:

- *health conditions, disabling conditions and functional dependencies* giving rise to the use of HACC services
- *short-term health circumstances* giving rise to the use of HACC services
- *referral pathways* into HACC for HACC service users
- *pattern of past, current and anticipated future use* of HACC services
- *personal support* available to HACC service users
- the *personal characteristics* of HACC service users giving rise to the use of HACC services
- *overlap of use of other services* of HACC clients.

To ensure that the results from the client survey would be generalisable to the Tasmanian HACC population, we surveyed a representative sample of HACC clients. Detail on the survey methodology is provided in the [technical report](#), including the survey questionnaire in full.

6.1 HEALTH CONDITIONS, DISABILITIES AND FUNCTIONAL LIMITATIONS

This section of the report will discuss the results from the survey that were designed to provide data on HACC clients' health conditions, disabling conditions and functional dependencies (questions 5-23). The large number of questions focused on this area reflects the limitations of existing data sources as well as the significance of this component of the conceptual framework. The HACC MDS does not include data on health conditions and disabling conditions and data on functional dependency is missing for approximately 45.9 per cent of HACC clients in the HACC MDS (2,802 clients had information on 12 items).

Questions 5-8 are focused on *health conditions*. The term *health condition* or *disability* is used to reflect common usage. Some clients may think of these conditions as disabilities, e.g., Down's syndrome, Parkinson's Disease.

The period of six-months was based on the ABS's definition of long-term as six months or longer. To assist with profiling HACC clients, participants were asked to indicate if they had one or more of 15 health conditions or disabilities following July 2013 that have lasted six months or more (Question 5). The conditions specified were supplied by DHHS as representing the most common conditions likely to be experienced by this client group. A number of examples are provided to assist respondents to understand the options provided.

Respondents were also given the opportunity to identify other conditions not listed. This data will be limited by a respondent's ability and willingness to name their health conditions. Question 6 asked participants to indicate which of the 15 listed conditions/disabilities (or their own open-ended response) caused them the most problems in everyday life (or the one they had the longest if they could not choose, or finally the first in alphabetical order). 97.9 per cent of HACC clients reported that they had one or more chronic health conditions or disabilities.

Table 84 shows both the long-term health conditions chosen by the participants and the condition that causes the most problems in their everyday life. The most common health conditions and disabilities reported were

- physical disability (52.4 per cent of HACC clients)
- joint, bone, muscle disease (48.3 per cent)
- mental health problem (35.7 per cent)
- respiratory disease or difficulty breathing (28.5 per cent)
- neurological condition (24.2 per cent)
- digestive disorder (22.4 per cent)
- sensory disability (20.8 per cent)
- diabetes (20.3 per cent)
- heart failure (12.3 per cent)
- cancer (11.8 per cent)
- acquired brain injury (9.8 per cent)
- intellectual disability (9.8 per cent)
- stroke (9.0 per cent) (Table 84).

As shown in Table 85 and Table 87, the profile of clients with long-term health conditions remains similar for those that use HACC services short- or long-term and whether they have a profound or severe core activity limitation or not.

Participants were asked for the duration of their health condition or disability:

- just over half (67.5 per cent) reported having their health condition or disability for 10 years or longer

- over a quarter have had their health condition or disability for between one and nine years (27.8 per cent)
- few have had their condition or disability for less than one year (3.7 per cent) (Table 88).

The results in Table 89 indicate that a higher proportion (72.9 per cent) of long-term users of HACC have had the chronic health condition that causes them the most problems for 10 years or longer as compared to short-term users (60.0 per cent).

Similarly Table 90 shows that a higher proportion (17.2 per cent) of clients who have a profound or severe activity limitation have had this chronic health condition or disability since birth.

Clients were asked whether the health condition or disability will improve, stay the same or worsen (Table 91). Few reported that they expected the condition to improve (7.3 per cent), with the majority expecting it to stay the same (31.7 per cent) or worsen (40.6 per cent). This, combined with responses to the previous questions, appears to indicate a permanence to the health condition or disability experienced for the majority of clients.

We also asked for information on a number of *disabling conditions or impairments*, both in terms of whether they were experienced and the extent to which they restricted everyday activities. The term '*restriction of everyday activities*' is used in the ABS SDAC (2012) in follow up questions for many of the categories of impairment used in that survey. The nine types of disabling conditions used in our survey are based on those used in SDAC, and are designed to cover the range of disabling conditions arising from disabling health conditions (Table 92).

The most commonly reported disabilities were:

- chronic pain or discomfort (65.6 per cent)
- limited use of arms, fingers, feet or legs (60.7 per cent)
- breathing difficulties or shortness of breath (35.7 per cent)
- mental health problems (31.9 per cent).

As shown in Table 93, with the exception of those individuals experiencing blackouts, seizures or loss of consciousness, 80 per cent and above of all other clients found their disabilities to be restrictive. The disabilities most commonly stated as severely restrictive were:

- limited use of arms, fingers, feet or legs (44.9 per cent)
- chronic or recurrent pain or discomfort (39.6 per cent)
- speech problems (37.7 per cent).

The HACC Client Survey explored the *functional status* of clients which is of central interest to the HACC program. Respondents were asked to rate the level of help they require with 11 possible types of daily activities, taken from the NDIS access checker used to determine eligibility for the scheme.

The daily activity reported as requiring the most help was cooking, cleaning, doing the shopping or doing jobs around the home or yard (43.2 per cent stated they needed a lot of help). These domestic activities, as well as coping with feelings and emotions, understanding, remembering and learning new things and moving around outside the home, were the activities that people most commonly reported needing some help with (38.8 per cent, 30.9 per cent, 28.8 per cent and 28.5 per cent respectively). The activities where people reported the highest frequency of *not* needing help were:

- eating (87.4 per cent)
- getting in or out of bed or moving around the home (72.0 per cent)
- understanding and being understood by other people (71.5 per cent)
- bathing or showering or dressing (65.8 per cent)

remembering to take medications (65.8 per cent) (Table 94).

Functional dependency is often reduced by use of special aids and equipment and we asked respondents about their use of these aids. Table 95 shows that 62.2 per cent of HACC clients use aids and equipment to assist them with everyday tasks.

Table 84 Type of long-term health conditions and conditions causing the most problems in everyday life reported by HACC client (Q5 & 6)

Long-term health conditions	Long-term health conditions (Q5)			Health condition causing the most problems in everyday life (Q6)	
	No.	% of all HACC clients in survey	% of all health conditions	No.	% of all HACC clients in survey
<i>Acquired brain injury (ABI)</i>	38	9.8	2.9	12	3.1
<i>Autism</i>	8	2.1	0.6	5	1.3
<i>Cancer</i>	46	11.8	3.6	7	1.8
<i>Diabetes</i>	79	20.3	6.1	11	2.8
<i>Digestive disorders</i>	87	22.4	6.7	10	2.6
<i>Down's syndrome</i>	3	0.8	0.2	2	0.5
<i>Heart disease including heart failure</i>	48	12.3	3.7	7	1.8
<i>An intellectual disability</i>	38	9.8	2.9	10	2.6
<i>Joint, bone, muscle diseases</i>	188	48.3	14.5	78	20.1
<i>Mental health problem</i>	139	35.7	10.8	21	5.4
<i>A neurological condition(s) e.g. Parkinson's, Multiple Sclerosis, Motor Neurone Disease or epilepsy</i>	94	24.2	7.3	27	6.9
<i>A physical disability</i>	204	52.4	15.8	48	12.3
<i>A respiratory disease or difficulty breathing</i>	111	28.5	8.6	14	3.6
<i>A sensory disability, e.g. hearing or vision</i>	81	20.8	6.3	9	2.3
<i>Effects from a stroke</i>	35	9.0	2.7	13	3.3
<i>Immune diseases/disorders</i>	15	3.9	1.2	4	1.0
<i>Urinary system diseases/disorders</i>	12	3.1	0.9	3	0.8
<i>Physical injury or issues</i>	17	4.4	1.3	5	1.3
<i>Diseases of the blood/blood vessels</i>	3	0.8	0.2	2	0.5
<i>Diseases of the circulatory system</i>	8	2.1	0.6	0	0.0
<i>Allergies</i>	1	0.3	0.1	0	0.0
<i>Nervous system issues</i>	7	1.8	0.5	1	0.3
<i>Medication problems</i>	2	0.5	0.2	0	0.0
<i>Inflammatory diseases</i>	1	0.3	0.1	1	0.3
<i>Skin diseases</i>	5	1.3	0.4	2	0.5
<i>Fibromyalgia</i>	4	1.0	0.3	1	0.3
<i>Liver diseases</i>	3	0.8	0.2	2	0.5
<i>Joint replacement</i>	2	0.5	0.2	0	0.0

Long-term health conditions	Long-term health conditions (Q5)			Health condition causing the most problems in everyday life (Q6)	
	No.	% of all HACC clients in survey	% of all health conditions	No.	% of all HACC clients in survey
<i>Hernias</i>	1	0.3	0.1	0	0.0
<i>Endocrine diseases or disorders</i>	4	1.0	0.3	1	0.3
<i>Prostate disorders</i>	1	0.3	0.1	0	0.0
<i>No health condition</i>	8	2.1	0.6	0	0.0
<i>Don't know/ no answer</i>	0	0.0	0.0	93	23.8
Total clients	389		100.0	389	100.0
Total health conditions	1293	332.7			

Source: Tasmanian HACC client survey 2015

Table 85 Type of long-term health conditions that causes the most problems in everyday life (Q6) reported by HACC client by long and short-term users of HACC services

	Short-term client not continuing	Short-term client continuing	Long-term client	Missing	Total
	No.	No.	No.	No.	No.
<i>Acquired brain injury (ABI)</i>	0	1	8	0	9
<i>Autism</i>	0	1	3	1	5
<i>Cancer</i>	1	0	2	1	4
<i>Diabetes</i>	0	2	5	0	7
<i>Digestive disorders</i>	0	1	7	0	8
<i>Down's syndrome</i>	0	0	2	0	2
<i>Heart disease including heart failure</i>	0	2	3	2	7
<i>An intellectual disability</i>	0	0	5	1	6
<i>Joint, bone, muscle diseases</i>	3	8	38	9	58
<i>Mental health problem</i>	1	1	12	1	15
<i>A neurological condition(s) e.g. Parkinson's, Multiple Sclerosis, Motor Neurone Disease or epilepsy</i>	0	4	14	7	25
<i>A physical disability</i>	1	6	26	5	38
<i>A respiratory disease or difficulty breathing</i>	1	1	6	2	10
<i>A sensory disability, e.g. hearing or vision</i>	0	0	6	1	7
<i>Effects from a stroke</i>	0	0	10	1	11
<i>Immune diseases/disorders</i>	0	1	3	0	4
<i>Urinary system diseases/disorders</i>	0	0	0	1	1
<i>Physical injury or issues</i>	1	2	2	0	5
<i>Diseases of the blood/blood vessels</i>	0	1	1	0	2
<i>Nervous system issues</i>	0	0	1	0	1

	Short-term client not continuing	Short-term client continuing	Long-term client	Missing	Total
	No.	No.	No.	No.	No.
<i>Inflammatory diseases</i>	0	0	1	0	1
<i>Skin diseases</i>	0	0	2	0	2
<i>Fibromyalgia</i>	0	0	1	0	1
<i>Liver diseases</i>	0	0	1	1	2
<i>Endocrine diseases or disorders</i>	0	0	1	0	1
<i>Don't know/ no answer</i>	7	12	42	18	79
Total clients	15	43	202	51	311

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 86 Type of long-term health conditions that causes the most problems in everyday life (Q6) by whether or not the client is still receiving HACC services at the time of the interview as reported by HACC clients (Q39)

	Yes		No		Don't know		Total	
	No.	%	No.	%	No.	%	No.	%
<i>Acquired brain injury (ABI)</i>	7	3.1	2	2.6	0	0.0	9	2.9
<i>Autism</i>	3	1.3	2	2.6	0	0.0	5	1.6
<i>Cancer</i>	1	0.4	3	3.9	0	0.0	4	1.3
<i>Diabetes</i>	3	1.3	4	5.2	0	0.0	7	2.3
<i>Digestive disorders</i>	6	2.6	2	2.6	0	0.0	8	2.6
<i>Down's syndrome</i>	2	0.9	0	0.0	0	0.0	2	0.6
<i>Heart disease including heart failure</i>	6	2.6	1	1.3	0	0.0	7	2.3
<i>An intellectual disability</i>	5	2.2	1	1.3	0	0.0	6	1.9
<i>Joint, bone, muscle diseases</i>	41	18.1	15	19.5	2	28.6	58	18.6
<i>Mental health problem</i>	11	4.8	4	5.2	0	0.0	15	4.8
<i>A neurological condition(s) e.g. Parkinson's, Multiple Sclerosis, Motor Neurone Disease or epilepsy</i>	21	9.3	4	5.2	0	0.0	25	8.0
<i>A physical disability</i>	33	14.5	5	6.5	0	0.0	38	12.2
<i>A respiratory disease or difficulty breathing</i>	7	3.1	3	3.9	0	0.0	10	3.2
<i>A sensory disability, e.g. hearing or vision</i>	5	2.2	2	2.6	0	0.0	7	2.3
<i>Effects from a stroke</i>	8	3.5	1	1.3	2	28.6	11	3.5
<i>Immune diseases/disorders</i>	4	1.8	0	0.0	0	0.0	4	1.3
<i>Urinary system diseases/disorders</i>	1	0.4	0	0.0	0	0.0	1	0.3
<i>Physical injury or issues</i>	3	1.3	2	2.6	0	0.0	5	1.6
<i>Diseases of the blood/blood vessels</i>	1	0.4	0	0.0	1	14.3	2	0.6
<i>Nervous system issues</i>	0	0.0	1	1.3	0	0.0	1	0.3

	Yes		No		Don't know		Total	
	No.	%	No.	%	No.	%	No.	%
<i>Inflammatory diseases</i>	1	0.4	0	0.0	0	0.0	1	0.3
<i>Skin diseases</i>	2	0.9	0	0.0	0	0.0	2	0.6
<i>Fibromyalgia</i>	1	0.4	0	0.0	0	0.0	1	0.3
<i>Liver diseases</i>	2	0.9	0	0.0	0	0.0	2	0.6
<i>Endocrine diseases or disorders</i>	1	0.4	0	0.0	0	0.0	1	0.3
<i>Don't know/ no answer</i>	52	22.9	25	32.5	2	28.6	79	25.4
Total clients	227	100.0	77	100.0	7	100.0	311	100.0

Source: Tasmanian HACC client survey 2015

Table 87 Type of long-term health conditions that causes the most problems in everyday life (Q6) reported by HACC client by whether or not a client has a profound or severe core activity limitation

	Profound or severe core activity limitation		No profound or severe core activity limitation		Missing		Total	
	No.	%	No.	%	No.	%	No.	%
<i>Acquired brain injury (ABI)</i>	6	5.2	2	2.2	1	1.0	9	2.9
<i>Autism</i>	2	1.7	2	2.2	1	1.0	5	1.6
<i>Cancer</i>	2	1.7	0	0.0	2	2.0	4	1.3
<i>Diabetes</i>	2	1.7	2	2.2	3	2.9	7	2.3
<i>Digestive disorders</i>	3	2.6	3	3.2	2	2.0	8	2.6
<i>Down's syndrome</i>	1	0.9	0	0.0	1	1.0	2	0.6
<i>Heart disease including heart failure</i>	4	3.4	2	2.2	1	1.0	7	2.3
<i>An intellectual disability</i>	5	4.3	0	0.0	1	1.0	6	1.9
<i>Joint, bone, muscle diseases</i>	24	20.7	19	20.4	15	14.7	58	18.6
<i>Mental health problem</i>	5	4.3	2	2.2	8	7.8	15	4.8
<i>A neurological condition(s) e.g. Parkinson's, Multiple Sclerosis, Motor Neurone Disease or epilepsy</i>	10	8.6	5	5.4	10	9.8	25	8.0
<i>A physical disability</i>	15	12.9	14	15.1	9	8.8	38	12.2
<i>A respiratory disease or difficulty breathing</i>	0	0.0	5	5.4	5	4.9	10	3.2
<i>A sensory disability, e.g. hearing or vision</i>	2	1.7	2	2.2	3	2.9	7	2.3
<i>Effects from a stroke</i>	3	2.6	4	4.3	4	3.9	11	3.5
<i>Immune diseases/disorders</i>	1	0.9	1	1.1	2	2.0	4	1.3
<i>Urinary system diseases/disorders</i>	0	0.0	1	1.1	0	0.0	1	0.3
<i>Physical injury or issues</i>	2	1.7	1	1.1	2	2.0	5	1.6
<i>Diseases of the blood/blood vessels</i>	0	0.0	1	1.1	1	1.0	2	0.6
<i>Nervous system issues</i>	0	0.0	0	0.0	1	1.0	1	0.3
<i>Inflammatory diseases</i>	0	0.0	0	0.0	1	1.0	1	0.3
<i>Skin diseases</i>	0	0.0	1	1.1	1	1.0	2	0.6

	Profound or severe core activity limitation		No profound or severe core activity limitation		Missing		Total	
	No.	%	No.	%	No.	%	No.	%
<i>Fibromyalgia</i>	0	0.0	1	1.1	0	0.0	1	0.3
<i>Liver diseases</i>	1	0.9	0	0.0	1	1.0	2	0.6
<i>Endocrine diseases or disorders</i>	1	0.9	0	0.0	0	0.0	1	0.3
<i>Don't know/ no answer</i>	27	23.3	25	26.9	27	26.5	79	25.4
Total clients	116	100.0	93	100.0	102	100.0	311	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 88 Duration of health condition causing the most problems in everyday life reported by HACC clients (Q7)

Duration	No.	%
<i>Since birth</i>	48	12.5
<i>For 10 years or longer</i>	210	55.0
<i>For between 1 and 9 years</i>	106	27.8
<i>For less than 1 year</i>	14	3.7
<i>Don't know/ no answer</i>	4	1.0
Total	382	100.0

Source: Tasmanian HACC client survey 2015

Table 89 Duration of health condition causing the most problems in everyday life reported by HACC clients (Q7) by long and short-term users of HACC services

Duration	Short-term client not continuing		Short-term client continuing		Long-term client		Missing		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Since birth</i>	1	6.7	8	18.6	26	13.1	9	18.4	44	14.4
<i>For 10 years or longer</i>	8	53.3	20	46.5	119	59.8	20	40.8	167	54.8
<i>For between 1 and 9 years</i>	4	26.7	12	27.9	51	25.6	13	26.5	80	26.2
<i>For less than 1 year</i>	2	13.3	3	7.0	1	0.5	5	10.2	11	3.6
<i>Don't know/ no answer</i>	0	0.0	0	0.0	2	1.0	1	2.0	9	3.0
Total	15	100.0	43	100.0	199	100.0	49	100.0	305	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 90 Duration of health condition causing the most problems in everyday life reported by HACC clients (Q7) by whether or not a client has a profound or severe core activity limitation

Duration	Profound or severe core activity limitation		No profound or severe core activity limitation		Missing		Total	
	No.	%	No.	%	No.	%	No.	%
Since birth	20	17.2	7	7.7	17	19.3	44	14.4
For 10 years or longer	62	53.4	54	59.3	51	58.0	167	54.8
For between 1 and 9 years	28	24.1	24	26.4	28	31.8	80	26.2
For less than 1 year	4	3.4	6	6.6	1	1.1	11	3.6
Don't know/ no answer	2	1.7	0	0.0	1	1.1	9	3.0
Total	116	100.0	91	100.0	88	100.0	305	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 91 HACC clients' expectations of whether health condition causing the most problems in everyday life will improve or worsen (Q8)

Expectations for future	No.	%
Get better	28	7.3
Stay the same	121	31.7
Get worse	155	40.6
Don't know/ no answer	78	20.4
Total	382	100.0

Source: Tasmanian HACC client survey 2015

Table 92 Types of disability reported by HACC clients (Q10 and Q11)

Disability	No.	% of all HACC clients in the survey	% of all disabilities reported
Loss of sight	37	9.5	3.5
Loss of hearing	44	11.3	4.2
Speech problems	53	13.6	5.0
Limited use of arms, fingers, feet or legs	236	60.7	22.5
Breathing difficulties or shortness of breath	139	35.7	13.2
Chronic or recurrent pain or discomfort	255	65.6	24.3
Blackouts, seizures or loss of consciousness	38	9.8	3.6
Mental health problem	124	31.9	11.8
Difficulty learning or understanding things	95	24.4	9.1
None of the above	29	7.5	2.8
Total HACC clients	389		100.0
Total disabilities	1050		

Source: Tasmanian HACC client survey 2015

Table 93 Impact of disability on restriction of daily activities reported by HACC clients (Q10_1 to Q11_5)

Disability	Severely restricts		Somewhat restricts		All restrictive		Does not restrict		Don't know/ no answer		All with the disability	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Loss of sight</i>	11	29.7	20	54.1	31	83.8	6	16.2	0	0	37	100.0
<i>Loss of hearing</i>	6	13.6	29	65.9	35	79.5	5	11.4	4	9.1	44	100.0
<i>Speech problems</i>	20	37.7	27	50.9	47	88.6	5	9.4	1	1.9	53	100.0
<i>Limited use of arms, fingers, feet or legs</i>	106	44.9	122	51.7	228	96.6	6	2.5	2	0.9	236	100.0
<i>Breathing difficulties or shortness of breath</i>	33	23.7	92	66.2	125	89.9	11	7.9	3	2.2	139	100.0
<i>Chronic or recurrent pain or discomfort</i>	101	39.6	147	57.7	248	97.3	7	2.8	0	0	255	100.0
<i>Blackouts, seizures or loss of consciousness</i>	12	31.6	12	31.6	24	63.2	13	34.2	1	2.6	38	100.0
<i>Mental health problem</i>	28	22.6	79	63.7	107	86.3	14	11.3	3	2.4	124	100.0
<i>Difficulty learning or understanding things</i>	28	29.5	58	61.1	86	90.6	9	9.5	0	0	95	100.0

Source: Tasmanian HACC client survey 2015

Table 94 Level of assistance needed with everyday activities reported by HACC clients (Q12A and Q12B)

Everyday activities	A lot of help		A little help		No help needed		Don't know		Not applicable		All HACC clients in survey	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Getting in or out of bed or moving around the home</i>	28	7.2	78	20.1	280	72	3	0.8	0	0	389	100.0
<i>Moving around outside the home</i>	64	16.5	111	28.5	194	49.9	2	0.5	18	4.6	389	100.0
<i>Bathing or showering or dressing</i>	58	14.9	73	18.8	256	65.8	2	0.5	0	0	389	100.0
<i>Eating</i>	9	2.3	38	9.8	340	87.4	2	0.5	0	0	389	100.0
<i>Cooking, cleaning, doing the shopping, or doing jobs around the home or yard</i>	168	43.2	151	38.8	57	14.7	0	0	13	3.3	389	100.0
<i>Remembering or taking your medications</i>	40	10.3	69	17.7	256	65.8	1	0.3	23	5.9	389	100.0
<i>Understanding and being understood by other people</i>	34	8.7	74	19	278	71.5	3	0.8	0	0	389	100.0
<i>Understanding, remembering and learning new things</i>	42	10.8	112	28.8	228	58.6	7	1.8	0	0	389	100.0
<i>Coping with feelings and emotions</i>	59	15.2	120	30.9	194	49.9	16	4.1	0	0	389	100.0
<i>Joining in community activities or hobbies such as church, sporting clubs or cultural associations</i>	53	13.6	67	17.2	171	44	8	2.1	90	23.1	389	100.0
<i>Getting or keeping a paid or voluntary job</i>	59	15.2	29	7.5	71	18.3	7	1.8	223	57.3	389	100.0

Source: Tasmanian HACC client survey 2015

Table 95 Use of aids and equipment to assist with everyday tasks reported by HACC clients (Q23)

Use of aids and equipment	No.	%
Yes	242	62.2
No	145	37.3
Don't know	2	0.5
Total	389	100.0

Source: Tasmanian HACC client survey 2015

6.2 SHORT-TERM HEALTH CIRCUMSTANCES

HACC services are also used by people who have a need for shorter-term assistance to live independently at home as a result of a temporary medical condition or hospitalisation arising from injury, illness or surgery. Responsibility for some aspects of the care of people prior and subsequent to hospitalisation lies

with hospitals and health services. However, developing information about the extent to which HACC plays a role in assisting people with shorter-term support needs is one of the central purposes of the study and the HACC Client Survey.

We examined the recent health experiences of HACC clients, i.e. since July 2013. This information is not collected in the HACC MDS. It was included to examine the extent to which HACC services were used to provide assistance to people experiencing short-term health problems. The period July 2013 to present covers the period from the beginning of the period used as the sampling frame to the time of interview.

We asked respondents if they had an illness, injury or surgery during this period, and if so what kind of illness, injury or surgery it was. If they answered positively, they were asked about:

- the type of illness or injury
- whether or not they received assistance at home as a result of this accident/injury
- the source of help if provided
- the type of help provided.

Illnesses and surgeries were the most common events reported (48.1 per cent and 41.9 per cent respectively), with 27.5 per cent of the participants having experienced an injury (Table 96). However, reviewing the prevalence of these health circumstances across the client group, the findings showed that 72.9 per cent of the clients had at least one of three health circumstances since July 2013 (Table 97), with 33.7 per cent having more than one.

Reviewing these results by length of time as a HACC client, we can see that 100 per cent of short-term clients had an illness, injury or surgery in the 18 month period prior to the HACC Client Survey (Table 98). The three most common short-term health conditions were:

- physical injuries (18.3 per cent)
- diseases of the musculoskeletal system and connective tissue (18.3 per cent)
- digestive surgeries (11.0 per cent) (Table 99).

To determine the pattern of HACC service use in regards to short term health circumstances, participants were asked about the help required at home, or change in help provided at home, as a result of their health circumstance. As Table 100 shows, participants were almost evenly divided between receiving help/change in help (48.8 per cent) and not receiving help/change in help (50.5 per cent).

For those who did receive help, this was most often provided by an organisation, nurse or other health worker (85.5 per cent) or a household or family member or friend (54.4 per cent) (Table 101).

Reviewing these results by length of time as a HACC client, Table 102 shows that short-term clients are more likely to receive a change in help due to the illness, injury or surgery. Of those participants who reported receiving help/change in help from an organisation, nurse or other health worker, the assistance was most often help with household tasks (reported by 81.4 per cent of participants), followed by help with personal care (37.3 per cent) and nursing care (33.9 per cent) (Table 103).

Table 96 Illnesses, injuries and surgery since July 2013 reported by HACC clients (Q25)

Illnesses, injuries and surgery	Illnesses		Injuries		Surgery	
	No.	%	No.	%	No.	%
Yes	187	48.1	107	27.5	163	41.9
No	202	51.9	282	72.5	226	58.1
Total	389	100.0	389	100.0	389	100.0

Source: Tasmanian HACC client survey 2015

Table 97 Health circumstance since July 2013 reported by HACC clients (Q25)

Health circumstance	No.	%
<i>Illness/injury/surgery</i>	283	72.9
<i>Don't know</i>	14	3.6
<i>Not applicable</i>	91	23.5
Total	388	100.0

Source: Tasmanian HACC client survey 2015

Table 98 Long and short-term users of HACC services by health circumstance since July 2013 reported by HACC clients

Long vs short-term clients	Illness/injury/surgery		None		Total	
	No.	%	No.	%	No.	%
<i>Short-term client not continuing</i>	15	100.0	0	0.0	15	100.0
<i>Short-term client continuing</i>	32	74.4	11	25.6	43	100.0
<i>Long-term client</i>	147	72.8	55	27.2	202	100.0
<i>Missing</i>	34	66.7	17	33.3	51	100.0
Total	228	73.3	83	26.7	311	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 99 Most serious type of illness, injury or surgery (ICD-10-AM categories) since July 2013 reported by HACC clients (Q26)

Illness/injury/surgery	No.	%
<i>S00-T98 Injury, poisoning and certain other consequences of external causes</i>	50	18.3
<i>M00-M99 Diseases of the musculoskeletal system and connective tissue</i>	47	17.1
<i>K00-K93 Diseases of the digestive system</i>	30	11.0
<i>J00-J99 Diseases of the respiratory system</i>	21	7.7
<i>C00-D48 Neoplasms</i>	21	7.7
<i>N00-N99 Diseases of the genitourinary system</i>	17	6.2
<i>R00-R99 Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified</i>	16	5.8
<i>A00-B99 Certain infectious and parasitic diseases</i>	15	5.5
<i>I00-I99 Diseases of the circulatory system</i>	13	4.8
<i>G00-G99 Disease of the nervous system</i>	13	4.7
<i>F00-F99 Mental and behaviour disorders</i>	10	3.7
<i>H00-H99 Diseases of the eyes and ears</i>	7	2.6
<i>O00-O99 Pregnancy, childbirth and the puerperium</i>	5	1.8
<i>D50-D89 Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism</i>	4	1.5
<i>E00-E89 Endocrine, nutritional and metabolic diseases</i>	3	1.1
<i>L00-L99 Diseases of the skin and subcutaneous tissue</i>	2	0.7
Total	274	100.0

Source: Tasmanian HACC client survey 2015

Table 100 Help at home, or change in help provided at home, received as a result of illness, injury or surgery since July 2013 as reported by HACC clients (Q27)

Help at home	No.	%
Yes	138	48.8
No	143	50.5
Don't know	2	0.7
Total	283	100.0

Source: Tasmanian HACC client survey 2015

Table 101 Provider of help at home received as a result of illness, injury or surgery since July 2013 as reported by HACC clients (Q28)

Provider of help at home	Yes		No		Total	
	No.	%	No.	%	No.	%
<i>Household or family member or friend</i>	75	54.4	63	45.6	138	100.0
<i>Organisation, nurse or other health worker</i>	118	85.5	20	14.5	138	100.0
<i>Other social connections</i>	17	12.3	121	87.7	138	100.0
<i>None of these</i>	0	0.0	138	100.0	138	100.0
<i>Don't know</i>	0	0.0	138	100.0	138	100.0

Source: Tasmanian HACC client survey 2015

Table 102 Long and short-term users of HACC services by usage of an organisation, nurse or other health worker as a result of the illness, injury or surgery

	Yes		No.		Total	
	No.	%	No.	%	No.	%
<i>Short-term client not continuing</i>	8	88.9	1	11.1	9	100.0
<i>Short-term client continuing</i>	17	89.5	2	10.5	19	100.0
<i>Long-term client</i>	57	83.8	11	16.2	68	100.0
<i>Missing</i>	12	80.0	3	20.0	15	100.0
<i>Total</i>	94	84.7	17	15.3	111	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 103 Type of help at home due to illness, injury or surgery provided by organisation, nurse or other health worker as reported by HACC clients (Q29)

Type of help at home provided	Yes		No		All receiving help at home by organisation, nurse or health worker	
	No.	%	No.	%	No.	%
<i>Help with housework</i>	96	81.4	22	18.6	118	100.0
<i>Nursing care in the home</i>	40	33.9	78	66.1	118	100.0
<i>Help with personal care</i>	44	37.3	74	62.7	118	100.0
<i>Provision of meals</i>	20	16.9	98	83.1	118	100.0
<i>Help with shopping</i>	25	21.2	93	78.8	118	100.0
<i>Transport to medical appointments</i>	30	25.4	88	74.6	118	100.0
<i>Transport elsewhere</i>	17	14.4	101	85.6	118	100.0
<i>Some other kind of help</i>	13	11.0	105	89.0	118	100.0
<i>None of these</i>	1	1.0	102	99.0	103	100.0
<i>Don't know</i>	1	0.8	118	99.2	118	100.0

Source: Tasmanian HACC client survey 2015

We asked specific questions about hospitalisation, distinguishing between the periods pre- and post-hospitalisation. While it is very likely that those having injury, illness or surgery were admitted to hospital, hospital admission is treated separately as an incident in its own right. We asked participants to indicate the number of overnight stays in hospital since July 2013. 54.2 per cent of HACC clients have had at least one overnight stay in hospital in the 18 month period prior to the survey (Table 104) and a higher proportion (47.5 per cent) of long-term users have had an overnight stay in hospital during this period (Table 105).

Of the reasons for hospital stays, diseases of the musculoskeletal system and connective tissue (24.1 per cent), diseases of the digestive system (12.8 per cent), and diseases of the circulatory system (9.5 per cent) were the most commonly reported (Table 106). The ICD-10-AM was used to classify the self-reported reasons and where participants did not provide enough detail to classify their reason, they were coded as unspecified surgery or illness.

Of those who stayed in hospital for at least one night, 18.5 per cent received help/change in help while waiting to go into hospital (Table 107). Participants reported receiving help/change in help from household or family member or friend (56.4 per cent) and an organisation, nurse or other health workers (71.8 per cent) (Table 108). The most common type of help received was help with housework (77.8 per cent), followed by help with personal care (44.4 per cent) and nursing care (37 per cent) (Table 109).

A higher percentage of those having had an overnight stay of at least one night in hospital (53.1 per cent) reported receiving help/change in help at home while recovering post-hospital than while waiting for their hospital appointment (Table 110). This was most often provided by an organisation, nurse or other health worker (86.6 per cent), followed by household or family member or friend (51.8 per cent) (Table 111). Similarly to previous questions about help/change in help received, help with housework was reported most frequently (72.2 per cent), followed by help with personal care (43.3 per cent) and nursing care in the home (39.2 per cent) (Table 112).

Table 104 Number of overnight stays in hospital since July 2013 reported by HACC clients (Q30)

Overnight stays	No.	%
<i>None</i>	172	44.3
<i>Once</i>	93	23.9
<i>Twice</i>	48	12.3
<i>Three times</i>	25	6.4
<i>Four or more times</i>	45	11.6
<i>Don't know</i>	6	1.5
Total	389	100.0

Source: Tasmanian HACC client survey 2015

Table 105 Long and short-term users of HACC services by at least one overnight stay in hospital since July 2013 reported by HACC clients

	Yes		No.		Don't know		Total	
	No.	%	No.	%	No.	%	No.	%
<i>Short-term client not continuing</i>	6	40.0	9	60.0	0	0.0	15	100.0
<i>Short-term client continuing</i>	17	39.5	26	60.5	0	0.0	43	100.0
<i>Long-term client</i>	96	47.5	104	51.5	2	1.0	202	100.0
<i>Missing</i>	21	41.2	30	58.8	0	0.0	51	100.0
Total	140	45.0	169	54.3	2	0.7	311	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 106 All reasons for hospital stays since July 2013 classified by ICD-10-AM reported by HACC clients (Q31)

Reasons for hospital stays due to illnesses, injuries or surgery	No.	%
<i>M00-M99 Diseases of the musculoskeletal system and connective tissue</i>	66	24.1
<i>K00-K93 Diseases of the digestive system</i>	35	12.8
<i>I00-I99 Diseases of the circulatory system</i>	26	9.5
<i>N00-N99 Diseases of the genitourinary system</i>	18	6.6
<i>J00-J99 Diseases of the respiratory system</i>	17	6.2
<i>C00-D48 Neoplasms</i>	16	5.8
<i>G00-G99 Disease of the nervous system</i>	13	4.7
<i>R00-R99 Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified</i>	12	4.4
<i>Unspecified surgery or illness</i>	12	4.4
<i>F00-F99 Mental and behaviour disorders</i>	10	3.6
<i>A00-B99 Certain infectious and parasitic diseases</i>	10	3.6
<i>S00-T98 Injury, poisoning and certain other consequences of external causes</i>	10	3.6
<i>Z00-Z99 Factors influencing health status and contact with health services Not reported</i>	8	2.9
<i>External causes of morbidity and mortality</i>	6	2.2
<i>E00-E89 Endocrine, nutritional and metabolic diseases</i>	6	2.2
<i>L00-L99 Diseases of the skin and subcutaneous tissue</i>	5	1.8
<i>H60-H99 Diseases of the ear and mastoid process</i>	2	0.7
<i>H00-H59 Diseases of the eye and adnexa</i>	1	0.4
<i>O00-O99 Pregnancy, childbirth and the puerperium</i>	1	0.4
Total	274	100.0

Source: Tasmanian HACC client survey 2015

Table 107 Help at home, or change in help provided at home, received while waiting for any appointment to go into hospital since July 2013 as reported by HACC clients (Q32)

Help at home	No.	%
Yes	39	18.5
No	132	62.6
Not applicable	38	18.0
Don't know	2	0.9
Total	211	100.0

Source: Tasmanian HACC client survey 2015

Table 108 Type of provider of help at home while waiting for any appointment to go into hospital since July 2013 as reported by HACC clients (Q33)

Type of provider of help at home	Yes		No		All	
	No.	%	No.	%	No.	%
<i>Household or family member or friend</i>	22	56.4	17	43.6	39	100.0
<i>Organisation, nurse or other health worker</i>	28	71.8	11	28.2	39	100.0
<i>None of these</i>	0	0.0	39	100.0	39	100.0
<i>Don't know</i>	0	0.0	39	100.0	39	100.0

Source: Tasmanian HACC client survey 2015

Table 109 Type of help at home while waiting to go into hospital since July 2013 provided by organisation, nurse or other health worker as reported by HACC clients (Q34)

Type of help at home provided	Yes		No		All receiving help at home by organisation, nurse or health worker	
	No.	%	No.	%	No.	%
<i>Help with housework</i>	21	75.0	7	25.0	28	100.0
<i>Nursing care in the home</i>	10	35.7	18	64.3	28	100.0
<i>Help with personal care</i>	12	42.9	16	57.1	28	100.0
<i>Provision of meals</i>	5	17.9	23	82.1	28	100.0
<i>Help with shopping</i>	6	21.4	22	78.6	28	100.0
<i>Transport to medical appointments</i>	10	35.7	18	64.3	28	100.0
<i>Transport elsewhere</i>	8	28.6	20	71.4	28	100.0
<i>Help with emotional and social support</i>	2	7.1	26	92.9	28	100.0
<i>Other medical help</i>	1	3.6	27	96.4	28	100.0
<i>Home modification</i>	1	3.6	27	96.4	28	100.0
<i>None of these</i>	0	0.0	28	100.0	28	100.0
<i>Don't know</i>	0	0.0	28	100.0	28	100.0

Source: Tasmanian HACC client survey 2015

Table 110 Help at home, or change in help while recovering at home after any hospitalisation since July 2013 as reported by HACC clients (Q35)

Help at home	No.	%
Yes	112	53.1
No	85	40.3
Not applicable	11	5.2
Don't know/ no answer	3	1.4
Total	211	100.0

Source: Tasmanian HACC client survey 2015

Table 111 Type of provider of help at home while recovering at home after any hospitalisation since July 2013 as reported by HACC clients (Q36)

Type of provider of help at home	Yes		No		All	
	No.	%	No.	%	No.	%
<i>Household or family member or friend</i>	58	51.8	54	48.2	112	100.0
<i>Organisation, nurse or other health worker</i>	97	86.6	15	13.4	112	100.0
<i>Other social connections/groups</i>	1	0.9	111	99.1	112	100.0
<i>None of these</i>	0	0.0	112	100.0	112	100.0
<i>Don't know</i>	0	0.0	112	100.0	112	100.0

Source: Tasmanian HACC client survey 2015

Table 112 Type of help at home while recovering at home after any hospitalisation since July 2013 as reported by HACC clients (Q37)

Type of help at home provided	Yes		No		Missing		All receiving help at home by organisation, nurse or health worker	
	No.	%	No.	%	No.	%	No.	%
<i>Help with housework</i>	70	72.2	23	25.7	2	2.1	97	100.0
<i>Nursing care in the home</i>	40	41.2	55	56.7	2	2.1	97	100.0
<i>Help with personal care</i>	42	43.3	53	54.6	2	2.1	97	100.0
<i>Provision of meals</i>	18	18.5	75	79.4	2	2.1	97	100.0
<i>Help with shopping</i>	17	17.5	78	80.4	2	2.1	97	100.0
<i>Transport to medical appointments</i>	24	24.7	71	73.2	2	2.1	97	100.0
<i>Transport elsewhere</i>	12	12.4	83	85.5	2	2.1	97	100.0
<i>Help with gardening</i>	1	1.0	94	96.9	2	2.1	97	100.0
<i>Help with emotional and social support</i>	1	1.0	94	96.9	2	2.1	97	100.0
<i>Other medical help</i>	1	1.0	94	96.9	2	2.1	97	100.0
<i>None of these</i>	0	0.0	84	100.0	0	0.0	84	100.0
<i>Don't know</i>	0	0.0	95	97.9	2	2.1	97	100.0

Source: Tasmanian HACC client survey 2015

6.3 PATHWAYS INTO HACC

The pathways, especially the referral pathways, into HACC services can also be used to build a picture of the reasons that people use HACC services. As such, the HACC Client Survey asked participants to determine their pathway into HACC so that we could infer the nature of the client's needs and the linkages between HACC and other services,

Participants were asked to choose from a list of health circumstances that may have triggered their service use, from which they could choose multiple responses or specify another reason.

The top three health circumstances that led to the usage of HACC services are:

- a long-term health condition or disability (67.1 per cent)
- an illness (29.6 per cent)
- surgery (24.9 per cent) (Table 113).

To investigate the pathways into HACC further, we asked respondents about the people who told them about HACC services or helped them to get in touch with these services.

Table 114 presents participants' self-reported referrer to HACC services; they could choose multiple responses and/or provide an open-ended response. Those open-ended responses were coded as:

- other medical staff (e.g. pharmacist, social worker)
- other government organisation (e.g. Centrelink)
- child's school
- partner's doctor
- local advertising
- workplace
- nursing home staff.

Responses were quite varied, with participants most commonly listing their doctor as their referrer (37.8 per cent), followed by someone from a community service organisation (31.4 per cent) and a nurse or other person working in a hospital (28.0 per cent).

Table 113 Circumstances that triggered use of HACC services as reported by HACC clients (Q38)

Circumstances triggering use of HACC services	Yes		No		Missing		All	
	No.	%	No.	%	No.	%	No.	%
<i>An illness</i>	115	29.6	273	70.2	1	0.2	389	100.0
<i>An injury</i>	70	18.0	318	81.8	1	0.2	389	100.0
<i>Surgery</i>	97	24.9	291	74.8	1	0.2	389	100.0
<i>A long-term health condition or disability</i>	261	67.1	127	32.7	1	0.2	389	100.0
<i>A short-term health condition or disability</i>	32	8.3	356	91.5	1	0.2	389	100.0
<i>A mental health problem</i>	19	4.9	370	95.1	0	0.0	389	100.0
<i>General ailment or ageing</i>	2	0.5	387	99.5	0	0.0	389	100.0
<i>Carer responsibilities</i>	8	2.1	381	97.9	0	0.0	389	100.0
<i>Because of others</i>	11	2.8	378	97.2	0	0.0	389	100.0
<i>No help received</i>	3	0.8	386	99.2	0	0.0	389	100.0
<i>No help needed</i>	4	1.0	385	99.0	0	0.0	389	100.0
<i>Don't know</i>	38	9.8	351	90.2	0	0.0	389	100.0

Source: Tasmanian HACC client survey 2015

Table 114 Person who first provided information about and/or assisted to contact HACC services as reported by HACC clients (Q38B)

Type of person	Yes		No		Don't know		All	
	No.	%	No.	%	No.	%	No.	%
Your doctor	147	37.8	242	62.2	0	0	389	100.0
A nurse or other person working in a hospital	109	28.0	280	72.0	0	0	389	100.0
A community nurse	55	14.1	334	85.9	0	0	389	100.0
Someone from a community service organisation	122	31.4	267	68.6	0	0	389	100.0
A family member	60	15.4	329	84.6	0	0	389	100.0
A friend or neighbour	43	11.0	346	89.0	0	0	389	100.0
Found out about it myself	35	9.0	354	91.0	0	0	389	100.0
Someone organised it on my behalf	11	2.8	378	97.2	0	0	389	100.0
Other medical staff	6	1.5	383	98.5	0	0	389	100.0
Other government organisation	3	0.8	386	99.2	0	0	389	100.0
School	2	0.5	387	99.5	0	0	389	100.0
Partner's doctor	1	0.3	388	99.7	0	0	389	100.0
Local advertising	1	0.3	388	99.7	0	0	389	100.0
Workplace	4	1.0	385	99.0	0	0	389	100.0
Nursing home staff	1	0.3	388	99.7	0	0	389	100.0
Don't know	20	5.1	369	94.9	0	0	389	100.0

Source: Tasmanian HACC client survey 2015

6.4 PATTERNS OF HACC SERVICE USE

The pattern of past, present and anticipated future use of HACC services can be used to infer (with some qualifications) the reasons for use of services. Length, intensity and types of service use, all provide clues to the reasons for becoming a HACC client. Clients' views about their future need for services are also important in understanding the reasons they use the service(s) as well as for estimating future demand. Clients expecting to cease using services within a short period of time are likely to be using the service for different reasons to those who anticipate lifelong use of HACC services.

We asked a series of questions about the use of HACC services generally. Respondents were referred to up to three HACC services they received during 2013-14 in order to ensure that they were considering the services under analysis rather than other services they may have received from other sources. This is the first point in the survey that specific reference is made to HACC service types.

The HACC MDS was used to identify up to three HACC services that were used by clients during 2013-14. These were named and read out to respondents at the beginning of the series of questions. The informal term for each service type (see the conversion chart at the end of the survey questionnaire in [Appendix I](#)) was used to describe the service type to respondents. It was decided that indirect service types were likely to be meaningless to many respondents and were not used. These included assessment and screening; case management; and client care coordination, unless it was the only service type for the period, in which case it was retained.

The HACC Client Survey asked respondents' whether they are still receiving the service(s) and for those that are, to provide a reason for continuing to receive the service. This is designed to provide another source of data on reasons for original and continuing use of services. The possible answers, which are read out to respondents, distinguish between long and short-term reasons for using services.

The majority of participants (71.5 per cent) were still receiving services at the time they completed the survey (Table 115) and 93.9 per cent of these clients indicated they were using these services for the same health condition or disability that initially triggered their use of services (Table 117).

As shown in Table 116, a lower proportion (26.7 per cent) of short-term HACC clients was still using HACC services at the time of the interview. Although showing the expected trend, this figure is higher than expected and may point to multiple entry and exits for short-term clients along the trajectory of their health circumstances. It should be noted that 1.4 per cent of HACC clients continue to receive services even though they have recovered from their health condition or disability (Table 117).

Table 115 Whether or not client is still receiving HACC services at time of interview as reported by HACC clients (Q39)

Still receiving HACC services	No.	%
Yes	278	71.5
No	102	26.2
Don't know	9	2.3
Total	389	100.0

Source: Tasmanian HACC client survey 2015

Table 116 Long and short-term users of HACC services by whether the client is still receiving HACC services at time of interview as reported by HACC clients

	Yes		No.		Don't know		Total	
	No.	%	No.	%	No.	%	No.	%
Short-term client not continuing	4	26.7	11	73.3	0	0.0	15	100.0
Short-term client continuing	29	67.4	13	30.2	1	2.4	43	100.0
Long-term client	160	79.2	36	17.8	6	3.0	202	100.0
Missing	34	66.7	17	33.3	0	0.0	51	100.0
Total	227	73.0	77	24.8	7	2.2	311	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 117 Reasons for still receiving HACC services as reported by HACC clients (Q40)

Reason	No.	%
I still have the health condition or disability that triggered my use of the services	261	93.9
I have a new health condition or disability that I need the services for	7	2.5
The services have continued even though I have recovered from my health condition or disability	4	1.4
Don't know	6	2.2
Total	278	100.0

Source: Tasmanian HACC client survey 2015

Data from the HACC MDS was used to determine the most used service type and second most used service type during the period 2013-14 for each client (Service type I and II) and this data was used to explore client specific service type.

As extensive information about past and current use of HACC services is available through the HACC MDS, the survey focused on clients' anticipated future use of HACC services and addressed the following:

- Are you still receiving the service type?
- Does the service meet your needs?
- Do you expect to be using it in the future?
- Do you expect to use the service regularly or intermittently as needed?
- For how much longer will you need the service?
- Did you and do you need more or less of the service?
- How could the service help and support you better?
- Are there any other services that you need?

Table 118 presents the service types received by participants, for both services covered in the survey. The most frequently used services overall were:

- domestic assistance (19.7 per cent)
- client care coordination (16.6 per cent)
- transport (7.3 per cent).

Table 119 shows that:

- 65.6 and 56.0 per cent of clients indicated that they are still using service type I and II respectively.
- 71.5 per cent of clients continue (at time of interview) to use either service type I or II.
- 4.9 per cent of HACC clients indicated that they have never received service type I or type II.

Reviewing these results by the service types, Table 120 shows that a higher proportion of HACC clients are no longer using the following services:

- nursing care (59.6 per cent)
- allied health (46.7 per cent),
- transport (31.6 per cent).

67.0 and 71.4 of the clients who had received type I or type II services indicated that service type I and service type II met their needs, mostly or completely. 6.9 and 7.3 per cent of the clients indicated that their needs were not being met (not really and not at all) by service type I and service type II respectively.

Table 121 which combines the results from service type I and II, shows that a higher proportion of clients reported that the following service types did not meet their needs:

- counselling and support (15.4 per cent)
- client care coordination (12.9 per cent)
- case management (12.5 per cent)
- home maintenance (12.5 per cent)
- nursing care (10.0 per cent).

81.0 and 77.0 per cent of clients expect to use service type I and II, respectively, in the future. Table 122 shows that a higher proportion of clients expected to use the following services in the future:

- centre-based daycare (100.0 per cent)
- domestic assistance (93.1 per cent)
- social support (91.3 per cent).

A higher proportion (30.0 per cent) of HACC clients indicated that they did not expect to use nursing services in the future.

75.9 and 70.8 per cent of the clients indicated that they would use service type I and service type II on a regular basis. Table 123 shows that a higher proportion of HACC clients indicated that they would use the following service types on a regular basis:

- centre-based daycare (100.0 per cent)
- domestic assistance (97.0 per cent)
- meals (92.9 per cent)
- social support (90.5 per cent).

While a high proportion of clients indicated they would use the following service types on an as needed basis:

- counselling and support (54.5 per cent)
- transport (51.1 per cent)
- nursing care (40.0 per cent).

78.9 and 82.5 per cent of clients expected to be using services for the rest of their lives. Table 124 shows that 80 per cent or more of HACC clients indicated that they expected to use the following services for the rest of their lives:

- home maintenance (90.5 per cent)
- client care coordination (86.7 per cent)
- personal care (84.0 per cent)
- domestic assistance (83.8 per cent).

Clients were asked if the amount of the service they received met their needs, and 63.1 and 67.6 per cent of clients reported their service was about right. Table 125 shows that 30 per cent or more of clients indicated that they needed more of the following service types:

- home maintenance (46.9 per cent)
- domestic assistance (33.8 per cent)
- counselling and support (33.3 per cent)
- centre-based daycare (30.8 per cent).

Four open-ended questions in the survey provided a chance to state what could be improved, what clients needed and general feedback (Question 47, 54, 62 and 82). The first three appeared in the Patterns of Use of HACC services section of the survey, after service I and service II. These are presented below, in Table 126.

As can be seen, there was quite a lot of detail provided by participants when answering these questions. Generally, what can be drawn from these questions is that participants would like more of their services (11.1 per cent), as well as more gardening and home maintenance and modification services (12.6 per cent) and domestic assistance (9.4 per cent) (such as oven cleaning and cooking in the home). A wide variety of other services (such as computer education, yard work, maintenance of home and yard, varied household tasks like window and oven cleaning and services for their pets) were also recorded.

A number of problems with service providers were stated, with the most frequent complaints being:

- the quality and scope of services (e.g. service not up to standard, cleaning should be expanded to include other rooms/items; 5.7 per cent)
- the need for more flexibility with services (e.g. more times available for care, more flexible payment options, being able to respond to emergencies; 5.2 per cent)
- the unreliability of services (such as turning up late, not turning up at all, not having back up staff when someone is sick; 4.2 per cent).

In regards to problems with the wider system, participants mentioned improved coordination of care at a wider level (2.2 per cent) and the need for more, secure funding (2.0 per cent) for services. A number (7.6 per cent) also recorded their positive feedback for the services they received, as well as in regards to the workers (1.5 per cent).

Participants were invited to record any feedback or comments, as well as feedback about the survey (Table 127). Similarly to previous responses, participants stated a need for more of their service (5.7 per cent), for gardening and home maintenance and modifications (4.4 per cent) and for domestic assistance (2.6 per cent). Participants stated that the organisation of the service provider was a problem (6.6 per cent), as was the lack of flexibility in the service (4.4 per cent) and the lack of security of the services (such as the services being cancelled, or the risk of them being cut; 3.5 per cent).

In regards to the wider system, participants had issues with the politics of the system (such as the funding bodies, wider level organization, upper management; 6.6 per cent), the funding (6.1 per cent) and the provision of information (the lack of information on the services, difficulty in finding out information; 5.3 per cent).

Participants recorded positive feedback in regards to the services (15.8 per cent), and were equally positive (3.9 per cent) and negative (3.9 per cent) about the survey.

Table 118 HACC Service types received during 2013-14 for which more detailed client information was requested

Service types	Service type 1		Service type 2		Total	
	No.	% of all service type 1	No.	% of all service type 2	No.	% of all service types 1 and 2
Assessment	11	2.8	0	0.0	11	1.4
Allied health care	26	6.7	4	1.0	30	3.9
Centre-based day care	5	1.3	8	2.0	13	1.7
Client care coordination	67	17.2	62	15.9	129	16.6
Case management	8	2.1	1	0.3	9	1.2
Personal care	25	6.4	18	4.6	43	5.5
Social support	22	5.6	7	1.8	29	3.7
Domestic assistance	111	28.5	42	10.8	153	19.7
Home maintenance	15	3.9	23	5.9	38	4.9
Nursing care	23	5.9	24	6.2	47	6.0
Counselling and support	14	3.6	5	1.3	19	2.4
Formal linen service	0	0.0	1	0.3	1	0.1
Meals	14	3.6	10	2.6	24	3.1
Home modification	0	0.0	0	0.0	0	0.0
Respite care	3	0.8	5	1.3	8	1.0
Transport	45	11.6	12	3.1	57	7.3
Total	389	100.0	389	100.0	778	100.0

Source: Tasmanian HACC client survey 2015 and extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 119 Whether or not client is still receiving specific service type at time of interview as reported by HACC clients (Q41 and Q48)

	Q41		Q48		Q41 & Q48	
	No.	%	No.	%	No.	%
Yes	255	65.6	121	56.0	278	71.5
No	92	23.7	57	26.4	84	21.6
Never received this service	29	7.5	28	13.0	19	4.9
Don't know	13	3.3	10	4.6	8	2.1
Total	389	100.0	216	100.0	389	100.0

Source: Tasmanian HACC client survey 2015

Table 120 Whether or not client is still receiving specific service type at time of interview by service type as reported by HACC clients (Q41 and Q48)

Service types	Still receiving service		Not still receiving service		Never received service		Don't know		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Assessment	4	36.4	5	45.5	1	9.1	1	9.1	11	100.0
Allied health care	14	46.7	14	46.7	2	6.7	0	0.0	30	100.0
Centre-based day care	13	100.0	0	0.0	0	0.0	0	0.0	13	100.0
Client care coordination	64	50.0	36	28.1	13	10.2	15	11.7	128	100.0
Case management	7	77.8	1	11.1	0	0.0	1	11.1	9	100.0
Personal care	26	60.5	9	20.9	8	18.6	0	0.0	43	100.0
Social support	19	65.5	4	13.8	5	17.2	1	3.4	29	100.0
Domestic assistance	131	86.8	14	9.3	6	4.0	0	0.0	151	100.0
Home maintenance	22	61.1	10	27.8	4	11.1	0	0.0	36	100.0
Nursing care	12	25.5	28	59.6	7	14.9	0	0.0	47	100.0
Counselling and support	9	50.0	4	22.2	3	16.7	2	11.1	18	100.0
Formal linen service	1	100.0	0	0.0	0	0.0	0	0.0	1	100.0
Meals	14	58.3	5	20.8	5	20.8	0	0.0	24	100.0
Home modification	-	-	-	-	-	-	-	-	-	-
Respite care	4	50.0	1	12.5	2	25.0	1	12.5	8	100.0
Transport	36	63.2	18	31.6	1	1.8	2	3.5	57	100.0
Total	376	62.1	149	24.6	57	9.4	23	3.8	605	100.0

Source: Tasmanian HACC client survey 2015

Table 121 Extent to which service met client's needs as reported by HACC clients (Q42)

Service types	Completely		Mostly		Somewhat		Not really		Not at all		Don't know		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Assessment	6	66.7	1	11.1	1	11.1	0	0.0	1	11.1	0	0.0	9	100.0
Allied health care	8	28.6	8	28.6	8	28.6	1	3.6	1	3.6	2	7.1	28	100.0
Centre-based day care	6	46.2	4	30.8	3	23.1	0	0.0	0	0.0	0	0.0	13	100.0
Client care coordination	36	35.6	29	28.7	18	17.8	10	9.9	3	3.0	5	5.0	101	100.0
Case management	3	37.5	4	50.0	0	0.0	1	12.5	0	0.0	0	0.0	8	100.0
Personal care	18	51.4	9	25.7	6	17.1	1	2.9	0	0.0	1	2.9	35	100.0
Social support	6	26.1	8	34.8	6	26.1	2	8.7	0	0.0	1	4.3	23	100.0
Domestic assistance	32	22.1	64	44.1	40	27.6	9	6.2	0	0.0	0	0.0	145	100.0
Home maintenance	11	34.4	6	18.8	11	34.4	4	12.5	0	0.0	0	0.0	32	100.0
Nursing care	26	65.0	7	17.5	2	5.0	3	7.5	1	2.5	1	2.5	40	100.0
Counselling and support	4	30.8	3	23.1	4	30.8	1	7.7	1	7.7	0	0.0	13	100.0
Formal linen service	0	0.0	0	0.0	1	100.0	0	0.0	0	0.0	0	0.0	1	100.0
Meals	8	42.1	5	26.3	4	21.1	1	5.3	0	0.0	1	5.3	19	100.0
Home modification	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Respite care	2	40.0	1	20.0	1	20.0	0	0.0	0	0.0	1	20.0	5	100.0
Transport	30	55.6	15	27.8	4	7.4	4	7.4	0	0.0	1	1.9	54	100.0
Total	196	37.3	164	31.2	109	20.7	37	7.0	7	1.3	13	2.5	526	100.0

Source: Tasmanian HACC client survey 2015

Table 122 Whether or not the client expects to use the HACC service in the future (Q43)

Service types	Yes		No		Don't know		Total	
	No.	%	No.	%	No.	%	No.	%
Assessment	6	66.7	2	22.2	1	11.1	9	100.0
Allied health care	18	64.3	4	14.3	6	21.4	28	100.0
Centre-based day care	13	100.0	0	0.0	0	0.0	13	100.0
Client care coordination	76	75.2	8	7.9	17	16.8	101	100.0
Case management	5	62.5	1	12.5	2	25.0	8	100.0
Personal care	28	80.0	5	14.3	2	5.7	35	100.0
Social support	21	91.3	1	4.3	1	4.3	23	100.0
Domestic assistance	135	93.1	4	2.8	6	4.1	145	100.0
Home maintenance	27	84.4	1	3.1	4	12.5	32	100.0
Nursing care	15	37.5	12	30.0	13	32.5	40	100.0
Counselling and support	11	84.6	1	7.7	1	7.7	13	100.0
Formal linen service	1	100.0	0	0.0	0	0.0	1	100.0
Meals	14	73.7	3	15.8	2	10.5	19	100.0
Home modification	-	-	-	-	-	-	-	-
Respite care	4	80.0	1	20.0	0	0.0	5	100.0
Transport	45	83.3	3	5.6	6	11.1	54	100.0
Total	419	79.7	46	8.7	61	11.6	526	100.0

Source: Tasmanian HACC client survey 2015

Table 123 How often clients expects to use HACC service in the future (Q44)

Service types	As needed		On a regular basis		Don't know		Total	
	No.	%	No.	%	No.	%	No.	%
<i>Assessment</i>	2	33.3	3	50.0	1	16.7	6	100.0
<i>Allied health care</i>	5	27.8	9	50.0	4	22.2	18	100.0
<i>Centre-based day care</i>	0	0.0	13	100.0	0	0.0	13	100.0
<i>Client care coordination</i>	28	36.8	41	53.9	7	9.2	76	100.0
<i>Case management</i>	1	20.0	4	80.0	0	0.0	5	100.0
<i>Personal care</i>	5	17.9	22	78.6	1	3.6	28	100.0
<i>Social support</i>	0	0.0	19	90.5	2	9.5	21	100.0
<i>Domestic assistance</i>	4	3.0	131	97.0	0	0.0	135	100.0
<i>Home maintenance</i>	8	29.6	18	66.7	1	3.7	27	100.0
<i>Nursing care</i>	6	40.0	9	60.0	0	0.0	15	100.0
<i>Counselling and support</i>	6	54.5	4	36.4	1	9.1	11	100.0
<i>Formal linen service</i>	0	0.0	1	100.0	0	0.0	1	100.0
<i>Meals</i>	1	7.1	13	92.9	0	0.0	14	100.0
<i>Home modification</i>	-	-	-	-	-	-	-	-
<i>Respite care</i>	1	25.0	3	75.0	0	0.0	4	100.0
<i>Transport</i>	23	51.1	21	46.7	1	2.2	45	100.0
Total	90	21.5	311	74.2	18	4.3	419	100.0

Source: Tasmanian HACC client survey 2015

Table 124 How much longer clients expect to use HACC services (Q45)

Service types	For six months or less		For six months to two years		For more than two years but not forever		For the rest of my life		Don't know		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Assessment</i>	0	0.0	0	0.0	0	0.0	4	1.4	0	0.0	4	100.0
<i>Allied health care</i>	1	33.3	1	4.2	3	12.5	8	2.8	1	4.8	14	100.0
<i>Centre-based day care</i>	0	0.0	1	4.2	1	4.2	9	3.1	2	9.5	13	100.0
<i>Client care coordination</i>	1	33.3	2	8.3	0	0.0	52	18.1	5	23.8	60	100.0
<i>Case management</i>	0	0.0	2	8.3	0	0.0	2	0.7	0	0.0	4	100.0
<i>Personal care</i>	0	0.0	2	8.3	1	4.2	21	7.3	1	4.8	25	100.0
<i>Social support</i>	0	0.0	1	4.2	1	4.2	15	5.2	2	9.5	19	100.0
<i>Domestic assistance</i>	0	0.0	6	25.0	9	37.5	109	37.8	6	28.5	130	100.0
<i>Home maintenance</i>	0	0.0	1	4.2	1	4.2	19	6.6	0	0.0	21	100.0
<i>Nursing care</i>	1	33.4	1	4.1	1	4.1	6	2.1	0	0.0	9	100.0
<i>Counselling and support</i>	0	0.0	2	8.3	2	8.3	4	1.4	1	4.8	9	100.0
<i>Formal linen service</i>	0	0.0	0	0.0	0	0.0	1	0.3	0	0.0	1	100.0
<i>Meals</i>	0	0.0	1	4.2	0	0.0	11	3.8	2	9.5	14	100.0
<i>Home modification</i>	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	100.0
<i>Respite care</i>	0	0.0	1	4.2	0	0.0	2	0.7	0	0.0	3	100.0
<i>Transport</i>	0	0.0	3	12.5	5	20.8	25	8.7	1	4.8	34	100.0
Total	3	100.0	24	100.0	24	100.0	288	100.0	21	100.0	360	100.0

Source: Tasmanian HACC client survey 2015

Table 125 Whether the client needed more or less of the HACC service (Q46)

Service types	Needed more		About right		Needed less		Don't know		Not applicable		Missing		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Assessment	3	30.0	5	50.0	1	10.0	1	10.0	0	0.0	1	10.0	10	100.0
Allied health care	4	14.3	18	64.3	1	3.6	3	10.7	2	7.1	2	7.1	28	100.0
Centre-based day care	4	30.8	9	69.2	0	0.0	0	0.0	0	0.0	0	0.0	13	100.0
Client care coordination	32	27.8	69	60.0	0	0.0	8	7.0	6	5.2	14	12.2	115	100.0
Case management	2	22.2	6	66.7	0	0.0	0	0.0	1	11.1	0	0.0	9	100.0
Personal care	7	20.0	26	74.3	1	2.9	1	2.9	0	0.0	8	22.9	35	100.0
Social support	7	29.2	13	54.2	0	0.0	0	0.0	4	16.7	5	20.8	24	100.0
Domestic assistance	49	33.8	94	64.8	0	0.0	2	1.4	0	0.0	8	5.5	145	100.0
Home maintenance	15	46.9	17	53.1	0	0.0	0	0.0	0	0.0	6	18.8	32	100.0
Nursing care	4	10.0	32	80.0	0	0.0	1	2.5	3	7.5	7	17.5	40	100.0
Counselling and support	5	33.3	6	40.0	1	6.7	1	6.7	2	13.3	4	26.7	15	100.0
Formal linen service	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	100.0
Meals	1	5.3	15	78.9	2	10.5	0	0.0	1	5.3	5	26.3	19	100.0
Home modification	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Respite care	1	16.7	4	66.7	0	0.0	1	16.7	0	0.0	2	33.3	6	100.0
Transport	11	19.6	40	71.4	1	1.8	1	1.8	3	5.4	1	1.8	56	100.0
Total	146	26.6	354	64.6	7	1.3	19	3.5	22	4.0	230	42.0	548	100.0

Source: Tasmanian HACC client survey 2015

Table 126 Suggestions and feedback about how the services could better helped and supported the clients

Codes		Q47		Q54		Q62		Total	
		No.	%	No.	%	No.	%	No.	%
<i>Services needed</i>	<i>Allied health services</i>	3	1.1	0	0.0	8	3.6	11	1.8
	<i>Case management</i>	3	1.1	0	0.0	2	0.9	5	0.8
	<i>Companion animals (incl. guide dogs)</i>	0	0.0	0	0.0	2	0.9	2	0.3
	<i>Domestic assistance</i>	18	6.6	6	6.0	32	14.4	56	9.4
	<i>Education</i>	0	0.0	0	0.0	2	0.9	2	0.3
	<i>Exercise, meditation and wellness</i>	2	0.7	0	0.0	4	1.8	6	1.0
	<i>Future needs will require more/different services</i>	4	1.5	1	1.0	8	3.6	13	2.2
	<i>Gardening and home maintenance and modifications</i>	15	5.5	9	9.0	51	23.0	75	12.6
	<i>Medical services</i>	6	2.2	1	1.0	2	0.9	9	1.5
	<i>More services/longer duration or frequency</i>	42	15.4	18	18.0	6	2.7	66	11.1
	<i>No more services needed</i>	0	0.0	1	1.0	0	0.0	1	0.2
	<i>Personal care</i>	2	0.7	1	1.0	2	0.9	5	0.8
	<i>Respite</i>	0	0.0	0	0.0	1	0.5	1	0.2
	<i>Social outings, support, activities</i>	6	2.2	0	0.0	17	7.7	23	3.9
	<i>Spring cleaning</i>	3	1.1	1	1.0	6	2.7	10	1.7
	<i>Transport</i>	5	1.8	2	2.0	12	5.4	19	3.2
<i>Problems with service provider</i>	<i>Communication</i>	11	4.0	2	2.0	1	0.5	14	2.4
	<i>Cost of services</i>	2	0.7	0	0.0	2	0.9	4	0.7
	<i>Irregularity of person rostered</i>	8	2.9	3	3.0	0	0.0	11	1.8
	<i>More flexibility with services</i>	14	5.1	9	9.0	8	3.6	31	5.2
	<i>Organisation</i>	9	3.3	3	3.0	2	0.9	14	2.4
	<i>Problem with how staff are treated</i>	2	0.7	2	2.0	0	0.0	4	0.7
	<i>Quality and scope of service</i>	22	8.1	8	8.0	4	1.8	34	5.7
	<i>Security of services</i>	6	2.2	1	1.0	1	0.5	8	1.3
	<i>Staff education/training</i>	5	1.8	2	2.0	0	0.0	7	1.2
	<i>Unreliability of services</i>	20	7.3	3	3.0	2	0.9	25	4.2
<i>Waiting time</i>	4	1.5	1	1.0	2	0.9	7	1.2	

Table 126 Suggestions and feedback about how the services could better helped and supported the clients continued

Codes		Q47		Q54		Q62		Total	
		No.	%	No.	%	No.	%	No.	%
<i>System problems</i>	<i>Better parking at hospitals</i>	0	0.0	1	1.0	1	0.5	2	0.3
	<i>Better public transport</i>	0	0.0	1	1.0	2	0.9	3	0.5
	<i>Funding</i>	6	2.2	4	4.0	2	0.9	12	2.0
	<i>Funding for equipment, medication and supplies</i>	0	0.0	0	0.0	2	0.9	2	0.3
	<i>Improved coordination of care</i>	8	2.9	3	3.0	2	0.9	13	2.2
	<i>Information provision</i>	3	1.1	3	3.0	4	1.8	10	1.7
	<i>Pension arrangements</i>	0	0.0	0	0.0	2	0.9	2	0.3
	<i>Politics</i>	2	0.7	0	0.0	2	0.9	4	0.7
	<i>Positive re NDIA</i>	0	0.0	0	0.0	1	0.5	1	0.2
	<i>Service management</i>	4	1.5	1	1.0	0	0.0	5	0.8
<i>General positive feedback re services</i>		30	11.0	9	9.0	6	2.7	45	7.6
<i>Positive feedback for workers</i>		6	2.2	2	2.0	1	0.5	9	1.5
<i>No feedback</i>		1	0.4	2	2.0	16	7.2	19	3.2
<i>No service received</i>		1	0.4	0	0.0	4	1.8	5	0.8
Total		273	100.0	100	100.0	222	100.0	595	100.0

Source: Tasmanian HACC client survey 2015

Table 127 Client comments about the services and survey

Codes		Total	
		No.	%
<i>Services needed</i>	<i>Allied health services</i>	2	0.9
	<i>Domestic assistance</i>	6	2.6
	<i>Education</i>	1	0.4
	<i>Exercise, meditation and wellness</i>	2	0.9
	<i>Future needs will require more/different services</i>	1	0.4
	<i>Gardening and home maintenance and modifications</i>	10	4.4
	<i>Medical services</i>	4	1.8
	<i>More services/longer duration or frequency</i>	13	5.7
	<i>Personal care</i>	1	0.4
	<i>Social outings, support, activities</i>	1	0.4
	<i>Spring cleaning</i>	1	0.4
	<i>Transport</i>	1	0.4
	<i>Work</i>	2	0.9
<i>Problems with service provider</i>	<i>Communication</i>	10	4.4
	<i>Irregularity of person rostered</i>	2	0.9
	<i>More flexibility with services</i>	10	4.4
	<i>Organisation</i>	15	6.6
	<i>Problem with how staff are treated</i>	1	0.4
	<i>Quality and scope of service</i>	5	2.2
	<i>Security of services</i>	8	3.5
	<i>Staff education/training</i>	6	2.6
	<i>Unreliability of services</i>	1	0.4
	<i>Waiting time</i>	3	1.3
<i>System problems</i>	<i>Funding</i>	14	6.1
	<i>Improved coordination of care</i>	7	3.1
	<i>Information provision</i>	12	5.3
	<i>Pension arrangements</i>	4	1.8
	<i>Politics</i>	15	6.6
	<i>Positive re NDIA</i>	1	0.4
	<i>Service management</i>	6	2.6

Table 127 Client comments about the services and survey continued

Codes	Total	
	No.	%
<i>General positive feedback re services</i>	36	15.8
<i>Positive feedback for workers</i>	3	1.3
<i>No feedback</i>	4	1.7
<i>No service received</i>	1	0.4
<i>General positive feedback re services</i>	1	0.4
<i>Positive survey feedback</i>	9	3.9
<i>Survey options/responses not suitable</i>	9	3.9
<i>Length of survey</i>	1	0.4
Total	228	100.0

Source: Tasmanian HACC client survey 2015

6.5 LEVELS OF PERSONAL SUPPORT

The reason for using HACC services is also linked to the availability of support from family and friends, particularly the availability of a carer, i.e. a person or persons providing regular and sustained care and assistance to the person without payment other than a pension or benefit. The availability of informal support of this kind is related to a number of factors including the person's living arrangements and the availability and capacity of family and friends to provide assistance.

It was hypothesised that with the low number of reported carers in the HACC MDS may be indicative of low levels of personal support. However, it is important to take into account the help the client may receive from the community: 61.4 per cent of HACC clients reported they had help with everyday activities and tasks from family, friends and neighbours (Table 128).

For those clients who received help from their family, friends and neighbours, 89.2 per cent had received a phone call or visit from their family, friend or neighbor in that time (Table 130).

There were no notable differences found between long- and short-term users and whether they had help with everyday activities and tasks from family, friends and neighbours (Table 129).

Table 128 Whether or not client has family, friends or neighbours to help with everyday activities and tasks as reported by HACC clients (Q63)

Has help with tasks	No.	%
Yes	239	61.4
No	150	38.6
Total	389	100.0

Source: Tasmanian HACC client survey 2015

Table 129 Long and short-term users of HACC services by whether or not client has family, friends or neighbours to help with everyday activities and tasks as reported by HACC clients

	Yes		No.		Total	
	No.	%	No.	%	No.	%
Short-term client not continuing	10	66.7	5	33.3	15	100.0
Short-term client continuing	26	60.5	17	39.5	43	100.0
Long-term client	117	57.9	85	42.1	202	100.0
Missing	40	78.4	11	21.6	51	100.0
Total	193	62.1	118	37.9	311	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 130 Whether or not family, friends or neighbours have telephoned or visited to check on wellbeing as reported by HACC clients (Q65)

Has received visit or telephone call	No.	%
Yes	214	89.5
No	25	10.5
Total	239	100.0

Source: Tasmanian HACC client survey 2015

6.6 DEMOGRAPHY

Clients of HACC differ in systematic and ongoing ways from the general Tasmanian population aged 15-64. Differences may include those of:

- age
- sex
- country of birth
- geographic location
- Aboriginality
- housing tenure
- main source of income
- income
- educational attainment
- employment status
- citizenship
- overall self-perceived health and wellbeing.

These personal characteristics also provide indications of reasons for using HACC services.

The demographic profile of people with disabilities differs significantly from the general population. If the profile of HACC clients is similar to that of the population of people with a disability this may suggest that this is the group primarily served by the HACC program. The overall socio-economic status of HACC clients may also indicate that HACC assistance is primarily directed to individuals with limited economic resources. In the HACC Client Survey, we used survey questions on personal characteristics designed to complement the data available through the HACC MDS.

HACC clients were asked their status as a carer, a person with a disability or health condition or both. Of those who completed the survey and were included in the sample for analysis:

- the majority (81.5 per cent) identified themselves as a person with a disability or health condition
- 5.1 per cent identified themselves as carers
- 7.5 per cent identified as both
- 5.4 per cent stated they were none of these
- 0.5 per cent responded as unsure.

Participants were also asked whether they would be completing the survey themselves or with assistance (such as a carer); in face-to-face interviews participants were recorded as answering on their own unless a third party was providing assistance. The vast majority of clients (91.3 per cent) answered the survey without help, while 8.2 per cent of participants had assistance and 0.5 per cent were unsure.

It is important to understand the Socio-economic status of HACC clients as this has a major bearing on their reasons for using services. We used a purpose-designed question to ascertain employment status for HACC recipients. It covers workforce involvement, unemployment, and reasons for not being in the workforce. Table 131 shows that most of the HACC clients are either retired (25.2 per cent) or not in the paid workforce for another reason (35.2 per cent), with few working in any paid capacity. A higher proportion of short-term HACC clients are engaged in paid work (13.3 per cent) as compared to long-term HACC clients (8.9 per cent) (Table 132). 11.6 per cent of the Tasmanian population aged 15-64 who need assistance with core activities are employed (Table 157).

The HACC Client Survey used a standard question about educational attainment and current study adapted to reflect the HACC client population. In terms of education, HACC clients most commonly reported a Year 10 or equivalent level of education and 15.4 per cent reported a Year 9 or below level of education. However, a number of participants reported having a TAFE trade certificate or diploma (22.1 per cent) or university degree or higher (11.8 per cent) (Table 133). A higher proportion of short-term clients have a tertiary education (46.7 per cent) as compared to long-term clients (35.6 per cent) (Table 134).

The question on household income provides broad income bands to minimise concerns about provision of this sensitive information. This is an important question as income is a key component of Socio-economic status. The income bands are designed to reflect the known characteristics of the HACC population, and to take into account the known income of those on the full DSP (single and couple rates). Just over half of the HACC clients (52.4 per cent) stated they had an annual household income of \$25,000 or less, and 26 per cent of participants reported an income in the range of over \$25,000 and up to \$40,000 (Table 135). A higher proportion (40.0 per cent) of short-term clients had an annual household income of above \$40,000 (Table 136). A high proportion (79.1 per cent) of clients living alone have a household income of \$25,000 or less (Table 137).

It is understood that there are different eligibility requirements for HACC and NDIS, specifically that clients need to be a resident of Australia in order to be eligible for the NDIS. The vast majority (99.5 per cent) of the sample were Australian citizens or permanent residents (Table 138). This seems to suggest that the majority of those with profound or severe activity limitations may be eligible for the NDIS.

We also asked general questions about health status, quality of life and emotional state which provide an indication of the ways that respondents view their overall health and wellbeing. These questions are related to the reasons that people use HACC services. *Are those who use HACC services people who are generally healthy but who from time to time require assistance to live independently? Or are they people who perceive themselves to be in poor health with low quality of life?*

Considering 97.9 per cent of HACC clients have at least one long-term (lasting longer than 6 months) chronic health condition or disability, 32.7 rated their overall health in the good to excellent range, 39.3 per cent indicated that their health was fair and 27.5 per cent as poor (Table 139). The self-rated quality of life for participants was quite high, with 39.1 per cent of participants reporting their quality of life as good and 10.5 per cent as very good (Table 141). Reviewing these results by the length of time as a client and we observe that short-term clients rate both their health (20.0 per cent very good) and quality of life (66.7 per cent very good) higher than long-term clients (Table 140 and Table 142).

Table 131 Current involvement in paid work as reported by HACC clients (Q68)

Involvement in paid work	No.	%
<i>I am working and have a full-time paid job</i>	9	2.3
<i>I am working and have a part-time or casual paid job</i>	32	8.2
<i>I am currently unemployed</i>	43	11.1
<i>I am retired</i>	98	25.2
<i>I am not in the paid work force for another reason</i>	137	35.2
<i>I care for someone else</i>	1	0.3
<i>Other type of work (e.g. seasonal, self-employed)</i>	3	0.8
<i>I volunteer/engage in work experience</i>	2	0.5
<i>I am a pensioner</i>	23	5.9
<i>I am a student</i>	2	0.5
<i>I am not working due to my health condition/disability</i>	34	8.7
<i>Don't know</i>	5	1.3
Total	389	100.0

Source: Tasmanian HACC client survey 2015

Table 132 Involvement in paid work reported by HACC clients by long and short-term users of HACC services

Involvement in paid work	Short-term client not continuing		Short-term client continuing		Long-term client		Missing		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Engaged in paid work</i>	2	13.3	3	7.0	18	8.9	9	17.6	32	10.3
<i>Unemployed</i>	3	20.0	5	11.6	22	10.9	5	9.8	35	11.3
<i>Retired</i>	6	40.0	7	16.3	55	27.2	14	27.5	82	26.4
<i>Pensioner</i>	0	0.0	7	16.3	10	5.0	2	3.9	19	6.1
<i>Not in workforce for another reason</i>	2	13.3	14	32.6	76	37.6	16	31.4	108	34.7
<i>Not working because of health condition or disability</i>	2	13.3	6	14.0	18	8.9	4	7.8	30	9.6
<i>Don't know/ no answer</i>	0	0.0	1	2.3	3	1.5	1	2.0	5	1.6
Total	15	100.0	43	100.0	202	100.0	51	100.0	311	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 133 Highest level of education completed as reported by HACC clients (Q69)

Highest level of education completed	No.	%
University degree or higher	46	11.8
TAFE trade certificate or diploma	86	22.1
Year 12 or equivalent	51	13.1
Year 11 or equivalent	15	3.9
Year 10 or equivalent	118	30.3
Year 9 or equivalent or less	60	15.4
No formal education	8	2.1
Don't know	5	1.3
Total	389	100.0

Source: Tasmanian HACC client survey 2015

Table 134 Level of completed education reported by HACC clients by long and short-term users of HACC services

Education completed	Short-term client not continuing		Short-term client continuing		Long-term client		Missing		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Tertiary education	7	46.7	11	25.6	72	35.6	15	29.4	105	33.8
Year 12 or equivalent	2	13.3	7	16.3	28	13.9	6	11.8	43	13.8
Below Year 12	6	40.0	22	51.2	96	47.5	29	56.9	153	49.2
No formal education	0	0.0	2	4.7	4	2.0	0	0.0	6	1.9
Don't know/ no answer	0	0.0	1	2.3	2	1.0	1	2.0	4	1.3
Total	15	100.0	43	100.0	202	100.0	51	100.0	311	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 135 Total annual income of household as reported by HACC clients (Q71)

Annual household income	No.	%
Over \$80,000	11	2.8
Over \$40,000 and up to \$80,000	36	9.3
Over \$25,000 and up to \$40,000	101	26.0
\$25,000 or less	204	52.4
Don't know	27	6.9
Refused	10	2.6
Total	389	100.0

Source: Tasmanian HACC client survey 2015

Table 136 Annual income of household reported by HACC clients by long and short-term users of HACC services

Yearly income	Short-term client not continuing		Short-term client continuing		Long-term client		Missing		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Over \$80,000	1	6.7	1	2.3	6	3.0	1	2.0	9	2.9
Over \$40,000 and up to \$80,000	5	33.3	3	7.0	18	8.9	1	2.0	27	8.7
Over \$25,000 and up to \$40,000	5	33.3	12	27.9	43	21.3	20	39.2	80	25.7
\$25,000 or less	3	20.0	22	51.2	118	58.4	23	45.1	166	53.4
Don't know/ no answer	0	0.0	4	9.3	12	5.9	5	9.8	21	6.8
Refused	1	6.7	1	2.3	5	2.5	1	2.0	8	2.6
Total	15	100.0	43	100.0	202	100.0	51	100.0	311	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 137 Annual income of household reported by HACC clients by living arrangements

Yearly income	Living alone		Lives with family		Lives with others		Total	
	No.	%	No.	%	No.	%	No.	%
Over \$80,000	1	0.9	8	4.8	0	0.0	9	3.0
Over \$40,000 and up to \$80,000	3	2.6	19	11.3	2	12.5	24	8.0
Over \$25,000 and up to \$40,000	16	13.9	56	33.3	5	31.3	77	25.8
\$25,000 or less	91	79.1	62	36.9	7	43.8	160	53.5
Don't know/ no answer	4	3.5	16	9.5	1	6.3	21	7.0
Refused	0	0.0	7	4.2	1	6.3	8	2.7
Total	115	100.0	168	100.0	16	100.0	299	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 138 Whether or not an Australian citizen or permanent resident as reported by HACC clients (Q72)

Australian citizen or permanent resident	No.	%
Yes	387	99.5
No	2	0.5
Don't know/ no answer	0	0.0
Total	389	100.0

Source: Tasmanian HACC client survey 2015

Table 139 Self-rating of health by HACC clients (Q73)

'Would you say that your health is ...'	No.	%
<i>Excellent</i>	3	0.8
<i>Very good</i>	36	9.3
<i>Good</i>	88	22.6
<i>Fair</i>	153	39.3
<i>Poor</i>	107	27.5
<i>Don't know</i>	2	0.5
Total	389	100.0

Source: Tasmanian HACC client survey 2015

Table 140 Health rating reported by HACC clients by long and short-term users of HACC services

Health rating	Short-term client not continuing		Short-term client continuing		Long-term client		Missing		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Excellent</i>	0	0.0	1	2.3	1	0.5	0	0.0	2	0.6
<i>Very good</i>	3	20.0	1	2.3	21	10.4	7	13.7	32	10.3
<i>Good</i>	2	13.3	13	30.2	43	21.3	13	25.5	71	22.8
<i>Fair</i>	8	53.3	13	30.2	77	38.1	17	33.3	115	37.0
<i>Poor</i>	2	13.3	14	32.6	60	29.7	14	27.5	90	28.9
<i>Refused</i>	0	0.0	1	2.3	0	0.0	0	0.0	1	0.3
Total	15	100.0	43	100.0	202	100.0	51	100.0	311	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

Table 141 Self-rating of quality of life by HACC clients (Q74)

'Would you say that your quality of life is ...'	No.	%
<i>Very good</i>	41	10.5
<i>Good</i>	152	39.1
<i>Neither poor nor good</i>	108	27.8
<i>Poor</i>	66	17.0
<i>Very poor</i>	16	4.1
<i>Don't know</i>	6	1.5
Total	389	100.0

Source: Tasmanian HACC client survey 2015

Table 142 Quality of life reported by HACC clients by long and short-term users of HACC services

Quality of life	Short-term client not continuing		Short-term client continuing		Long-term client		Missing		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Excellent</i>	3	20.0	3	7.0	20	9.9	7	13.7	33	10.6
<i>Very good</i>	7	46.7	15	34.9	80	39.6	19	37.3	121	38.9
<i>Good</i>	2	13.3	13	30.2	57	28.2	11	21.6	83	26.7
<i>Fair</i>	3	20.0	10	23.3	35	17.3	9	17.6	57	18.3
<i>Poor</i>	0	0.0	1	2.3	8	4.0	4	7.8	13	4.2
<i>Refused</i>	0	0.0	1	2.3	2	1.0	1	2.0	4	1.3
Total	15	100.0	43	100.0	202	100.0	51	100.0	311	100.0

Source: Tasmanian HACC client survey 2015 linked with data from HACC MDS for Tasmania for July 2013-June 2014 inclusive. Data is based only on the 311 HACC clients who provided consent for the survey data to be linked with the administrative data collected by DHHS

6.7 OTHER SERVICE USE

Clients of HACC services typically also use a range of other health and community services and their overall pattern of service use can provide an indication of their reasons for use of HACC services. Of particular importance is the overlapping use of assistance provided through HACC and Disability Services. The proportion of HACC clients also using Specialist Disability Services indicates the proportion of HACC clients who have long-term disabilities, given the eligibility requirements for Disability Services. Similarly, if a HACC user has recently been hospitalised, this may be evidence (in association with other data) of the use of HACC to assist in post-hospitalisation recovery. Recent or regular use of mental health services similarly may suggest that HACC is being used to provide support during mental health episodes.

To give a clearer picture of the HACC clients in their use of wider health and community services, a number of questions were asked to determine whether they are heavy users of the health system; whether or not they use Specialist Disability Services and whether they expect to be covered by the NDIS.

Use of General Practitioner services was common, with 45.3 per cent of HACC clients stating they went to the GP 6-20 times, and 33.2 per cent more than 20 times, since July 2013 (Table 143). Just under half of the sample had not visited the hospital emergency department since July 2013 (45.8 per cent), while 45.0 per cent had visited the emergency department 1-5 times and few clients had been more than 5 times (7.7 per cent) (Table 144). HACC clients made more use of other hospital services (such as specialists), with just under a third not using these services at all, 39.1 per cent visiting the hospital 1-5 times and 27.8 per cent visiting the hospital more than 5 times (Table 145).

HACC clients were also asked about the funding they received and their perceived eligibility for the NDIS, as well as their possession of concession cards:

- relatively few participants (13.6 per cent) received funding from Tasmania Disability Services, and fewer still from the NDIS (1.5 per cent)
- over half of the participants (59.9 per cent) were unsure of whether they would be eligible for the NDIS
- only 11.8 per cent thought that they would be eligible (Table 146).

The self-reported estimation of eligibility for the NDIS should be used with caution. We compared these results with the Specialised Disability Services data, where 15.2 per cent of HACC clients were receiving funding from Specialised Disability Services. Reviewing the client survey linked data (311 clients), while there are 44 (14.1 per cent) HACC clients who are registered with Specialised Disability Services and 44 (14.1 per cent) HACC clients who indicated in the survey that they receive funding from Specialised

Disability Services, only 18 of these clients indicated that they are receiving these services. Similarly only 15 of the 44 HACC/DS clients indicated that they would be eligible for the NDIS.

The most common concession card that people reported being in possession of was the pensioner concession card (82.0 per cent), followed by:

- the health care card (43.7 per cent)
- Commonwealth seniors' health card (12.1 per cent)
- the Department of Veterans' Affairs card (1.3 per cent) (Table 147).

Table 143 Number of visits to a General Medical Practitioner for your own health since July 2013 as reported by HACC clients (Q76)

Number of GP visits for own health	No.	%
<i>None</i>	6	1.5
<i>1-5 times</i>	69	17.7
<i>6-20 times</i>	176	45.3
<i>More than 20 times</i>	129	33.2
<i>Don't know</i>	9	2.3
Total	389	100.0

Source: Tasmanian HACC client survey 2015

Table 144 Number of visits to a hospital emergency department for your own health since July 2013 as reported by HACC clients (Q77)

Number of emergency department visits for own health	No.	%
<i>None</i>	178	45.8
<i>1-5 times</i>	175	45.0
<i>More than 5 times</i>	30	7.7
<i>Don't know</i>	6	1.5
Total	389	100.0

Source: Tasmanian HACC client survey 2015

Table 145 Number of hospital visits to see a health professional for your own health since July 2013 as reported by HACC clients (Q78)

Number of hospital visits to see a health professional for own health	No.	%
<i>None</i>	123	31.6
<i>1-5 times</i>	152	39.1
<i>More than 5 times</i>	108	27.8
<i>Don't know</i>	6	1.5
Total	389	100.0

Source: Tasmanian HACC client survey 2015

Table 146 In receipt of or eligible for Specialist Disability Services or NDIS funding as reported by HACC clients (Q79, Q79B and Q80)

Receipt of / eligibility for specialist disability services funding	Funding from Tasmania Disability Services		Funding from NDIS		Anticipated eligibility for NDIS	
	No.	%	No.	%	No.	%
Yes	53	13.6	6	1.5	46	11.8
No	303	77.9	314	80.7	110	28.3
Don't know	33	8.5	69	17.8	233	59.9
Total	389	100.0	389	100.0	389	100.0

Source: Tasmanian HACC client survey 2015

Table 147 Possession of concession cards as reported by HACC clients (Q81)

Possession of concession cards	Health care card		Pensioner concession card		Commonwealth seniors' health card		Department of Veterans' Affairs card	
	No.	%	No.	%	No.	%	No.	%
Yes	170	43.7	319	82.0	47	12.1	5	1.3
No	219	56.3	70	18.0	342	87.9	384	98.7
Total	389	100.0	389	100.0	389	100.0	389	100.0

Source: Tasmanian HACC client survey 2015

7 CURRENT AND FUTURE POTENTIAL DEMAND

FACTS UP FRONT

- The proportion of the Tasmanian population who have a disability (as defined as those with profound, severe, moderate and mild activity limitations using the *Survey of Disability, Ageing and Carers* (SDAC) criteria) aged 15-64 were collapsed into two groups, individuals with a profound/severe activity limitation (3.8 per cent) and those with a mild/moderate activity limitation (7.0 per cent).
- Tasmania has a higher proportion of people aged 15-64 who need assistance due to a profound/severe disability as compared to the Australian population (3.8 per cent vs 2.6 per cent).
- 38.6 per cent of individuals with a profound/severe disability who needed assistance were aged 55-64 and 25.6 per cent were aged 45-54.
- 85 per cent of individuals with a profound/severe disability who needed assistance with core activities were not in the labour force, compared to 24 per cent of those who do not need assistance.
- For the Tasmanian population, the population of people with a profound or severe disability is anticipated to grow over time, reaching a population of around 50,000 in 2061.
- The Tasmanian population with a profound or severe disability aged 15-64 is expected to decrease (approximately 0.08 per annum), so that in fifty years it is projected that the population of people with a profound or severe disability will decrease by 4.3 per cent, from 12,263 to 11,735.
- Similarly, it is anticipated that the proportion of individuals with a mild/moderate disability will decrease by 4.3 per cent, from 23,512 to 22,501.
- 38 to 40 per cent of individuals aged 15-64 who have a mild/moderate disability have indicated that their disability needs were unmet.

In this chapter, we consider the estimated demand for HACC services based on information obtained from the HACC Client Survey, the HACC MDS and other secondary data sources to derive estimates of future demand.

The HACC Client Survey and the review of existing administrative data sources provided evidence of the current usage and demand for HACC services. However, the information examined in previous chapters is based only on data recorded for the provision of services to HACC clients. The primary aim of this chapter is to examine evidence of current and future demand for HACC services based on the profile of HACC clients, the needs of the wider community, and projections for changes in the population of Tasmania.

The profile of the entire adult population will necessarily differ to that of the HACC client population as the HACC data sets only include people who have accessed HACC services. There is a section of the population who have a disability but do not access HACC services for several reasons. Firstly, a disability may be manageable by the individual so there is no current need for access to the services being offered through HACC. Individuals could also be accessing other programs and services. In either case, knowing the profile of non-HACC service users is important in providing evidence for future need and demand.

To do this, we use accessible data from the *Survey of Disability Ageing and Carers* (SDAC) and the 2011 Census. These data sources are both implemented and administered by the ABS. Analysis of the 2011 Census data on disability has been undertaken to identify the prevalence of core activity limitations amongst the Tasmanian population aged 15-64 years old. The Census asks questions on needs assistance, and we have used this to estimate the population with disability; the Census is based on total population coverage so these estimates are likely to be the most accurate. Analysis of the SDAC allows for detailed profiling of the Tasmanian population with a disability because it disaggregates categories of

disability and provides information about the socio-economic and demographic characteristics as well as the geographical distribution. Further information on the characteristics of these data sets is available at [Appendix I](#).

7.1 WHAT THE ABS DATA CAN TELL US

Information on the level of service need for people with activity limitation is collected in the Census. However, this has not always been the case. In 2006, for the first time, the Census asked questions about activity limitations of all members of the population and specifically about the provision of unpaid care, help or assistance to people with a disability. These questions were also included in the 2011 Census. Analysis of these Census data items provides an indication of the potential number and proportion of Tasmanians who may need assistance from formal programs such as HACC and Specialist Disability Services (in transition to the NDIS) to address their activity limitations.

The two Census variables relevant to need and demand for HACC services are called *Core Activity Need for Assistance* (ASSNP) and *Unpaid Assistance to a Person with a Disability* (UNCAREP).¹¹ The ASSNP variable was developed to measure the number of people with a profound or severe disability, defined as:

'Those people needing help or assistance in one or more of the three core activity areas of self-care, mobility and communication, because of a long-term health condition (lasting six months or more), a disability (lasting six months or more), or old age' (ABS 2011b: 198).

This definition derives from the conceptual framework that underpins SDAC, making the data comparable. The SDAC has been collecting information to measure disability in Australia since 1981 so these underlying concepts have been tried and tested. SDAC identifies a person as having a disability if they *'have a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities'* (ABS 2011a).

Twelve types of everyday activities are recognised by SDAC including activities relating to schooling, employment, reading or writing, household chores, property maintenance, meal preparation, and so on. Three of these everyday activities are identified in SDAC as core activity areas: self-care, mobility, and communication. Inability to undertake tasks within these activity areas are referred to as *core activity limitations (or restrictions)*. The specific tasks involved are, for example, self-care tasks like showering or bathing, dressing, eating, toileting, and bladder or bowel control.

In the SDAC conceptual framework, there are four levels of core activity limitations:

1. A *profound* core activity limitation is when a person is unable to do, or always needs help or supervision with, a task.
2. A *severe* limitation is when a person sometimes needs help or supervision with a core activity task or has difficulty understanding or being understood by family and friends.
3. A *moderate* limitation is when the person needs no help or supervision but has difficulty with a core activity task.
4. A *mild* disability means that the person needs no help and has no difficulty with any of the core activity tasks, but uses aids and equipment or has significant limitations in what they can accomplish.

A person's overall level of core activity limitation is determined by their highest level of limitation in these activities.

The SDAC uses a complex set of questions to identify the number of people with profound or severe core activity limitations (disability). However, in the 2006 and 2011 Censuses, a much simpler method is employed. Information is gathered via three questions:

¹¹ ASSNP and UNCAREP are the codes used to identify these variables in the Census Dictionary (ABS 2011b).

1. Does the person ever need someone to help with, or be with them for self-care activities? *For example: doing everyday activities such as showering, dressing or toileting.*
2. Does the person ever need someone to help with, or be with them for, body movement activities? *For example: getting out of bed, moving around at home, or at a place away from home.*
3. Does the person ever need someone to help with, or be with them for communication activities? *For example: understanding, or being understood by others.*

Three possible responses are: Yes always; Yes sometimes, and No. The Yes, always response corresponds with a profound core activity limitation. The response Yes, sometimes corresponds with a severe core activity limitation. There are no responses that correspond with moderate and mild core activity limitations. The ABS simply combines the Yes, always and Yes, sometimes responses and labels this as the group that *Has need for assistance with core activities*, i.e., the number of people with a profound or severe disability.

Having identified all who need assistance with core activities, the ABS then excludes those who fall within this group but whose disability is not related to 'a long-term health condition (lasting six months or more), a disability (lasting six months or more), or old age'. The main group excluded is people whose disability is the result of 'a short-term health condition (lasting less than six months)'. This is a significant exclusion as it is known from other sources - including the HACC MDS - that HACC clients include significant numbers whose activity limitations result from such short-term health conditions.

The other relevant Census variable, *Unpaid Assistance to a Person with a Disability (UNCAREP)*, is relatively straightforward. The relevant Census question is:

In the last two weeks did the person spend time providing unpaid care, help or assistance to family members or others because of a disability, a long-term illness or problems related to old age?

This includes all of those receiving Carer Allowance or Carer Payment, but excludes work done through a voluntary organisation or group and work unrelated to a person's disability or health condition. The response options are a simple No or Yes.

Unpaid caring includes, but is not limited to, activities such as

- bathing, dressing, toileting and feeding
- helping a person to move around
- helping a person to communicate
- providing emotional support
- helping with or supervising medication
- dressing wounds
- cleaning, laundry, cooking, and meal preparation
- performing housework and household management
- driving or accompanying a person to appointments or activities (ABS 2011b: 261).

This explanation of the ABS's methodologies is required in order to ensure that the resulting data is interpreted correctly. The main findings are set out below. Wherever possible, findings are drawn from the ABS Community Profile data for Tasmania (and Statistical Areas within Tasmania) as this provides a full census count. However, descriptions of the characteristics of those with core activity limitations or assisting those with core activity limitations are drawn from the Confidentialised Unit Record File (CURF) (5 per cent) of the 2011 Census, as this source makes it possible to undertake more detailed analysis of Census variables.

7.2 TASMANIANS NEEDING ASSISTANCE WITH CORE ACTIVITIES

The number and proportion of people in Tasmania and Australia needing assistance with core activities is shown in Table 148. The table compares findings for the whole population and for the population aged 15-64 years, which closely corresponds to the age range of adult HACC clients.¹²

The proportion of the whole population of Tasmania with need for assistance with core activities (profound or severe disability) is 5.8 per cent, which is higher than for the broader Australian population (4.6 per cent). For the population aged 15-64, this difference is even more marked. 3.8 per cent of Tasmanians aged 15-64 are categorised as having a need for assistance with core activities compared with 2.6 per cent for all Australians.

Table 149 shows the breakdown by age and sex of the Tasmanian population aged 15-64 who have a need for assistance with core activities. Males (6,373) slightly outnumber females (5,890) both overall and in all age groups except 35-44. The most striking point in the table is the strong relationship between older age and need for assistance with core activities. 38.6 per cent of persons in the age range 15-64 requiring assistance with core activities are aged 55-64 and a further 25.6 per cent are aged 45-54. The proportion of the population within age groups needing assistance with core activities rises from 2.2 per cent for those aged 15-19 to 7.1 per cent for those aged 55-64. This suggests that future demand for services such as HACC will be considerably impacted by changes in the age composition of the population, and particularly by the proportion of the population aged 45-64.

It is possible to identify changes in the number and proportion of persons requiring assistance over the period 2006 to 2011, and these changes are shown in Table 150. Across all age groups the proportion of persons requiring assistance increased slightly by between 0.2 (25-34) and 0.8 per cent (55-64) and by 0.5 per cent for all aged 15-64. There were no noteworthy changes in the age profile of persons requiring assistance with core activities, other than a 2.3 per cent increase in the proportion of persons aged 55-64, an increase that reflected the sizeable increase in the overall population in that age group.

Table 151 shows the population needing assistance in each of the different regions of Tasmania. This shows regional differences in age. There are fewer younger people in the South East, and a higher number of older people in the West and North West. However, the proportion needing assistance is fairly similar across regions. In all regions roughly 40 per cent of all needing assistance are in the oldest age group, aged between 55-64.

Table 148 Core Activity Need for Assistance in Tasmania and Australia, 2011

Core Activity Need for Assistance (ASSNP)	Tasmania				Australia			
	Population aged 15-64		Whole population		Population aged 15-64		Whole population	
	No.	%	No.	%	No.	%	No.	%
<i>Has need for assistance with core activities</i>	12,263	3.8	28,726	5.8	377,492	2.6	998,601	4.6
<i>Does not have need for assistance with core activities</i>	295,047	92.0	444,216	89.7	13,172,634	91.8	19,287,676	89.7
<i>Not Stated</i>	13,469	4.2	22,412	4.5	801,286	5.6	1,221,442	5.7
Total population	320,779	100.0	495,354	100.0	14,351,412	100.0	21,507,719	100.0

Source: ABS 2011 Census Community Profile for Tasmania and Australia.

¹² Adult HACC clients are defined in this report as clients aged 18-64; and 18-49 for those with Indigenous status.

Table 149 The Tasmanian population aged 15-64 needing assistance with core activities, by age and sex, 2011

Age group	Males			Females			Persons		
	No.	% of all needing assistance	% of age group	No.	% of all needing assistance	% of age group	No.	% of all needing assistance	% of age group
15-19	450	7.1	2.7	263	4.5	1.7	713	5.8	2.2
20-24	312	4.9	2.1	230	3.9	1.6	542	4.4	1.8
25-34	613	9.6	2.3	532	9.0	1.9	1,145	9.3	2.1
35-44	943	14.8	3.0	1,046	17.6	3.1	1,989	16.2	3.1
45-54	1,595	25.0	4.6	1,548	26.3	4.2	3,143	25.6	4.4
55-64	2,460	38.6	7.5	2,271	38.6	6.7	4,731	38.6	7.1
Total	6,373	100.0	4.0	5,890	100.0	3.6	12,263	100.0	3.8

Source: ABS 2011 Census Community Profile for Tasmania.

Table 150 The Tasmanian population aged 15-64 needing assistance with core activities, by age, 2006 and 2011

Age group	2006			2011			Change 2006-2011		
	No.	% of all needing assistance	% of age group	No.	% of all needing assistance	% of age group	No.	% of all needing assistance	% of age group
15-19	542	5.3	1.7	713	5.8	2.2	171	0.5	0.5
20-24	432	4.2	1.5	542	4.4	1.8	110	0.2	0.3
25-34	1,019	10.0	1.9	1,145	9.3	2.1	126	-0.7	0.2
35-44	1,811	17.7	2.7	1,989	16.2	3.1	178	-1.5	0.4
45-54	2,715	26.5	3.9	3,143	25.6	4.4	428	-0.9	0.5
55-64	3,707	36.3	6.3	4,731	38.6	7.1	1,024	2.3	0.8
Total	10,226	100.0	3.3	12,263	100.0	3.8	2,037	0.0	0.5

Source: ABS 2006 and 2011 Census Community Profile for Tasmania.

Table 151 The Tasmanian population aged 15-64 needing assistance with core activities, by Statistical Area 4 regions, 2011

Age group	Hobart			Launceston and North East			South East			West and North West		
	No.	% of all needing assistance	% of age group	No.	% of all needing assistance	% of age group	No.	% of all needing assistance	% of age group	No.	% of all needing assistance	% of age group
15-19	286	6.1	2.1	211	6.4	2.2	39	3.2	2.1	172	5.7	2.3
20-24	231	4.9	1.6	148	4.5	1.8	34	2.8	2.6	124	4.1	2.2
25-34	499	10.6	1.9	273	8.3	1.9	97	7.9	3.0	275	9.1	2.5
35-44	801	17.1	2.9	493	15.0	2.8	197	16.1	4.1	490	16.2	3.5
45-54	1,191	25.4	4.0	821	25.0	4.2	334	27.3	5.9	785	26.0	4.9
55-64	1,678	35.8	6.2	1,344	40.9	7.2	522	42.7	8.6	1,175	38.9	7.9
Total	4,686	100.0	3.4	3,290	100.0	3.7	1,223	100.0	5.4	3,021	100.0	4.4

Source: ABS 2011 Census Community Profile for SA4 areas of Tasmania.

This analysis of people with core activity limitations is extended using the SDAC data, and a detailed explanation on why SDAC data was used is provided in the [technical report](#). In summary, SDAC is based on a sample of survey respondents, not the full population as per the Census; this means that the estimates from the Census are generally more accurate in determining the nature and prevalence of disability in the Tasmanian population.

However, SDAC is valuable because it drills further into the nature of disability, disaggregating the categories of mild and moderate disability. This is important because these people are of particular interest to the HACC Program as actual and/or potential clients.

SDAC is a survey with complex sample selection and nonresponse patterns, so relative standard errors are reported for most statistics.

We have provided the following tables of estimates from SDAC data:

1. *Disability status of all persons living in Tasmania aged 15-64, 2012* - provides overall picture of disability and activity limitations for our population, corresponding to Tables 3.1 and 3.2 in SDAC Tasmania (ABS 2013e).
2. *The breakdown of the types of disability based on the reported conditions, for all persons aged 15-64, Tasmania 2012* - shows the proportion and prevalence of health conditions in the population, and provides a measure of the proportion of people who have physical or mental/behavioural health conditions and the relationship with disability status, corresponding to Table 12 in SDAC Tasmania (ABS 2013e).
3. *Activities for which assistance is needed, all persons with a disability aged 15-64, Tasmania 2012* - shows the different kinds of activity limitations and the extent to which needs have been met, corresponding partly to Table 14.1 and 14.2 in SDAC Tasmania (ABS 2013e).
4. *Extent to which need for assistance is met, all persons with a disability aged 15-65, Tasmania 2012* - shows extent of needs met for different levels of disability, an extension of Tables 14.1 and 14.2 in SDAC Tasmania (ABS 2013e).

The weighted estimates of totals and proportions correspond to the full population. The total population of 318,520 is the number of people in Tasmanian aged between 15-64. Of these, the population with a disability is estimated as 63,383. As a proportion this is approximately 20 per cent with a disability or long-term limiting condition that leads to a restriction or limitation in core activities.

This comprises 4,733 (7 per cent) with profound disability, 11,283 (18 per cent) with severe disability, 11,185 (18 per cent) with moderate disability, and 19,522 (31 per cent) with mild disability. Of the remaining

Tasmanian population with a disability, 8,239 (13 per cent) are estimated to have a disability that is related to a schooling or employment restriction.

There is a notable difference between the number of people (16,016) with a profound/severe disability estimated by the SDAC as compared to the Census (12,263). This may indicate that the SDAC and Census definitions of activity limitation may be perceived differently and may also be associated with sampling error as the SDAC is a survey specifically targeted at people with disabilities and their carers, whereas the census asks questions of activity limitation to everyone. It is for this reason that the Census is the preferred data source, however, due to its limitation in the scope of disabilities, the SDAC estimation of individuals under 65 who have mild to moderate disabilities of 30,707 will be used, but adjusted based on the observed differences found between the profound/severe disability population estimates. Adjusted, the population estimate of under 65's with a mild to moderate disability is estimated to be 23,512, which is 13.6 per cent of the Tasmanian population.

In terms of the age profile, almost a quarter (22 per cent) of those with profound disability are aged 40-44 years old. However for those with severe activity limitation, the largest group are those aged 60-64, who make up a quarter (23 per cent) of this disability group. A similar trend is noticed for those with moderate disability, with roughly 30 per cent aged between 60-64 (Table 152).

Table 152 Disability status of all persons living in Tasmania aged 15-64, 2012

	Profound core activity limitation		Severe core activity limitation		Moderate core activity limitation		Mild core activity limitation		Schooling or employment restriction		With disability – no restrictions or limitations		No reported disability				Total			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	With long-term health condition		Without long-term health condition		No.	%		
All persons	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Estimates (counts) and proportions (%)																				
15-19	427	1.35	273	0.86	265	0.84	701	2.21	1270	2.80	888	2.80	2989	9.43	24872	78.50	31685	100.0		
20-24	195	0.64	140	0.46	413	1.36	995	3.27	511	1.68	683	2.25	4964	16.34	22476	73.99	30377	100.0		
25-29	143	0.51	206	0.73	437	1.56	913	3.25	330	1.17	588	2.09	4905	17.46	20572	73.23	28093	100.0		
30-34	345	1.23	957	3.42	128	0.46	1430	5.11	735	2.63	580	2.07	5513	19.70	18297	65.38	27986	100.0		
35-39	308	1.07	1079	3.75	215	0.75	484	1.68	452	1.57	542	1.88	6663	23.15	19035	66.14	28779	100.0		
40-44	1037	3.04	1617	4.73	781	2.29	744	2.18	897	2.62	1081	3.16	7248	21.21	20761	60.77	34165	100.0		
45-49	429	1.28	1546	4.60	1172	3.49	2909	8.65	1134	3.37	829	2.47	8850	26.33	16743	49.81	33612	100.0		
50-54	633	1.73	1172	3.21	1832	5.01	2997	8.20	1192	3.26	1262	3.45	12191	33.36	15264	41.77	36543	100.0		
55-59	581	1.67	1713	4.94	2777	8.01	4274	12.32	960	2.77	1143	3.30	12615	36.37	10623	30.63	34686	100.0		
60-64	635	1.95	2580	7.92	3166	9.71	4076	12.51	759	2.33	829	2.53	11994	36.80	8561	26.27	32594	100.0		
Total	4733	1.49	11283	3.54	11185	3.51	19522	6.13	8239	2.59	8422	2.64	77933	24.47	177204	55.63	318520	100.0		

Table 152 Disability status of all persons living in Tasmania aged 15-64, 2012 continued

Relative standard error of estimated totals																		
	Profound core activity limitation		Severe core activity limitation		Moderate core activity limitation		Mild core activity limitation		Schooling or employment restriction		With disability – no restrictions or limitations		No reported disability				Total	
15-19	247	-	193	-	188	-	296	-	427	-	363	-	637	-	1832	-	2036	-
20-24	195	-	140	-	238	-	356	-	272	-	311	-	856	-	1759	-	2020	-
25-29	143	-	206	-	259	-	362	-	238	-	277	-	846	-	1785	-	2039	-
30-34	254	-	388	-	128	-	462	-	315	-	291	-	918	-	1704	-	2051	-
35-39	220	-	411	-	155	-	232	-	263	-	253	-	945	-	1606	-	1932	-
40-44	360	-	444	-	306	-	275	-	350	-	351	-	958	-	1595	-	1982	-
45-49	220	-	435	-	372	-	620	-	367	-	344	-	1064	-	1472	-	2001	-
50-54	291	-	378	-	464	-	569	-	369	-	373	-	1192	-	1311	-	1949	-
55-59	302	-	446	-	571	-	746	-	345	-	387	-	1265	-	1168	-	2010	-
60-64	296	-	607	-	626	-	736	-	313	-	316	-	1237	-	1065	-	1980	-
<i>Total</i>	816	-	1231	-	1150	-	1537	-	1033	-	1029	-	2830	-	3553	-		-

Notes

1. Weighted estimates and proportions using the sampling weights
2. The relative standard errors are given for the weighted estimates
3. The percentage for each disability is based on the weighted population estimate

According to the SDAC survey results (Table 153), the weighted prevalence of those with conditions that are associated with physical disability is 50,714 Tasmanians aged between 15-64 years old. This represents 16 per cent of people in this age cohort. 34,293 Tasmanians in this age group have other disability, a proportion of 11 per cent, and 80 per cent of the Tasmanian population (255,138 people) have no disability. This figure is smaller than the reported disability rate, because it includes the proportion with long-term health conditions, but not classified as having a disability.

Disaggregating the results further, of those with a physical disability, approximately 8 per cent have profound activity limitation, and 22 per cent have severe activity limitation. Different results are observed when looking at those conditions associated with intellectual disability; 27 per cent have profound activity limitation and 13 per cent have severe activity limitation (Table 153).

Table 154 provides the prevalence rates and numbers of people by the different activities where assistance is needed, for the various disability subgroups. This table allows us to explore the different core activities that require assistance. The definitions of the different disability subgroups are based on restrictions and limitations on a range of core activities; this table shows the specific activities, and allows us to create profiles of disability status by the type of activity limitation and restriction.

- Of those needing help with meal preparation, a significant proportion, 81 per cent, have either profound or severe disability (46 per cent with profound and 35 per cent with severe disability).
- 80 per cent of the population aged 15-64 do not need any assistance, and this is predominantly those without any disability.
- 63,382 people are reported as needing assistance with any of the listed core activities; of this group, the largest proportion (30 per cent) require property assistance, and the next largest is 25 per cent who are classified as needing 'other' core activity help.

Table 155 shows the number and proportion of people and the extent to which their needs were met:

- Overall, most people stated that their needs were either fully met or partially met.
- The proportion of people with profound disability who believed their needs were fully met was 56 per cent, while 44 per cent reported that their needs were partially met.
- No person with profound disability reported that their needs were not met.
- For those with severe disability, the proportions were: 62 per cent fully met, 36 per cent partially met; and around 10 per cent not met.

Moving on to those with moderate disability, 36 per cent reported fully met needs, 25 per cent had their needs partially met, whereas 6 per cent did not have their needs met.

Similar proportions are reported for those with mild disability, with 32 per cent fully met needs, 25 per cent partially met needs and 3 per cent with unmet needs.

Roughly, 50 per cent of those with mild disability and 40 per cent with moderate disability were recorded as not applicable, referring to the fact their conditions did not lead to core activity limitation requiring assistance.

Finally, Table 155 shows that 1,533 of the population of Tasmanians aged 15-64, (representing a proportion of 0.5 per cent) have their disability needs unmet. However, this is primarily those with moderate (40 per cent) or mild (38 per cent) core activity limitations. One explanatory factor could be that when their diagnosis was made, they did not need assistance with activities, but over time their condition might have worsened, leading them to require some assistance and finding their needs unmet.

This result seems to tie in with the observations in Table 154. For instance 53 per cent of those requiring assistance with self-care have a moderate disability, while 91 per cent of those requiring assistance with mobility functions have a moderate disability. In addition, 33 per cent of cognitive/emotional, 22 per cent of health-care, 33 per cent of private transport, and 51 per cent of public transport activities are carried out for those with mild disability. Further, 55 per cent of the proportion of people who need assistance with reading or writing tasks have a schooling or employment activity limitation

Table 153 Type of disabilities reported for all persons with a disability aged 15-64, Tasmania 2012

	Profound core activity limitation		Severe core activity limitation		Moderate core activity limitation		Mild core activity limitation		Schooling or employment restrictions		With disability but no limitation or restriction		No reported disability				Total	
													With long-term health condition		Without long-term health condition			
Estimates (counts) and proportions (%)																		
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Physical disability</i>	3912	7.71	10923	21.54	9739	19.20	15275	30.13	4426	8.73	6640	12.70	0	-	0	-	50714	100.0
<i>Intellectual disability</i>	2386	27.11	1126	12.79	1144	13.00	1500	17.04	1515	17.22	1129	12.84	0	-	0	-	8801	100.0
<i>Emotional conditions or mental illness</i>	2788	21.12	2846	21.56	1877	14.22	3505	26.54	1236	9.36	949	7.19	0	-	0	-	13200	100.0
<i>Other disability</i>	3446	10.05	8573	25.00	7260	21.16	8638	25.18	4090	11.92	2285	6.66	0	-	0	-	34293	100.0
<i>No disability</i>	0	-	0	-	0	-	0	-	0	-	0	-	77933	30.55	177204	69.45	255138	100.0
Total	4733	1.49	11283	3.54	11185	3.51	19522	6.13	8239	2.59	8422	2.64	77933	24.47	177204	55.63	318520	100.0
Relative standard error of estimated totals																		
<i>Physical disability</i>	744	-	1185	-	1074	-	1364	-	750	-	6440	-	-	-	-	-	2347	-
<i>Intellectual disability</i>	596	-	368	-	367	-	468	-	466	-	403	-	-	-	-	-	1095	-
<i>Emotional conditions or mental illness</i>	628	-	613	-	474	-	636	-	422	-	370	-	-	-	-	-	1287	-
<i>Other disability</i>	694	-	1055	-	938	-	1035	-	723	-	539	-	-	-	-	-	1993	-
<i>No disability</i>	-	-	-	-	-	-	-	-	-	-	-	-	2830	-	3553	-	3060	-
Total	816	-	1213	-	1150	-	1537	-	1033	-	1029	-	2830	-	3553	-	-	-

Notes: 1. Weighted estimates and proportions using the sampling weights; 2. The relative standard errors are given for the weighted estimates; 3. The percentage for each disability is based on the weighted population estimate

Table 154 Activities for which assistance is needed, all persons with a disability aged 15-64, Tasmania 2012

	Profound core activity limitation		Severe core activity limitation		Moderate core activity limitation		Mild core activity limitation		Schooling or employment restrictions		With disability but no limitation or restriction		No reported disability				Total			
													With long-term health condition		Without long-term health condition					
Estimates (counts) and proportions (%)																				
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%		
Self-care	-	-	369	47.21	413	52.79	-	-	-	-	-	-	-	-	-	-	-	-	782	100.0
Mobility	-	-	117	9.25	1144	90.72	-	-	-	-	-	-	-	-	-	-	-	-	1261	100.0
Communication	-	-	128	100.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	128	100.0
Cognitive or emotional tasks	128	1.98	-	-	597	9.27	2111	32.78	2032	31.56	1572	24.41	-	-	-	-	-	-	6439	100.0
Health care	143	7.80	444	24.16	296	16.11	411	22.34	544	29.59	-	-	-	-	-	-	-	-	1838	100.0
Reading or writing tasks	-	-	137	11.61	-	-	215	18.28	649	55.07	177	15.02	-	-	-	-	-	-	1178	100.0
Private Transport	-	-	1140	48.41	106	4.51	769	32.66	193	8.19	147	6.26	-	-	-	-	-	-	2355	100.0
Public Transport	422	8.97	962	20.42	903	19.17	2424	51.45	-	-	-	-	-	-	-	-	-	-	4711	100.0
Household chores	297	6.45	699	16.72	1551	34.70	1082	25.87	353	8.44	326	7.80	-	-	-	-	-	-	4182	100.0
Property maintenance	1018	5.49	5210	28.08	5498	29.63	5238	28.23	1111	6.00	480	2.59	-	-	-	-	-	-	18555	100.0
Meal preparation	2752	45.89	2078	34.65	667	11.12	296	4.94	204	3.40	-	-	-	-	-	-	-	-	5997	100.0
Other	-	-	-	-	109	0.68	6976	43.72	3153	19.76	5719	35.84	-	-	-	-	-	-	15957	100.0
Not Needed	-	-	-	-	-	-	-	-	-	-	-	-	77933	30.55	177204	69.45	-	-	255138	100.0
Total	4733	1.49	11283	3.54	11185	3.51	19522	6.13	8239	2.59	8422	2.64	77933	24.47	177204	55.63	-	-	318520	100.0

Table 154 Activities for which assistance is needed, all persons with a disability aged 15-64, Tasmania 2012 continued

Relative standard error of estimated totals																		
<i>Self-care</i>	-	-	267	-	242	-	-	-	-	-	-	-	-	-	-	-	360	-
<i>Mobility</i>	-	-	117	-	357	-	-	-	-	-	-	-	-	-	-	-	376	-
<i>Communi-cation</i>	-	-	128	-	-	-	-	-	-	-	-	-	-	-	-	-	128	-
<i>Cognitive or emotional tasks</i>	128	-	-	-	300	-	497	-	536	-	466	-	-	-	-	-	919	-
<i>Health care</i>	143	-	262	-	174	-	205	-	278	-	-	-	-	-	-	-	488	-
<i>Reading or writing tasks</i>	-	-	137	-	-	-	156	-	299	-	177	-	-	-	-	-	404	-
<i>Private Transport</i>	-	-	389	-	106	-	331	-	151	-	147	-	-	-	-	-	561	-
<i>Public Transport</i>	218	-	374	-	346	-	531	-	-	-	-	-	-	-	-	-	764	-
<i>Household chores</i>	214	-	287	-	433	-	369	-	210	-	231	-	-	-	-	-	737	-
<i>Property maintenance</i>	369	-	826	-	804	-	826	-	366	-	246	-	-	-	-	-	1496	-
<i>Meal preparation</i>	637	-	515	-	274	-	216	-	145	-	-	-	-	-	-	-	897	-
<i>Other</i>	-	-	-	-	109	-	954	-	642	-	830	-	-	-	-	-	1399	-
<i>Not needed</i>		-	-	-	-	-	-	-	-	-	-	-	2830	-	3553	-	3060	-
<i>Total</i>	816	-	1213	-	1150	-	1537	-	1033	-	1029	-	2830	-	3553	-	-	-

Notes

1. Weighted estimates and proportions using the sampling weights
2. The relative standard errors are given for the weighted estimates
3. The percentage for each disability is based on the weighted population estimate

Table 155 Extent to which need for assistance is met, all persons with a disability aged 15-64, Tasmania 2012

	Profound core activity limitation		Severe core activity limitation		Moderate core activity limitation		Mild core activity limitation		Schooling or employment restrictions		With disability but no limitation or restriction		No reported disability				Total	
													With long-term health condition		Without long-term health condition			
Estimates (counts) and proportions (%)																		
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Fully met</i>	2659	11.30	6973	29.62	4032	17.13	6162	26.18	2512	10.67	1201	5.10	0	-	0	-	23538	100.0
<i>Partly met</i>	2704	17.37	4045	33.89	2840	20.78	2049	17.17	730	6.11	559	4.68	0	-	0	-	11937	100.0
<i>Not met</i>	0	-	138	8.98	620	40.45	582	37.94	194	12.62	0	-	0	-	0	-	1533	100.0
<i>Not applicable</i>	0	-	128	0.05	4053	1.44	10728	3.81	4803	1.71	6662	2.37	77933	27.68	177204	62.95	281512	
Total	4733	1.49	11283	3.54	11185	3.51	19522	6.13	8239	2.59	8422	2.64	77933	24.47	177204	55.63	318520	100.0
Relative standard error of estimated totals																		
<i>Fully met</i>	633	-	975	-	690	-	873	-	581	-	412	-	-	-	-	-	1708	-
<i>Partly met</i>	519	-	714	-	547	-	523	-	302	-	286	-	-	-	-	-	1216	-
<i>Not met</i>	-	-	138	-	240	-	244	-	137	-	-	-	-	-	-	-	393	-
<i>Not applicable</i>	-	-	128	-	724	-	1165	-	797	-	904	-	2830	-	3553	-	2650	-
Total	816	-	1213	-	1150	-	1537	-	1033	-	1029	-	2830	-	3553	-	-	-

Notes

1. Weighted estimates and proportions using the sampling weights
2. The relative standard errors are given for the weighted estimates
3. The percentage for each disability is based on the weighted population estimate

7.3 CORE ACTIVITY ASSISTANCE AND SOCIAL DISADVANTAGE

To undertake more detailed analysis of the characteristics of persons living in Tasmania requiring assistance with core activities we used the 5 per cent Confidentialised Unit Record File (CURF) of the 2011 Census. This is because the Community Profile data is not in a form allowing the construction of cross-tabulations other than for age, sex and geographic location. The CURF is a 5 per cent sample of the Census population, and consequently there are small differences in the estimates of the number of persons with need for assistance with core activities between the Community file data and the 5 per cent CURF.

For the whole Tasmanian population, the 2011 Census count as reported in the Community Profile data is 28,726 persons with need for assistance with core activities (see Table 148). The estimate derived from the 5 per cent CURF is slightly lower at 27,600 (with an associated error) persons. For Tasmanians aged 15-64, the 2011 Census enumerates 12,263 persons with need for assistance with core activities. The estimate derived from the 5 per cent CURF is similarly lower at 11,020 persons aged 15-64.

Table 157 to Table 159 show that demand for assistance is associated with socio-economic status and economic participation. Table 156 shows that 7.5 per cent of Indigenous people need core activity assistance compared with 3.4 per cent of non-Indigenous people. 77 per cent of those on the lowest weekly income bracket (\$399 or less) state that they have a need for assistance with performing core activities. This is compared with only 3 per cent who have a weekly income of \$800 or more. 85 per cent of those that need assistance with core activities are reported to be not in the labour force. For those that do not need assistance, the corresponding proportion is 70 per cent.

Table 156 The Tasmanian population aged 15-64 needing assistance with core activities, by Indigenous status, 2011

Indigenous status	Has need		Does not have need		Not stated		Total	
	No.	%	No.	%	No.	%	No.	%
<i>Indigenous</i>	860	7.5	10,320	89.6	340	3.0	11,520	100.0
<i>Non-Indigenous</i>	9,980	3.4	277,780	95.1	4,180	1.4	291,940	100.0
<i>Not stated</i>	180	1.7	2,400	22.3	8,160	76.0	10,740	100.0
Total	11,020	3.5	290,500	92.5	12,680	4.0	314,200	100.0

Source: ABS 2011 Census, 5 per cent CURF. Note: The 5 per cent CURF data has been weighted to sum up to the population counts.

Table 157 The Tasmanian population aged 15-64 needing assistance with core activities, by labour force status, 2011

Labour force status	Has need		Does not have need		Not stated		Total	
	No.	%	No.	%	No.	%	No.	%
<i>Employed</i>	1,280	11.6	204,340	70.3	1,940	15.3	207,560	66.1
<i>Unemployed</i>	240	2.2	14,340	4.9	140	1.1	14,720	4.7
<i>Not in labour force</i>	9,380	85.1	69,960	24.1	1,740	13.7	81,080	25.8
<i>Not stated</i>	120	1.1	1,860	0.6	8,860	69.9	10,840	3.5
Total	11,020	100.0	290,500	100.0	12,680	100.0	314,200	100.0

Source: ABS 2011 Census, 5 per cent CURF. Note: The 5 per cent CURF data has been weighted to sum up to the population counts.

Table 158 The Tasmanian population aged 15-64 needing assistance with core activities, by educational attainment, 2011

Highest level of school completed	Has need		Does not have need		Not stated		Total	
	No.	%	No.	%	No.	%	No.	%
Year 12	2,360	21.4	117,820	40.6	1,080	8.5	121,260	38.6
Year 11	680	6.2	31,880	11.0	120	0.9	32,680	10.4
Year 10	3,940	35.8	101,700	35.0	1,140	9.0	106,780	34.0
Year 9	1,920	17.4	22,900	7.9	320	2.5	25,140	8.0
Year 8 or below	1,540	14.0	7,940	2.7	200	1.6	9,320	3.0
Not stated	580	5.3	8,620	3.0	9,820	77.4	19,020	6.1
Total	11,020	100.0	290,500	100.0	12,680	100.0	314,200	100.0

Source: ABS 2011 Census, 5 per cent CURF.

Note: The 5 per cent CURF data has been weighted to sum up to the population total.

Table 159 The Tasmanian population aged 15-64 needing assistance with core activities, by personal income, 2011

Total personal income (weekly)	Has need		Does not have need		Not stated		Total	
	No.	%	No.	%	No.	%	No.	%
\$399 or less	8,520	77.3	101,520	34.9	1,400	11.0	111,440	35.5
\$400-\$799	1,860	16.9	78,400	27.0	780	6.2	81,040	25.8
\$800 or more	320	2.9	102,920	35.4	760	6.0	104,000	33.1
Not stated	320	2.9	7,660	2.6	9,740	76.8	17,720	5.6
Total	11,020	100.0	290,500	100.0	12,680	100.0	314,200	100.0

Source: ABS 2011 Census, 5 per cent CURF.

Note: The 5 per cent CURF data has been weighted to sum up to the population counts.

We used the SDAC data set to interrogate these trends further, with attention to the following:

1. *Income (quintiles) and disability status of all persons aged 15-64, Tasmania 2012.* Corresponding partly to Tables 8.1 and 8.2 in SDAC Tasmania (ABS 2013e). Income is also a key factor associated with use of HACC services and this table shows the strength of the relationship of income and activity limitations.
2. *Main source of personal income and disability status of all persons aged 15-65, Tasmania 2012.* Corresponding partly to Tables 8.1 and 8.2 in SDAC Tasmania (ABS 2013e). Source of income (especially pension and benefit) is also a key factor associated with use of HACC services and this table shows the strength of the relationship of income and activity limitations.

In measuring income, we used a person level variable, for which the SDAC survey asks participants for their source of income and the amount received. This amount was then equalised into gross weekly income. This refers to all sources of income that a person may receive. All survey respondents in the household component were asked whether they receive income from "wages & salary, pensions, child support, superannuation, workers' compensation, own unincorporated business, rental property and dividends". They were also asked for other additional income sources. This final income figure is then presented in quintiles, based on the distribution of total incomes, and provided by the ABS when coding the SDAC results on income.

As in most of these surveys where responses rely on people's recollections of their incomes, there is the possibility that for those persons that do receive incomes from sources that are not explicitly mentioned in the list above, their estimate of the amount of income received might be an under-estimate. However, as the list of income sources is fairly comprehensive, it is expected that this will have a minimal impact on accuracy of the estimates. In addition, through grouping the incomes figures into quintile bands, we can mitigate against this recall error in reporting (Table 160 and Table 161).

The results in Table 160 and Table 161 show that there are differences in income according to disability status.

- People with a disability appear to be poorer in terms of their weekly reported income.
- 64 per cent of those with profound disability have incomes in the lower two quintiles.
- 60 per cent of the population with severe disability are in the bottom two quintiles of income.
- For those with moderate or mild disability, this proportion is 65 per cent and 48 per cent respectively.
- 61 per cent of those with schooling or employment restrictions to core activity have incomes in the lower two quintiles.
- On the other hand, 36 per cent of the population who have a disability but no restrictions or limitations in core activities have incomes in the bottom two quintiles.
- These figures are larger than those who have no disability.
- The proportion of those people in Tasmanian aged 15-64 with no disability but with a long-term limiting condition in the bottom two quintiles of income is 26 per cent, and a roughly similar proportion of 30 per cent is found for those with no disability or limiting condition.

Even though 21 per cent of the Tasmanian population aged between 15-64 years are estimated to receive, as their main source of income, income from the government and pension, there are marked differences when considering those with a disability.

- 88 per cent of those with a profound disability declare that income from government and pensions is their main source of income.
- 65 per cent of severely disabled people are in receipt of government and pension income primarily.
- Similarly, the proportions are 60 per cent and 49 per cent for those with moderate and mild disability, respectively.
- Of those with a disability that restricts their schooling or employment the proportion is 45 per cent. However, when compared to the population without disability this proportion drops down to 12 per cent (Table 161).

Considering those that report income from wages and salaries, similar findings can be made from Table 160 and Table 161. At a population level, as this population is the most productive and economically active, 59 per cent of Tasmanians aged 15-64 report that their main source of income is from wages and salaries. This is broadly in line with the figures that show that Tasmania has a lower labour force participation rate than the national average. This proportion is 67 per cent for those Tasmanians in this age group without a disability or long-term limiting condition. However, only 2 per cent of those that have a profound disability, 19 per cent of those with a severe disability and 17 per cent of those with a moderate disability respectively have employee income as a main source of income. 60 per cent of those with schooling or employment restrictions are reported to participate in the labour force since they declare employee income to be their main source of income.

Table 160 Weekly income (quintiles) and disability status of all persons aged 15-64, Tasmania 2012

	Profound core activity limitation		Severe core activity limitation		Moderate core activity limitation		Mild core activity limitation		Schooling or employment restriction		With disability but no restriction or limitation		No reported disability				Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	With long-term health condition		Without long-term health condition			
Estimates (counts) and proportions (%)																		
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Lowest quintile</i>	870	18.38	1665	14.76	2565	22.93	2950	15.11	2857	34.68	1463	17.37	10949	14.05	36602	20.66	59921	18.81
<i>Second quintile</i>	2139	45.19	5139	45.55	4671	41.76	6425	32.91	2172	26.36	1601	19.01	9310	11.95	16866	9.52	48324	15.17
<i>Third quintile</i>	485	10.26	2057	18.23	1487	13.29	4093	20.97	1198	14.54	1921	22.81	16435	21.09	33239	18.76	60915	19.12
<i>Fourth quintile</i>	0	0	612	5.43	727	6.50	2269	11.62	720	8.74	1781	21.15	16932	21.73	34909	19.70	57951	18.19
<i>Highest quintile</i>	0	0	199	1.77	671	6.00	1513	7.75	535	6.50	643	7.64	15013	19.26	26973	15.22	45548	14.30
<i>Not known</i>	1238	26.16	1611	14.28	1064	9.51	2272	11.64	757	9.18	1012	12.02	9293	11.92	28615	16.15	45861	14.40
Total	4733	100.0	11283	100.0	11185	100.0	19522	100.0	8239	100.0	8422	100.0	77933	100.0	177204	100.0	318520	100.0
Relative standard error of estimated totals																		
<i>Lowest quintile</i>	335	-	461	-	558	-	648	-	646	-	469	-	1197	-	2184	-	2653	-
<i>Second quintile</i>	559	-	813	-	756	-	884	-	542	-	449	-	1125	-	1499	-	2361	-
<i>Third quintile</i>	265	-	529	-	422	-	722	-	392	-	499	-	1447	-	2049	-	2608	-
<i>Fourth quintile</i>	0	-	320	-	290	-	536	-	281	-	458	-	1445	-	2115	-	2563	-
<i>Highest quintile</i>	0	-	143	-	279	-	446	-	241	-	292	-	1395	-	1906	-	2359	-
<i>Not known</i>	422	-	481	-	369	-	526	-	291	-	343	-	1104	-	1966	-	2372	-
Total	816	-	1213	-	1150	-	1537	-	1033	-	1029	-	2830	-	3553	-	-	-

Notes: 1. Weighted estimates and proportions using the sampling weights; 2. The relative standard errors are given for the weighted estimates; 3. The percentage for each disability is based on the weighted population estimate

Table 161 Main source of personal income and disability status of all persons aged 15-64, Tasmania 2012

	Profound core activity limitation		Severe core activity limitation		Moderate core activity limitation		Mild core activity limitation		Schooling or employment restrictions		With disability but no limitation or restriction		No reported disability				Total	
													With long-term health condition		Without long-term health condition			
Estimates (counts) and proportions (%)																		
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<i>Wages or Salary</i>	83	1.75	2070	18.35	1904	17.02	5896	30.20	2705	32.83	4997	59.33	50670	65.02	118432	66.83	186756	58.6
<i>Business income</i>	111	2.35	0	-	97	0.86	439	2.25	0	-	111	1.32	433	0.56	1084	0.61	2275	0.71
<i>Gov't pension/ allowance</i>	4146	87.60	7343	65.08	6746	60.31	9554	48.94	3695	44.85	1569	18.63	11897	15.27	21695	12.24	66647	20.92
<i>Other</i>	106	2.24	939	8.32	1758	15.72	2496	12.79	953	11.56	657	7.80	10448	13.41	15774	8.90	33131	10.40
<i>Not applicable</i>	0	0	116	1.03	131	1.17	109	0.56	98	1.19	0	0	725	0.93	1645	0.93	2823	0.89
<i>Not known</i>	286	6.04	815	7.22	550	4.91	1027	5.26	788	9.56	1087	12.91	3760	4.82	18575	10.48	26888	8.44
Total	4733	100.0	11283	100.0	11185	100.0	19522	100.0	8239	100.0	8422	100.0	77933	100.0	177204	100.0	318520	100.0

Table 161 Main source of personal income and disability status of all persons aged 15-64, Tasmania 2012 continued

Relative standard error of estimated totals																		
<i>Wages or Salary</i>	83	-	536	-	469	-	857	-	566	-	784	-	2403	-	3345	-	3424	-
<i>Business Income</i>	111	-	0	-	97	-	230	-	0	-	111	-	222	-	394	-	538	-
<i>Gov't pension/ allowance</i>	772	-	971	-	895	-	1091	-	715	-	453	-	1253	-	1715	-	2699	-
<i>Other</i>	106	-	395	-	476	-	591	-	368	-	297	-	1167	-	1479	-	2055	-
<i>Not applicable</i>	0	-	116	-	311	-	109	-	98	-	0	-	336	-	487	-	633	-
<i>Not known</i>	203	-	313	-	281	-	352	-	330	-	394	-	679	-	1600	-	1865	-
Total	816	-	1213	-	1150	-	1537	-	1033	-	1029	-	2830	-	3553	-	-	-

Notes

1. Weighted estimates and proportions using the sampling weights
2. The relative standard errors are given for the weighted estimates
3. The percentage for each disability is based on the weighted population estimate

7.4 UNPAID ASSISTANCE FOR PEOPLE WITH A DISABILITY

There are a number of services provided by HACC to carers so we used the census data to look at people who provide unpaid assistance to people with a disability.

Table 162 shows the number of persons providing unpaid assistance to a person with a disability. This shows that roughly the same proportion of Tasmanians provide unpaid assistance when compared to Australia as a whole.

Table 163 shows the profile of those providing unpaid assistance to persons with a disability, by age and sex. This shows that the largest age group are those aged between 55-64, with over 30 per cent of males and females providing unpaid assistance to persons with a disability. In addition, roughly 4 per cent of young people (aged 15-19) are carers to people with a disability.

Table 162 Persons providing unpaid assistance to a person with a disability in Tasmania and Australia, 2011

Unpaid assistance to a person with a disability (UNCAREP)	Tasmania				Australia			
	Population aged 15 -64		Population aged 15 and over		Population aged 15 - 64		Population aged 15 and over	
	No.	%	No.	%	No.	%	No.	%
<i>Provided unpaid assistance (in last two weeks)</i>	38,192	11.9	46,645	11.6	1,576,818	11.0	1,896,957	10.9
<i>No unpaid assistance provided (in last two weeks)</i>	263,713	82.2	324,845	80.9	11,716,132	81.6	13,990,156	80.6
<i>Not Stated</i>	18,871	5.9	29,993	7.5	1,058,462	7.4	1,476,583	8.5
Total population	320,776	100.0	401,483	100.0	14,351,412	100.0	17,363,696	100.0

Source: ABS 2011 Census Community Profile for Tasmania and Australia.

Table 163 Persons in the Tasmanian population aged 15-64 providing unpaid assistance to a person with a disability, by age and sex, 2011

Age group	Males			Females			Persons		
	No.	% of all providing assistance	% of age group	No.	% of all providing assistance	% of age group	No.	% of all providing assistance	% of age group
15-19	635	4.5	3.8	706	2.9	4.5	1,341	3.5	4.1
20-24	624	4.4	4.2	963	4.0	6.6	1,587	4.2	5.4
25-34	1,654	11.7	6.2	3,067	12.8	10.7	4,721	12.4	8.5
35-44	2,752	19.4	8.8	4,943	20.6	14.6	7,695	20.1	11.9
45-54	4,070	28.7	11.7	6,950	29.0	18.9	11,020	28.9	15.4
55-64	4,457	31.4	13.5	7,371	30.7	21.8	11,828	31.0	17.7
Total	14,192	100.0	9.0	24,000	100.0	14.7	38,192	100.0	11.9

Source: ABS 2011 Census Community Profile for Tasmania.

7.5 PROJECTING FUTURE NEED AND DEMAND

The ABS also provides population projections for Australia, and these projections are further provided sub-regional geographies by states and territories, and capital cities. The projections are simple illustrations of the population growth under specific demographic assumptions. It is important to note that any future growth (or decline) in population is dependent on four aspects of demography. These are the current population, the number of births, the number of deaths, and net migration.

All the projections are based on the estimated resident population which is the current population estimate. In years that there has been a census this is the census population count. For non-census years, this population is the previous year's population estimate, plus the number of births and the number of in-migrants, subtracted the number of deaths and number of out-migrants. So for example, the population in 2012 (a non-census year) is given by the population in 2011 (a census year), plus the number of new births, plus the number of in-migrants, minus the number of deaths, and minus the number of out-migrants. This can be done nationally, and at a state level, and also by age and sex. This is because migration and fertility affect younger people differently to those who are older; so too does death, and it is important to take this into account in any projections. However, to project into future, assumptions are required for the future levels of fertility (number of births), life expectancy (number of deaths) and migration (both internal and overseas).

The ABS provides population projections using these demographic assumptions based on national and international trends. The ABS has different permutations and combinations of these different demographic aspects for describing population change and growth. However, to illustrate the possible scenarios for the Australian population growth and change, three main population projection series have been selected by the ABS:

- *Series B* largely reflects current trends in fertility, life expectancy at birth and migration,
- *Series A* and *Series C* are based on high and low assumptions for each of these variables respectively, as detailed in the table below (Table 164).

Therefore, the three series can be taken as the most realistic projections (*Series B*) of population sizes, bounded by the upper (*Series C*) and lower (*Series A*) limits of population projection, were these different high and low assumptions expected to prevail over the projection period.

Taken together, the *Series B* projections represent the long-term current trends of population growth and change, while the *Series A* and *C* projections give the possible range of outcomes of population growth (and/or decline) in the foreseeable future.

The ABS projections are provided in disaggregated form by single-year age and sex. This approach takes account of the age-sex distribution of Australia, but more importantly the local region when projecting the trends in population change.

Table 164 Demographic Assumptions underlying the Australian population projections

ASSUMPTIONS				PROJECTED POPULATION AT 30 JUNE		
			Life expectancy at birth(a)			
	Total fertility rate(b) babies per woman	Net overseas migration(c) persons	Males years	Females years	2061 million	2101 million
Series A	2.0	280 000	92.1	93.6	48.3	70.1
Series B	1.8	240 000	85.2	88.3	41.5	53.6
Series C	1.6	200 000	85.2	88.3	36.8	42.4
(a) From 2061						
(b) From 2026						
(c) From 2021						
				Observed average	Medium assumption	Phased in by
Total fertility rate(d)				1.9	1.8	2025-26
Life expectancy at birth(e)(f)						
Male				79.7	85.2	2060-61
Female				84.2	88.3	2060-61
Net overseas migration(d)				199 860	240 000	2020-21
Average annual growth rate(d)				1.6
.. not applicable						
(d) Observed average of financial years 2010-2012.						
(e) Observed average of calendar years 2009-2011.						
(f) Note that the Australia level projections go out to 2101.						

Source: ABS Population Projections, Australia, 2012 (base) to 2101. Cat 3222.0

These projections are also provided sub-nationally, and for the Tasmanian population, the ABS estimates that the population will increase if current rates of fertility, birth and death, and migration continue. However, there is a projected marginal decrease in the future. The reason for this is that in general the age distribution of the Tasmanian population is slightly older on average than the rest of Australia. This is mostly due to the fact that Tasmania experiences out-migration of young people to other states and territories to pursue education, employment and training opportunities (there are 31 per cent of 20-44 year olds compared to the 36 per cent nationally), combined with an increased in-migration of older people into the state for retirement reasons (there are 44 per cent of over 45 year olds compared to 39 per cent in Australia as whole).

These projections are for the whole population, and our interest is specifically for Tasmanians with a disability, particularly in regards to the HACC client target group, i.e. those aged 15-64 years old.

In considering the projections, we have broadly defined the HACC target group as those with a disability as defined from the ABS census. This definition differs slightly from the HACC definition (as detailed in earlier chapters of the report), since it focuses on core activity limitation. This is used to identify the prevalence of core activity limitations amongst the Tasmanian population, aged between 15-64 years old.

The analysis of the core activity and need for assistance is based on a series of questions asked in the census. This is then used to derive a measure of the number of people with a profound or severe disability. According to this definition, people with a profound or severe disability are defined as those needing help or assistance in one or more of the three core activity areas of self-care, mobility and communication. This need for assistance is because of a disability, long-term health condition or old age. Clearly, the population with a disability according to this ABS census definition is broader than the subgroup of people who actually have need for (and/or use) HACC services, or for that matter other specialist disability services provided by the government. There are in fact many people who have some core activity limitation due to their disability, but are able to function effectively without any need for assistance from the HACC program.

To start with, we estimated the population with a disability, as those classified as needing assistance in the Census. This population is 11,020 of Tasmanians aged 15-64 years old (in 2011). This definition of core activity need for assistance is a similar definition as that used for the *Survey of Disability, Ageing and Carers* (SDAC). However, while the concept being measured is the same in the survey and census, there are differences in the output which reflect the differences in the populations about whom the questions are being asked. The census asks these questions of the whole population, while the SDAC specifically targets people with a disability and their carers for inclusion in the sample. For example, the population with a disability, defined as those with profound, severe, moderate and mild activity limitation according to the SDAC is 46,733 people. When adding those with activity limitation relating to schooling and/or employment, and those with a disability but no activity limitation, this figure goes up to 63,383, and implies that 19.9 per cent of the population aged 15-64 have a disability.

This is an indication that the SDAC and Census definitions of activity limitation may be perceived differently, potentially leading to divergent estimates of future demand for HACC Program services. For our projections, we use the Census definition for two reasons:

1. The projections are based on census figures, and so for comparability it is better to use this definition.
2. The SDAC is a survey, so has associated sampling error, whereas the census asks questions of activity limitation to everyone.

That said, these projections should be taken as an indication of the population who have specific core activity limitations, and therefore under-estimates the full spectrum of those with a disability.

In our projections of the Tasmanian population that report a need for assistance due to core activity limitation, we have based the population growth on the ABS assumptions for the projected trend in the population size, age-sex structure, distribution of birth and deaths, and net internal and overseas migration for Tasmania. This provides an indication of the projections for the population with disability (based on core activity limitation). Since this population is not constant but differs with age, the proportion of those requiring assistance will vary by age, and will be influenced to different extents by migration, fertility and mortality.

The projections presented are based on the estimate of the disability population, aged 15-64 years old in Tasmania from the 2011 census, and then aged forwards over time. The population projections span the period 30 June 2012 to 30 June 2061. The base of 30 June is used as the date from which the estimated resident population is measured so that we have a comparable period of measurement. The ageing forwards of the population over time takes into account the different assumptions of fertility, mortality, and migration. Since we are restricting our projections for only the Tasmanian population, these projections can therefore take into account the characteristics of the Tasmanian population. However, the assumptions are state-based, and crucially assume that the fertility and migration rates are the same for those with and without a disability. In essence, these projections might actually under-estimate the true future demand. For instance, migration is often concentrated amongst the young, able population.

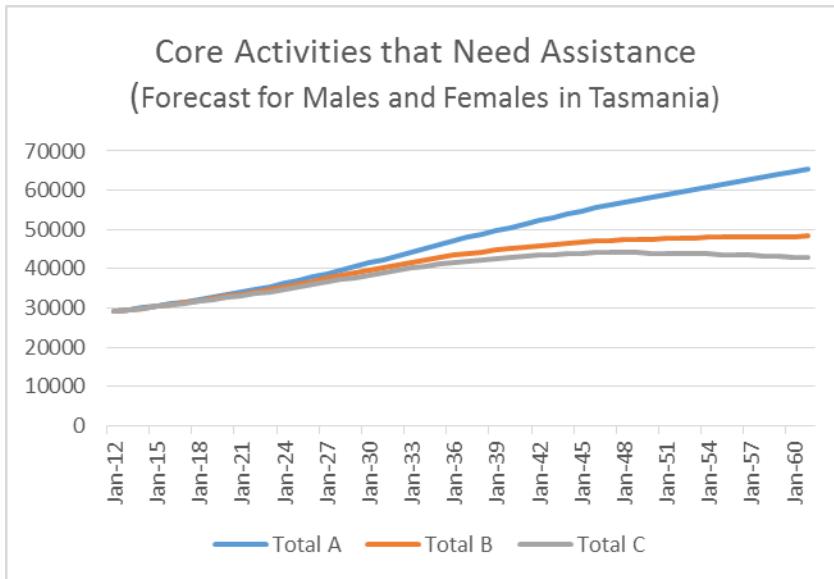
Based on the current estimated population of 5.6 per cent needing assistance, Figure 4 to Figure 6 give the projections of the disability population in Tasmania, and this shows that the current estimate of under 30,000 is anticipated to grow over time, reaching a population of around 50,000 in 2061, using current trends and projections (Series B). If we are to assume that the demographic conditions are at their high rates (Series C), this could lead to a population with disability over 65,000. This represents an increase in over 15,000 people.

For the following figures showing the population projections, the orange line represents the current forecast (Series B), while the upper bound is represented by the blue line (Series C), and the lower bound is shown by the grey line (Series A).

Figure 4 to Figure 6 illustrate the projections for the number of Tasmanians with a disability. However, since the HACC program provides services for people within the defined ages of 15 – 64 years old, Figure 7 to Figure 9 examine the projections specifically restricted to this age group. When we restrict our

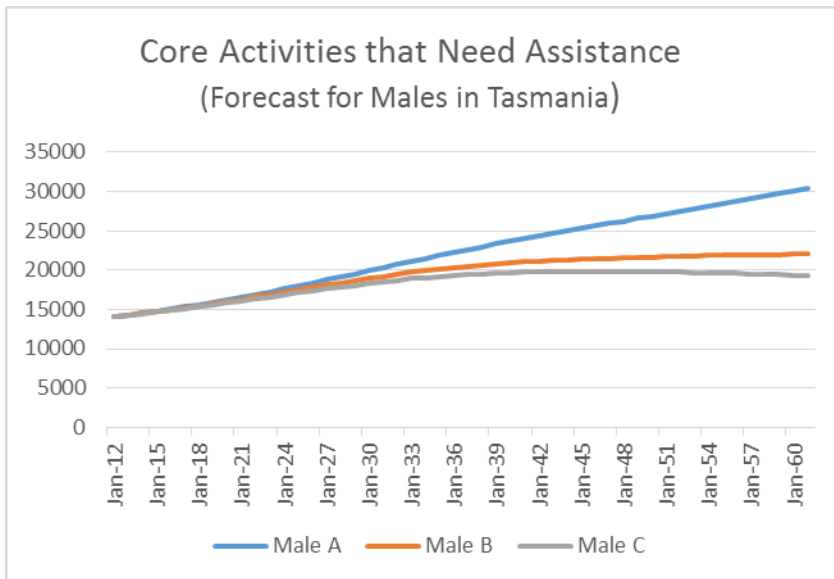
population to this age group the proportion of those needing assistance goes down to roughly 4 per cent. This makes sense because most of the activity limitation projections are due to ageing.

Figure 4 Projections for Total Number of Tasmanians with Disability (All)



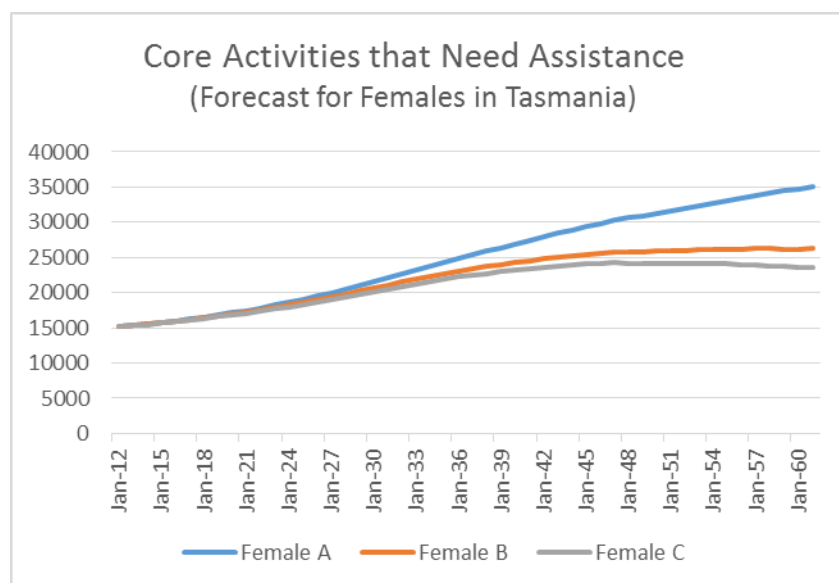
Series A Series B (current) Series C

Figure 5 Projections for Number of Tasmanians with Disability (Male only forecast)



Series A Series B (current) Series C

Figure 6 Projections for Total Number of Tasmanians with Disability (Female only forecast)



Series A Series B (current) Series C

Table 165 provides the specific estimates for the total projections, and gender-specific estimates, for different years, so as to give an indication as to the growth, over the 50 year period of projections. We can deduce that there are slight differences in the projections, for the restricted group, and this could be mainly be attributable to the fact that this series does not include the elderly population (aged 65 and over) who are more likely to be in need of assistance due to old age related limiting illnesses. Additionally, the 15-64 age group are the most economically active, and therefore more affected by internal and overseas migration. This will form a key aspect of their population projections.

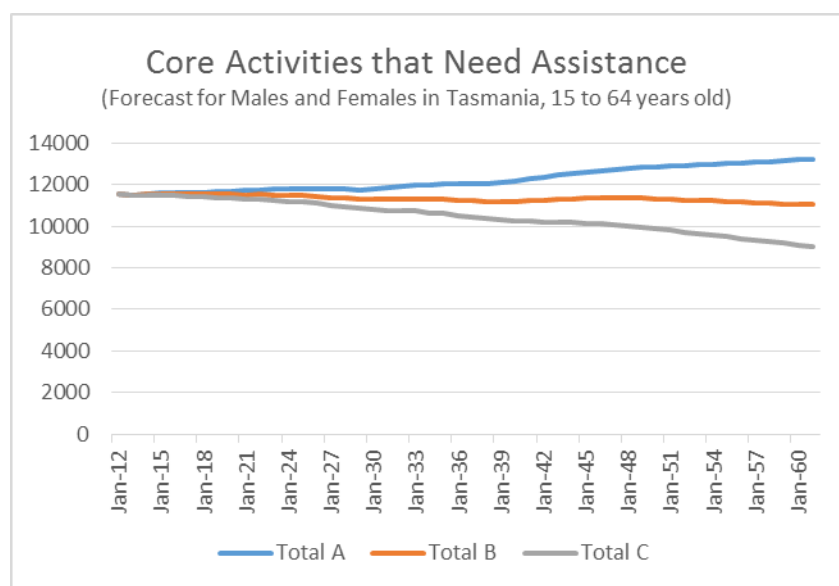
The Tasmanian population with a disability aged 15-64, under current demographic conditions (Series B) is expected to decrease, at a steady rate from the present estimates of 11,552 to a population of 11,052 in 2060, which is a 4.3 percentage point decrease over the 50 years. This decrease is much steeper when the projection assumptions are at their low rates. When the assumptions are at their high rates, there is a projected increase in the number of people with a disability. Taking these results together, the Tasmanian population with a disability is currently estimated to be 11,552. However, in 50 years under current conditions, this is expected to decline to 11,052 but with a possible range of 9,104 at the lower end, and 13,179 at the upper end.

The projections show if current trends in the profile of the population in Tasmania persist, there will be more males than females in need of assistance, as the current trend. However, the number of females needing assistance will increase at a faster rate than the number of males. This will be largely driven by the Tasmanian population being expected to continue to age faster than the rest of Australia, combined with female life expectancy expected to continue to exceed male life expectancy.

Table 165 Projecting Future Population with Disability, aged 15-64 years old in Tasmania (2012 – 2060)

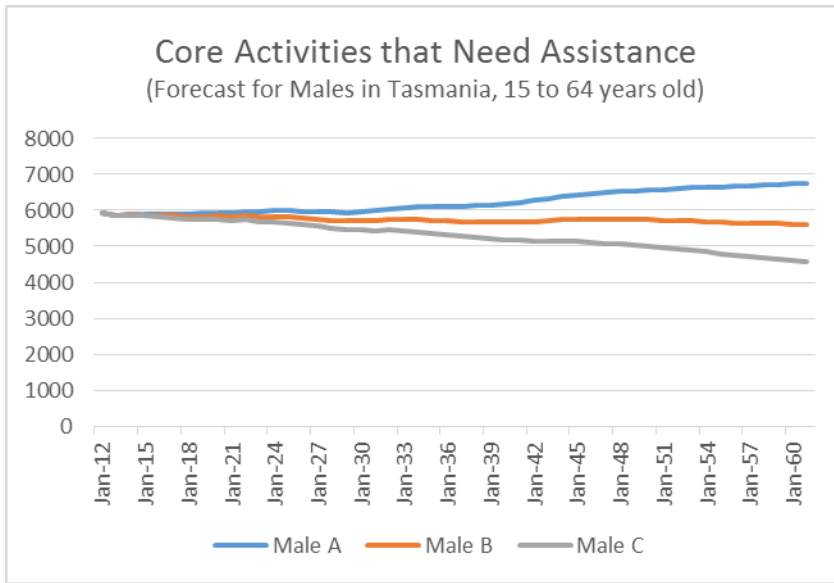
	Jun-12	Jun-15	Jun-20	Jun-25	Jun-30	Jun-35	Jun-40	Jun-45	Jun-50	Jun-55	Jun-60
Total A	11,552	11,576	11,695	11,804	11,786	12,017	12,187	12,611	12,864	13014	13179
Total B	11,552	11,532	11,523	11,483	11,288	11,290	11,198	11,344	11,315	11178	11052
Total C	11,552	11,486	11,352	11,169	10,801	10,590	10,267	10,152	9,872	9486	9104
Males A	5,918	5,884	5,935	5,984	5,961	6,110	6,188	6,422	6,564	6644	6733
Males B	5,918	5,859	5,842	5,814	5,698	5,726	5,667	5,749	5,742	5671	5609
Males C	5,918	5,835	5,751	5,649	5,446	5,364	5,181	5,129	4,994	4796	4604
Females A	5,635	5,693	5,760	5,820	5,825	5,907	6,000	6,189	6,300	6370	6446
Females B	5,635	5,673	5,681	5,670	5,590	5,564	5,537	5,595	5,573	5507	5443
Females C	5,635	5,651	5,601	5,520	5,355	5,226	5,086	5,023	4,879	4690	4501

Figure 7 Projections for Number of Tasmanians with Disability (All aged 15-64 years old)



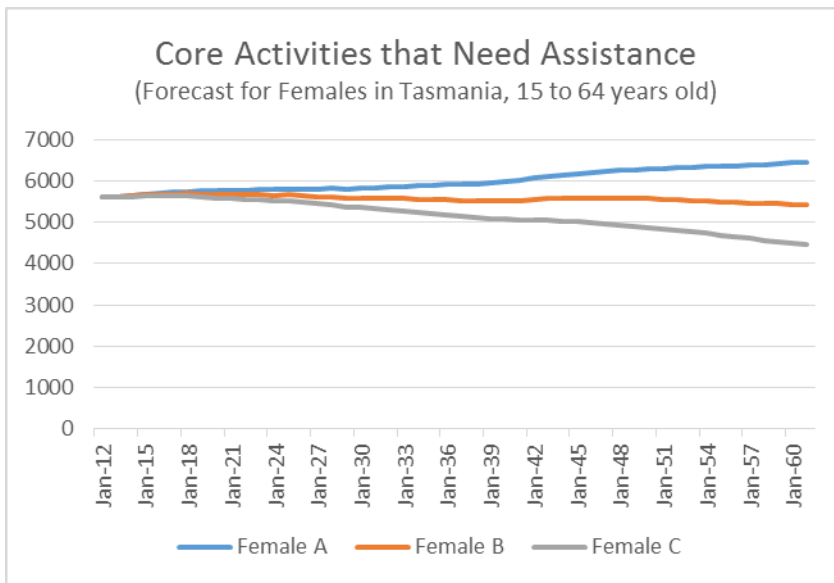
Series A Series B (current) Series C

Figure 8 Projections for Number of Tasmanians with Disability (Males only aged 15-64 years old)



Series A Series B (current) Series C

Figure 9 Projections for Number of Tasmanians with Disability (Females aged 15-64 years old)



Series A Series B (current) Series C

7.6 SUMMARY AND IMPLICATIONS

This section has investigated the unmet need and future demand for specialist disability services in Tasmania, for the population who fall under the HACC program jurisdiction, i.e. those aged 15-64 years old. Of particular interest was to develop reliable estimates of the current population with a disability, and then derive a framework for producing estimates of the future population with a disability. These estimates have provided predictions of the future demand for the HACC program, and Tasmanian specialist disability services in general. The projections were derived using two nationally representative data collections, the ABS 2011 Census, with the ABS future population projections for Australia and the ABS SDAC.

When compared to the Australian population, analysis of the ABS 2011 census data on disability has shown that there is a higher prevalence of profound or severe activity limitations amongst the Tasmanian population. This was attributable to the demography of Tasmania.

This data was then combined with population projections to produce estimates of future trends in the number of Tasmanians with core activity limitations aged between 15- 64 years old. This showed that this population was projected to decrease by 4.3 per cent, based on current rates of demographic trends. The reason is that most of the Australian projected population growth is expected to be driven by migration.

However, the trend is that Tasmanians tend to move to the mainland for education and employment reasons. The population aged 15-64 are the prime demographic group. Thus although the projections show an increasingly ageing Tasmanian population, this does not have an effect on those aged 15-64, which is the population of interest for the HACC program.

The ABS SDAC offers a different viewpoint of the disability population, and the analysis has furnished us with a more detailed picture of Tasmanians, in terms of the type of disability, and activity limitations. This survey asks questions on the different activities and is therefore able to classify people into those with profound, severe, moderate and mild activity limitations. Further distinctions are made for those with limitations or restrictions in education or employment, and long-term limiting conditions.

The patterns of unmet need reflect the distribution of core activity limitations in the population. The majority of people either had their needs fully or partially met. However, those that have an unmet need are predominantly with mild or moderate disability. A possible explanation of this is that those with severe or profound disability have more established routes of access to services to manage their disability, whereas those with mild or moderate disability might be transitioning and still working out their needs. Those with mild and moderate disabilities will not likely meet the eligibility criteria for the NDIS and if they require support to maintain living independently in their community they would need to access the HACC Program. It is estimated that there are 23,707 (7.3 per cent) Tasmanians aged 15-64 who have a mild/moderate disability and even with taking the decrease of 0.08 per annum into account, this still leaves a pool of potential clients for the HACC program of 22,501. Stakeholder interviews with HACC MDS reporting outlets indicated that there are groups of people, due to language, cultural, or other barriers that do not currently access HACC services even though they would meet the criteria to do so.

8 CONCLUSIONS

8.1 COMPREHENSIVE CLIENT PROFILE OF THE TASMANIAN HACC PROGRAM

From the 1980s to 2011, the Tasmanian HACC program was shaped by national goals that stressed the objectives of enabling clients to live independently in their own homes and preventing or delaying admission to residential care. The split in responsibility for the program in 2011 brought to light the lack of knowledge about persons using HACC in this younger age group, such as why they were using services, what functional limitations they experienced and what they required to live independently. Using a range of secondary data sources complemented by a client survey, insight was gained into the reasons individuals under 65 use HACC services. The data showed that 33.6 per cent of clients live alone and 17.8 per cent are public housing tenants, both of which are almost three times higher than in the Tasmanian population. 36.2 per cent have at least one core activity limitation (7 items, not restricting to only those with complete information on all 7). 15.2 per cent of these clients are also Specialised Disability Services clients, indicating they have more complex needs. This provides some information around why HACC clients may be using services – the proportion of people who are without potential live-in support and who are economically disadvantaged is much higher than in the rest of the Tasmanian population.

The client survey provided additional information around the health conditions, showing that 97.9 per cent of clients have least one long-term (lasting longer than 6 months) chronic health condition or disability. Administrative health records show that 56.6 per cent of the clients received at least one public health (hospital, emergency, hospital based services and community nursing) service during the period 2013-14. These findings indicate that a high proportion of HACC clients use community services to support their healthcare needs in order to remain living independently in the community.

The HACC MDS data shows that 10.3 per cent of clients used HACC services for less than 6 months. Life tables indicated that once a client receives services past 6 months, the probability of them ceasing services is very small, with a probability of 0.01 after the first year. These clients who cease using services before 6 months are younger than other HACC clients (below 40), with a higher proportion of:

- referrals from psychiatric/mental health service or facility (59.7 per cent)
- services used for nursing care (47.5 per cent)
- hospital admissions (60.3 per cent)

What can firstly be drawn from all of the information presented on the HACC clients is that the HACC program caters for a range of different people with different needs, as explored in the profiling of subgroups and complimented by findings from the survey. For people who are short term users, service use is more likely to be triggered by acute situations, however the vast majority of people surveyed had at least one long term health condition or disability. There are clear overlaps with disability services, mental health services and primary health, with the linkage between disability services and HACC arguably stronger and better defined than for the latter two. The way in which HACC can better support mental health and primary health services is a potential area to explore for future directions. However, it is likely that the HACC program will play a smaller role in mental health system now that the NDIS has broadened their scope to include people experiencing mental health problems.

8.2 CURRENT AND FUTURE POTENTIAL DEMAND (UNMET NEED) FOR BASIC COMMUNITY CARE SERVICES PROVIDED BY THE TASMANIAN HACC PROGRAM

Based on the current rates of demographic trends, the Tasmanian population with a profound or severe disability is anticipated to grow over time, reaching a population of around 50,000 in 2061. However, if we restrict the projections to the Tasmanian population with a profound or severe disability aged 15-64, the projections predict a decrease (approximately 0.08 per annum), so that in fifty years it is projected that this population will decrease by 4.3 percentage points, from 12,263 to 11,735. Similarly, based on these

estimations, it is anticipated that the proportion of individuals with a mild/moderate disability will decrease by approximately 4.3 percentage points, from 23,512 to 22,501. The reason for this is that most of the Australian projected population growth is expected to be driven by migration associated with economic and employment reasons. It is projected that while there will be growth in the overall population of people with disabilities, for Tasmania this growth will be focused in the 65 and over age group (or 50 and over for Indigenous Australians) due to the ageing population and the predicted migration rate of younger persons to the mainland. The data also showed that 38 to 40 per cent of individuals aged 15-64 who have a mild/moderate disability have indicated that their disability needs were unmet and this may be an area that the HACC Program wants to consider servicing. Interviews with HACC MDS reporting outlets indicated that there are groups of people, due to language, cultural, or other barriers that do not currently access HACC services even though they would meet the criteria to do so and the HACC program may want to consider strategies to reach these groups.

8.3 THE IMPACT OF POLICY CHANGES (PRIMARY HEALTH, DISABILITY, MENTAL HEALTH) ON THE DEMAND FOR HACC SERVICES

The HACC program has played an important role in supporting long-term disability by providing a service for clients seeking Specialist Disability Services, who would otherwise end up on a waitlist. 15.2 per cent of HACC clients also receive Specialist Disability Services. The phased introduction of the NDIS between 2013 and 2019, which will eventually replace specialised disability services funded through the Tasmanian Government, will have a number of direct and indirect impacts on the Tasmanian HACC program, including its client profile. Firstly, the number of persons who receive services under a fully implemented NDIS is expected to exceed those receiving services under state-based specialist disability services programs. This will affect the current demand on the HACC program and we attempt to use the data sources to determine a rough estimation of the proportion of HACC clients that would be eligible for the NDIS. It is important to note that estimations are based on current data available and are unable to take into account negotiations around responsibilities and policy development being undertaken by the Commonwealth and State and Territory Governments that will affect the determination of eligibility and impact on Tasmanian HACC services.

The activity limitations data collected in the HACC MDS provides some insight, in that it tells us who meets the criteria of profound or severely disabled (based on 7 items) and it is estimated that 36.2 per cent of the Tasmanian HACC population meet this criteria. The NDIS extends this criteria to also include 'Can they do daily jobs, handle money and make decisions?' and 'Can they make and keep friends and cope with feelings and emotions?' The HACC MDS captures information on whether they 'Can handle their own money?' and it is estimated that 39.8 per cent of the HACC Program may be eligible for NDIS with the additional criteria.

It is important to take into consideration that 35.1 per cent of the activity limitation data captured in the HACC MDS is missing. Survey data was used to explore this missing data, and the results showed that between 54.2 per cent and 84.3 per cent of the missing data did not have a limitation in the comparable activities. These results along with the statistical tests between the groups seem to suggest that the missing data on limitations may be largely due to service providers' not entering data for clients who have no activity limitations. However, there is still a group (approximately 15.7 to 45.8 per cent) that have activity limitations that have not been reported on the HACC MDS.

To explore the proportion of clients not yet eligible for the NDIS, who may meet the criteria of not being able to cope with feelings and emotions (which seems to fall into the area of mental health), the survey asked clients if they needed help to 'Cope with their feelings and emotions'. The inclusion of this information should be treated with caution, as this is an over estimation of the potential eligibility figures, as comparative analysis between the HACC MDS and the survey data using the data collected on the MDS, showed that the survey data was 6 to 8 percentage points higher. That is, the survey data showed a 44 per cent eligibility using only the profound or severely disabled criteria and 46.3 per cent when handling money was included. There is of course also the missing data to factor in. These figures do seem to suggest that with the inclusion of mental health within the NDIS, the NDIS may have more of an impact on the HACC Program than anticipated. However, until the further investigations are completed to better understand the

linkages with Mental Health Services and the cohort of clients referred by mental health services, we are unable to fully quantify what additional impact on the Tasmanian HACC Program there might be.

8.4 POLICY DEVELOPMENT AND PROGRAM MANAGEMENT IMPLICATIONS FOR THE TASMANIAN HACC PROGRAM

National and State health care policy in recent years have stressed the importance of reform to primary health care in order to manage the growing prevalence of chronic disease and to reduce demand for expensive hospital-based treatment. Reform of primary health care was one of the themes of the health services reform process in Tasmania set out in the recent Green Paper (December 2014) and White Paper (March 2015). These documents emphasised the importance of greater access to local primary health care services; more opportunities for treatment to take place at home or in non-hospital settings; better community management of people with chronic conditions; hospital avoidance; and timely return to home after hospital treatment.

Unlike the HACC program's role in disability services, its role in Tasmania's primary health care system is not widely or formally acknowledged. However, there is evidence that many of the services provided through the HACC program operate as part of the primary health care system. HACC services receive many referrals from the health services (totalling 29.6% of all referrals), especially GPs and hospitals. It is also reported that HACC services play a number of important primary health care roles: providing community care for patients during their recovery after discharge from hospital; preventing hospital admissions through assisting people to live independently; supporting people living at home with chronic illness; case managing individuals with complex health conditions; and assisting individuals to access health services via community transport. The survey showed that the majority of the clients have at least one chronic health condition or disability and half of the clients recorded on the MDS during the period 2013-14 accessed health services. Interviews with HACC service providers indicated that the HACC program's role in the broader healthcare system could be:

- aiding recovery after discharge from hospital
- long-term care for chronic illness, often to people living in disadvantaged circumstances not qualifying for the NDIS
- improving access to healthcare through transportation
- providing case management
- providing healthcare services such as community nursing and allied health.

However it was also noted by service providers that the linkages and referrals to the HACC program from primary healthcare services had some issues, such as the Accesspoint not being able to set up services immediately post-discharge and the paucity of information collected by referrers. This appears to be an opportunity where the HACC program could more clearly define its role in the broader healthcare system, as post-acute services could be an area to develop..

8.5 SERVICE GAPS

A number of service gaps were identified by service providers and clients, through interviews and open-ended responses to survey questions. This dialogue created an opportunity for people to identify gaps regardless of their perceived ability to be implemented. The main gaps identified were:

- services aimed at re-enablement
- hospital avoidance programs
- social support for mental health clients
- computer education
- cooking in the home
- services for pets
- flexibility of services (e.g. payment options, responding to emergencies)

In future planning, the HACC program may want to consider some of these suggestions.

8.6 QUALITY DATA REPORTING

Profiling the group 0-17, produced some questionable data, such as individuals 0-4 living alone and receiving a pension. Throughout the HACC Client Survey sampling process, the researchers came across numerous instances where the year of birth was recorded incorrectly, which results in more than one unique SLKs to be generated for the same individual. Going forward, DHHS may want to consider auditing the HACC MDS to check the quality of data entered by the service providers.

The client survey did show that 1.4 per cent of clients indicated that they receive services even though they have recovered from their health condition or disability. 6.8 per cent of long-term clients have no activity limitations and have been a client for one year or longer. Taking the missing data into account, a projected 29.7 to 42.5 per cent of long-term clients have no activity limitations. The review processes of HACC MDS reporting outlets may need to be explored further by the HACC program.

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APPENDIX I: TECHNICAL REPORT

PROJECT OBJECTIVES AND RESEARCH QUESTIONS

The *objectives* of the research project were:

1. To develop a comprehensive profile of current clients of the Tasmanian HACC program.
2. To develop estimates of potential future demand for the 'basic community care' services provided by the Tasmanian HACC program.
3. To estimate the impact on need and demand for HACC services of policy changes in related service areas including disability, primary health and mental health services.
4. To consider the policy and program management implications for the Tasmanian HACC program of findings in these three areas.
5. To meet the ethical requirements of all regulatory bodies and to conduct the research in an ethical manner and with appropriate consultation with stakeholders.

Initial consideration of these objectives and of the HACC program context and operations resulted in the formulation of a broad, underlying research question and a set of specific research questions. The broad research question adopted for the study was: *Why do clients currently need and use HACC services?*

The specific research questions stemming from this question were identified and listed as follows:

1. What are the main impacts on the client profile of the Tasmanian HACC program of the current and anticipated policy and service environment?
2. What are the demographic characteristics of the HACC client population? What does this tell us about why people need and use HACC services?
3. What is the role of the HACC program in supporting people with long-term or chronic illness and disability? What are the implications of the NDIS for this role?
4. What is the role of the HACC program in supporting people with short-term health conditions?
5. What is the role of the HACC program in supporting people with mental health issues?
6. What is the role of the HACC program in supporting people requiring palliative care?
7. What is the likely future demand for HACC services given the changing demographic environment?
8. What are the policy implications of the HACC client profile analysis?

The study was designed to address these specific questions. It aimed to identify the characteristics of current service users and to put these findings into the wider context of the changing characteristics of the Tasmanian population and the changes taking place in the policy and service environment.

Several of the specific research questions listed above refer to sub-groups of HACC clients identified during the initial stages of the project through preliminary interviews with Tasmanian HACC program managers. The sub-groups listed above are not necessarily discrete and mutually exclusive: some clients may belong to several of these groups. The client profile is of necessity a picture of the complex diversity of the HACC client population rather than a precise client classification.

The main elements of this diversity are set out in the table below. The table suggests that the three main dimensions of diversity amongst HACC clients are the term, circumstances and continuity of assistance required. The first level of diversity is the term or period of assistance. Broadly speaking, we can distinguish long-term (Type 1) and short-term (Type 2) clients. Long-term clients, we might speculate, are those with chronic health conditions leading to functional limitations that require assistance from HACC. Type 2

clients, on the other hand, are those who have short-term functional limitations requiring HACC services for a short-term only.

Table 166 A typology of current HACC clients

Level 1: Term of assistance	Level 2: Circumstances of assistance	Level 3: Continuity of assistance
Type 1: People with a long-term chronic health condition resulting in functional (activity) limitations requiring assistance from HACC for them or their carers	Type 1a: People who receive services from Specialist Disability Services/NDIS who also need assistance from HACC services to address their functional (activity) limitations	Type 1a (i): People requiring continuous assistance
		Type 1a (ii): People requiring episodic assistance
	Type 1b: People who do not meet the threshold of eligibility for Specialist Disability Services/NDIS but who have functional (activity) limitations requiring assistance from HACC	Type 1b (i): People requiring continuous assistance
		Type 1b (ii): People requiring episodic assistance
Type 2: People with time-limited, short-term health conditions resulting in functional (activity) limitations requiring assistance from HACC for them or their carers	Type 2a: People requiring assistance prior to or after hospitalisation to meet their functional (activity) limitations	Type 2a (i): People requiring continuous assistance
		Type 2a (ii): People requiring episodic assistance
	Type 2b: Other people with time limited functional (activity) limitations, e.g. after an adverse health event such as an injury or illness	Type 2b (i): People requiring continuous assistance
		Type 2b (ii): People requiring episodic assistance
	Type 2c: People requiring palliative care who require, or whose carers require, assistance as a result of functional (activity) limitations	Type 2c (i): People requiring continuous assistance
		Type 2c (ii): People requiring episodic assistance

Level 2 of the typology focuses on the circumstances giving rise to the need for assistance from HACC services. For long-term clients two groups can be distinguished: those who are clients of Specialist Disability Services or the NDIS who also need assistance from HACC (Type 1a) and those who, despite having long-term health conditions resulting in functional (activity) limitations, do not meet the eligibility requirements for Specialist Disability Services/ NDIS (Type 1b). The full implementation of the NDIS during 2016-2019 will have an impact on the size of each of these groups. The more comprehensive the range of services provided by the NDIS, the smaller will be the number of HACC clients falling within Type 1a. The wider the eligibility requirements for the NDIS, the smaller will be the number of HACC clients falling within Type 1b.

For short-term clients, three sets of circumstances leading to use of HACC services can be distinguished. The first set of circumstances are associated with hospitalisation, either assistance with activities provided while waiting for a hospital procedure or post-acute care during the period of rehabilitation after surgery or a hospital stay for some other reason (Type 2a). Just as demand for long-term HACC usage is impacted by the scope and eligibility requirements of Specialist Disability Services or the NDIS, so the demand for HACC services associated with pre- and post-acute care is impacted by the level and nature of services provided through the hospital or community health services. The second set of circumstances associated with short-term care involves other adverse health events not involving hospitalisation such as injury or illness (Type 2b). For example, a General Practitioner (GP) may seek support from HACC for a patient who is not coping with an illness or injury at home, but who does not require hospitalisation. People who have limited social support, including some of those living alone or who do not have carers, are more likely than

other people to require support from HACC. Similarly, people with limited financial resources are more likely than other people to require HACC services in these circumstances.

Type 2c are HACC clients receiving palliative care at home. This group is identified as a distinct group because there is evidence that HACC receives more than 20 per cent of its referrals from palliative care services. The period of time that they receive HACC services will vary depending on the nature of their health condition. Some may be longer-term HACC clients who have moved into the final stages of their illness.

Level 3 in Table 1 distinguishes those HACC clients receiving continuous care from those receiving episodic or intermittent care. Each of the sub-types identified in levels 1 and 2 might include both types of clients. Certain types of clients may be more likely to fall into one or other of these two groups. For example, HACC services for people who have mental health issues may tend to be required on an episodic basis given that many people with mental health issues are intermittently unwell. Clients with physical or intellectual disabilities may be more likely to need ongoing, continuous assistance.

While Table 1 draws attention to some of the main sub-groups or types of HACC clients for purposes of this study, there are clearly other ways of responding to the question: Why do clients need and use HACC services? It is important to distinguish between types of disability (physical, intellectual and psychiatric), and the severity of the functional (activity) limitations experienced by a client. It is also necessary to consider the social and psychological factors associated with use of HACC services. The extent to which an individual lives in an enabling/disabling environment, including the level of personal support available, will impact on HACC service use, as will the client's own level of resourcefulness and resilience. Use of HACC is also related to accessibility issues: age, sex, ethnicity, Aboriginality, locality and socio-economic status can all play a role in determining who has access to HACC.

In summary, the schema presented in the table above provided a way of commencing the investigation into the question, 'Why do clients currently need and use HACC services?' It suggests that the distinction between long and short-term clients is of central importance, and it proposes categories of circumstances leading to HACC service use, whether that be continuous or intermittent. This table, together with the eight research questions listed earlier, provided a conceptual framework to steer the research process.

OVERVIEW OF RESEARCH METHODS

The study reported here took place between August 2014 and April 2015. Ethics approval was granted by the University of Tasmania (UTAS) Health and Medical Human Research Ethics Committee (HREC) and by the Tasmanian Scientific Research Advisory Committee (TSRAC), and endorsed by the appropriate University of Queensland ethics committees.

The study comprised four inter-related sub-projects each of which contributed to project objectives. A brief summary of the methodology of each sub-project is provided below and further details are provided in the relevant chapters of the report.

Analysis of the policy and service environment

The Tasmanian HACC program operates in a rapidly changing environment with major changes occurring in policy and service provision in the related areas of disability, primary health care and mental health. The aim of this component was to develop an understanding of the relationships between the HACC Program and these three areas. Changes in the policy and organisational environment provide new opportunities and demands for the HACC Program, and have implications for where the program will be located in the wider health and human services field. An understanding of this environment was also required to develop the client survey and to interpret the data from each of the other sub-projects.

A number of methods were used to build an understanding of the HACC Program and its relationship with the policy and organisational environment. A literature review was undertaken covering broad developments at national and state level in home and community care, primary health care, disability and

mental health policy and service provision. A total of 23 interviews took place with persons involved in policy development, management and service provision both in DHHS and in associated organisations in order to relate themes from the wider literature to the Tasmanian context, and to understand the particularities of the local context. On the basis of material gathered from these sources, we developed our analysis of the policy and services environment.

The organisations from which stakeholders were engaged were:

- Anglicare Tasmania Inc.
- Bapcare Services
- Care Assessment Consultants Pty Ltd.
- Community Transport Services
- DHHS – Data Custodians
- DHHS – Disability and Community Services
- DHHS – Community Nursing
- DHHS – Service Purchasing and Performance
- DHHS – Strategic Planning
- DHHS – THO North
- DHHS –THO South
- Family Based Care Association North West Inc.
- GC Services Inc.
- Hobart District Nursing Service Inc.
- Integrated Living Inc.
- Launceston VFC Services Inc.
- Meals On Wheels Tasmania Inc.
- Medicare Local Tasmania
- Mersey Community Care Association Inc.
- Mission Australia
- National Disability Insurance Agency (NDIA)
- TasCarepoint
- Wattle Group Inc.

Analysis of existing data sources to profile clients

Three data sets containing information about HACC clients were identified and analysed as part of the process of profiling clients. Steps were taken to ensure the confidentiality of data relating to individual clients and data from these sources was only linked to client survey data with the written permission of clients and using a Statistical Linkage Key to ensure the anonymity of data. The data sets examined were:

- The Home and Community Care (HACC) Minimum Data Set (MDS).
- The Specialist Disability Services Minimum Data Set (NMDS).
- Data sets included in Health Central, the data repository of the Tasmanian Department of Health and Human Services.

The most extensively used of these three data sets was the HACC MDS, a national data set covering the activities of the HACC program in each of the States and Territories. DHHS made available to the research team a data extraction from the HACC MDS covering all HACC clients who were provided services in Tasmania during the period 1 July 2013 to 30 June 2014. This data was analysed to provide a detailed picture of many of the characteristics of the HACC client group for 2013-14. This data was not originally collected with the objectives of the research project in mind. There are also other limitations of the data set for the purpose of profiling clients which are discussed in the report. However, analysis of the HACC MDS provided detailed information concerning several aspects of the client profile of HACC clients including:

- Demographic profile (age, sex, ethnicity, language, Indigenous status, housing tenure, living arrangements, main pension or benefit);
- Sources of referral (pathways) to HACC;

- Activity limitations (functional status); and
- Pattern of use of HACC services.

Some variables were obtained directly from the data set. In other cases, it was possible to create new variables from the data available in the data set.

Extensive use was also made of the Specialist Disability Services NMDS, a collation of nationally comparable data about services provided under the National Disability Agreement. As with the HACC MDS, DHHS made available to the research team a data extraction from the DS NMDS covering all Specialist Disability Services clients who were provided services in Tasmania during the period 1 July 2013 to 30 June 2014. The relevance of this data set to the project lies in the capacity to link client data in the DS NMDS with client data in the HACC MDS using the Statistical Linkage Key (SLK). A proportion of Tasmanian HACC program clients are also clients of the Tasmanian Specialist Disability Services. Using the SLK, data from the DS NMDS can be accessed for those clients who are jointly engaged with both programs while maintaining the confidentiality of the data. Furthermore, comparisons can be made between HACC clients who are Specialist Disability Services clients and those who are not, across a number of variables.

Selective use was also made of data drawn from particular data sets included in Health Central, the data repository of the Tasmanian Department of Health and Human Services. This extensive data repository was used to obtain data concerning two aspects of HACC clients not available from other data sources:

- Their health conditions; and
- Their use of health services.

As with the DS NMDS, data from these sources were linked to HACC clients using the SLK.

The findings from these three sources are presented in the statistical overview of HACC clients.

Survey of HACC clients

A survey of clients of the Tasmanian HACC program was undertaken with the aim of developing a client profile focused on understanding why clients need and use HACC services. The HACC MDS was used as the sampling frame for the survey and the sample was drawn from the 5,178 clients who used HACC services during the period 1 July 2013 and 30 June 2014. All clients who could be contacted were invited to take part in the survey and clients were provided with a choice of on-line, telephone and face-to-face interviews. The interview was designed to be completed within a maximum time period of 30 minutes. A total of 388 clients completed the survey. The survey focused on the following areas:

- The health conditions, disabling conditions and functional dependencies giving rise to the use of HACC services;
- Personal characteristics of HACC clients;
- The personal support available to HACC clients;
- Referral pathways into HACC;
- The pattern of past, current and anticipated future use of HACC services; and
- Overlap with use of other services.

A data set comprising data from the client survey and selected variables from other sources (HACC MNDS, DS NMDS and Health Central) was constructed and the data analysed (only for the 311 clients who gave permission to link their data). The findings are reported as a comprehensive profile of HACC clients.

Analysis of existing data sources to estimate future demand

Three existing data sets have been used to provide estimates of the current and future incidence of persons with activity limitations in the Tasmanian population. These are:

- The ABS 2011 Census.
- The ABS Population Projections for Australia, 2012 (base) to 2011.

- The ABS Survey of Disability, Ageing and Carers (SDAC), 2012.

The research team accessed the ABS 2011 Census in the form of the Community Profile data for Tasmania and other regions and in the form of the Confidentialised Unit Record File (CURF) of the 5 per cent sample of respondents. The analysis focused on the Census variables Core Activity Need for Assistance (ASSNP) and Unpaid Assistance to a Person with a Disability (UNCAREP) which provide data concerning activity limitations of members of the population and the provision of unpaid care, help or assistance to people with a disability. Analysis of these Census data items provides an indication of the potential number and proportion of Tasmanians who may need assistance from formal programs such as HACC and Specialist Disability Services (in transition to the NDIS) to address their activity limitations.

ABS Census data is used to identify the estimated number of people in the Tasmanian population aged 18-64 with activity limitations and their characteristics. ABS population projections are then used to estimate the size of this group in the future under a range of different assumptions of fertility, migration and mortality for the Tasmanian population.

This Census analysis is supplemented with data drawn from the 2012 *National Survey of Disability, Ageing and Carers* (SDAC). Using the SDAC Confidentialised Unit Record File, estimates of the incidence of disability and activity limitations are derived for the Tasmanian population aged 15-64. A number of characteristics of these populations are then presented based on the same data source. These findings are reported in our projections of future demand for HACC services.

ADDITIONAL DETAIL: SECONDARY DATA USED IN CLIENT GROUP ANALYSIS

A statistical linkage key (SLK) derived from the name, birth date and gender of each client was used to link data from the HACC MDS with their data from the other sources. The data was de-identified (researchers were unable to identify clients based on the data provided). Researchers were provided with the SLK code only.

HACC clients aged under 18 were excluded from the main data set used. This was because the client survey of HACC clients was restricted to adults aged 18-64 years due to the difficulties of obtaining informed consent for persons aged under 18. It was considered desirable for the analysis of HACC MDS data to be conducted on the same group from which the sample for the client survey was chosen. A total of 5,178 persons aged 18-64 were recorded in the HACC MDS as HACC clients in the year commencing 1 July 2013.

Home and Community Care Minimum Data Set

Description of data set: The Home and Community Care Minimum Data Set (HACC MDS) is a national data set that records data on the activities and services provided to clients of the HACC program from all states and territories. The data set has been de-identified and no individual clients are able to be identified from the data set. The objectives of the HACC MDS as set out in the User Guide (AIHW 2012: 2) are:

- To provide HACC program managers with a tool to access data required for policy development, strategic planning and performance monitoring against agreed output/outcome criteria;
- To assist HACC service providers to provide high quality services to their clients by facilitating improvements in the internal management of HACC- funded service delivery; and
- To facilitate consistency and comparability between HACC data and other aged, community care and health data collections. The HACC MDS comprises data provided by service providers on services and clients of the HACC program.

All service providers receiving funding under the HACC program are required to submit quarterly data to their State and Territory governments on services provided to clients, as specified in the National User Guide (AIHW 2012). Data is collected on clients' personal details and circumstances, carers, service episodes and assistance provided. The data is then forwarded to the National Data Repository maintained by the Commonwealth Government, to populate the HACC MDS. The HACC MDS is a key source for developing a comprehensive profile of current clients of the Tasmanian HACC program. It was designed to provide relevant data for informing policy development and strategic planning and has undergone a number of reviews since its establishment in 2001 to ensure that it is fit for purpose. Despite its limitations, it is widely acknowledged by stakeholders as an authoritative source of data on the HACC program. The data set is sufficiently flexible to enable data extracts to be made for specific analytical purposes

DHHS provided ISSR with two data extracts from the HACC MDS for clients aged less than 65 years:

- *Extract 1:* Comprises the quarterly data deposits from Tasmanian service providers spanning the period 1st July 2013 to 30th June 2014. Each record in this dataset corresponds to a single service provided to a client.
- *Extract 2:* Comprises a summary of clients reported in Extract 1. Each record in this dataset corresponds to summary information for a unique client.

Data from these extracts were used to develop a profile of Tasmanian HACC clients for the period 1st July 2013 to 30th June 2014. HACC clients aged less than 18 years were excluded from the primary analytic data set to align with the age range of the HACC client survey which was restricted to adults aged 18-64. Obtaining informed consent from persons aged less than 18 to participate in the survey was beyond the scope of this study. A total of 5,178 persons aged 18-64 were recorded as clients in the HACC MDS in the

year commencing 1st July 2013. A separate analysis of HACC MDS data for HACC clients aged 0-17 is provided in this report.

Variables recorded in HACC MDS Extracts: The User Guide (AIHW 2012) provides a detailed description of all data items, including definitions of terms, recorded in the HACC MDS. Data Extracts 1 and 2 contain data for 80 different items which are recorded in corresponding variables appearing as columns in the data set. A list of the key variables is provided at the end of this technical report). These variables are classified as capturing information related to:

- the client – personal details;
- the client – circumstances;
- the carer – if one exists;
- the service episode;
- the assistance provided; and
- the total assistance provided.

The variables in the data extracts can be used to profile the characteristics of clients and their living circumstances to identify diverse sub-groups of clients and to examine the relationships of these sub-groups to the types and quantity of service(s) received as well as the duration of the services received.

Data limitations: The HACC MDS has a number of significant limitations that must be recognised when analysing and interpreting the data. These limitations have contributed to the decision to supplement data from the HACC MDS with client survey data. Firstly, as an administrative data set, the HACC MDS is selective in the data items recorded for the purpose of reporting. For example, while the HACC MDS includes data on the functional status of clients it does not include data on the health condition or impairment leading to functional limitations. Secondly, the data set is limited by the quality of the data submitted by service providers. While the User Guide and data monitoring processes are designed to maximise the quality of data entered, the large number and varying capabilities and resources of service providers present significant challenges to data integrity. For these reasons, it is difficult to assess the overall quality of the data. Thirdly, the occurrence of missing data is extensive which limits interpretation of findings from empirical analyses. Appropriate documentation of the limitations of the data is presented with analytical findings throughout the report.

Specialist Disability Services National Minimum Data Set

Description of data set: The Specialist Disability Services National Minimum Data Set (DS NMDS) is an annual collation of nationally comparable data on services provided under the National Disability Agreement. Since 1991, disability support services in Australia have been provided under four national disability agreements, most recently the National Disability Agreement (NDA) commencing in 2009 (AIHW 2014b). Under the NDA, the Disability Administrators in all Australian jurisdictions are responsible for ensuring 'that DS NMDS information will be comparable across all jurisdictions and years' (AIHW 2014b). The Tasmanian data for the DS NMDS is controlled and managed by Disability and Community Services within DHHS.

The Data Guide provides many examples of how DS NMDS data have been used for planning, national program evaluation and to monitor achievement of program objectives and agreed priorities. The Data Guide emphasises that the data set can also be used to obtain:

- a profile of all people receiving a NDA service in a financial year;
- information on carer arrangements, which enables monitoring and planning for ageing carers; and
- information about the mix of services provided to some service users which can be linked to users' characteristics such as their support needs, disability group, carer arrangements and whether they live in metropolitan or rural locations (AIHW 2014b: 2).

Contribution to objectives: The DS NMDS data was used to identify the number and types of clients receiving services under both HACC and Disability Services, enabling a comparison between the characteristics of HACC clients who are clients of Specialist Disability Services and those who are not.

Further, the information in the DS NMDS on joint HACC-DS clients was used to provide a more detailed description of this group and the services they received from Disability Services.

The key questions that the DS NMDS data (in conjunction with HACC data) was used to address were:

- What proportion of HACC clients are also clients of Disability Services?
- What are the primary (and other) disability groups of joint DS/HACC clients?
- What are the support needs of joint DS/HACC clients?
- What proportion of joint DS/HACC clients has individual funding status?
- What are the differences between joint DS/HACC clients and HACC only clients (personal characteristics, personal support, functional status, service use)?
- What combinations of services are used by joint DS/HACC clients?

Access and availability: A data extraction from the DS NMDS covering all Specialist Disability Services clients in receipt of services in Tasmania during the period 1 July 2013 to 30 June 2014 was made available to the research team by DHHS. The data extraction contained SLK data only for Specialist Disability Services clients who were also a sub-group of the 5,178 HACC clients receiving services during the same period of time. The SLK variable enabled the linkage of these clients with their data from other secondary data sources.

Variables available: The DS NMDS consists of approximately 30 primary variables and sub-variables relating to service users and services received. These are listed in at the end of this technical report.

The main variables used were:

- Demographic variables (age, sex, country of birth, language spoken at home, geographic location, Indigenous origin, housing tenure, residential setting, pension status, living arrangements);
- Disability information (disability group, support needs, individual funding status, presence of carer); and
- Service information (for example, what combinations of services are used by those who are both DS/HACC clients).

Data limitations: DS NMDS data extract had two main limitations. Firstly, the extract contained year of birth data rather than month and year which means that indigenous clients who would not have turned 50 until after 30 June 2014, and non-indigenous clients who would not have turned 65 until after 30 June 2014, were not included in the analysis. Therefore, the reported number of Specialist Disability Services clients aged 18-64 in the period 1 July 2013 to 30 June 2014 will be a conservative number. The second limitation is that some data items in the HACC MDS do not have a corresponding data item in the DS NMDS, for example, language spoken at home and housing tenure. Analyses using these variables compared the DS/HACC clients with the HACC only clients.

Health Central (iPM)

Description of data sets: In 2010, a more robust information and communication technology system through Health Central was implemented. Data is collected through Health Central from DHHS's Patient Information and Administration Management System (the iPM) and the Emergency Department Information Systems (EDIS) on a monthly basis. Typically, indicators are produced to monitor performance levels (DHHS 2013:4). This is the main health care and management information system for Tasmanian health services. The information management system includes numerous elements which are used for patient management, planning, funding and accountability purposes.

Contribution to objectives: The de-identified Health Central data was used to identify the proportion of Tasmanian HACC clients that used a health related service during the period 1 July 2013 to 30 June 2014. This data was also used to indicate how frequently Tasmanian HACC clients used these services and the health conditions that necessitated the use of these health related services.

Access and availability: Four data sets were made available by DHHS:

- Emergency Department Presentations 2013-14;

- Non-admitted Patient Service Events 2013-14;
- Hospital Admissions 2013-14; and
- Community Nursing 2013-14.

These data sets were restricted to the clients that could be matched to the HACC MDS 2013-14 extraction via the de-identified SLK variable and only variables required to address the research questions were included, that is, service usage, reason for referral and referral source. All data sets were password protected.

Variables available: The main variables provided were: service usage, reason for referral and referral source. However, the reason for referral as discussed in the limitations below, was not comparable across the data sets.

Data limitations: A major data limitation is around the quality of the data. It was not possible for ISSR to determine the accuracy of the data recorded. This is a particular concern for personal details (name, family name, date of birth and gender), which impacts the accuracy of creating the SLK and linking the datasets.

A limitation that impacts all the Health Central data sets is the challenge of identifying a suitable classification for health conditions that enables the data to be interrogated in a meaningful way. Further, the four data sets recorded health conditions differently. For example, the Emergency Department Presentations data set and Hospital Admissions' data set had variables ('ED_DiagnosisCode' and 'PrimaryDiagnosisCode') that were aligned to the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM) codes and then assigned to 20 main groups. ICD-10-AM is a derived version of the World Health Organization (WHO) ICD-10. However, the Non-admitted Patient Service Events and the Community Nursing data sets did not have variables that could be aligned with the ICD-10-AM codes. While the Community Nursing data captured the reason ('ReferralDiagnosisDescription') for a client needing the nursing service (e.g. wound management, financially disadvantaged, or they were from a remote or isolated area), rather than the disease that caused the need, many of the referral diagnosis descriptions could be aligned with ICD-10-AM codes.

The final noted limitation pertains to the Community Nursing dataset, where data is collated from the Tasmanian Health Organisations (THOs) and does not include data from non-government organisations that offer nursing services such as District Nursing. Hence, we have missing data for about 8.4 per cent (n=433) of the HACC clients who have indicated that they access nursing services. In addition, data custodians at DHHS have indicated that there may be some over reporting regarding the funding referral source. Approximately 48 per cent of the services are expected to be funded by HACC, however, the data indicates that 72 per cent of the THO nursing services for this group during this period is funded by HACC. It is recommended that the Community Nursing data be interpreted with caution.

ADDITIONAL DETAIL: UNDERSTANDING FUNCTIONAL STATUS

The functional status data included in this report takes three forms. There are seven items where functional status is measured by asking the client if they can perform a certain task and classifying the responses as:

- Yes, always
- Yes, with help
- No.

These items/questions are:

1. Housework: 'Can you do your housework?'
2. Transport: 'Can you get to places out of walking distance?'
3. Shopping: 'Can you go out shopping for groceries or clothes (assuming you have transportation)?'
4. Medication: 'Can you take your own medicine?'
5. Money: 'Can you handle your own money?'
6. Walking: 'Can you walk?'
7. Bathing and showering: 'Can you take a bath or shower?'

A further five items take a similar form except that the responses are classified as:

- Yes, always
- Yes, sometimes
- No.

These items/questions are:

1. Communication: 'Can you communicate (understand or be understood by others) without help?'
2. Dressing: 'Can you dress yourself without help?'
3. Eating: 'Can you eat without help?'
4. Toileting: 'Can you manage the toilet without help?'
5. Getting out of bed/moving around: 'Can you get out of bed or move around at home (or places away from home) without help?'

The final two items involve an assessment by the service provider drawing on all available information, but not asking the client for their self-assessment. The assessment is a simple yes/no. These items/questions are:

1. Memory problems or confusion: 'Does the person have memory problems or get confused?'
2. Behavioural problems: 'Does the person have behavioural problems, e.g. aggression, wandering or agitation?'

This set of items was developed in response to the recommendation that a '*common approach to the measurement of dependency is desirable if HACC clients are to receive the services appropriate to their needs*' (AIHW 2012: 166).

Some items were taken from the National HACC Functional Screening Instrument which was developed to identify those clients who require further assessment to determine their level of dependency. Others were chosen to enable comparisons of levels of dependency of HACC clients with population data such as that obtained through the ABS *Survey of Disability, Ageing and Carers* (SDAC) and the Census (AIHW 2012: 162).

These different purposes are reflected in the diversity of items. Most items are concerned directly with a client's capacity to undertake activities where HACC services can provide assistance: they are direct measures of need for assistance from HACC. However, a sub-set of the items correspond closely with core activities as defined by the ABS in the conceptual framework underpinning the SDAC (AIHW 2009: 31-33).

In SDAC, a person is defined as having a disability if he/she has at least one of 17 limitations, restrictions or impairments that has lasted or is likely to last for 6 months and that restricts everyday activities. Those identified as having a disability in this sense are then asked about their need for assistance with '*core activities of self-care, mobility and communication*'. Those reporting a core activity limitation are the population with '*disability and a specific limitation or restriction*' (AIHW 2009: 31). The ABS lists core activities as:

- Self-care – bathing or showering, dressing, eating, using the toilet, and bladder or bowel control;
- Mobility – getting in and out of a bed or chair, moving around at home and going to or getting around a place away from home; and
- Communication – understanding and being understood by others: strangers, families and friends.

With respect to these core activities, the ABS defines a person's overall activity limitation in terms of the highest level of limitation that the person experiences in any of the core activity areas. The four levels of core activity limitation are:

- Profound – unable to do, or always needs assistance to perform the core activity;
- Severe – sometimes needs assistance to perform the core activity;
- Moderate – does not need assistance, but has difficulty performing the core activity; and
- Mild – has no difficulty performing a core activity but uses aids or equipment due to disability.

These categories are widely used in describing the prevalence of various levels of '*disability with core activity limitation*' in the community.

Because the functional status data in the HACC MDS includes most of the core activity limitations used by the ABS in SDAC, this data can be used to estimate the number and proportion of HACC clients who have a core activity limitation (as defined by the ABS) and whether or not this core activity limitation is profound or severe (also as defined by the ABS). The six core activity limitations included in the ABS definitions and available in the HACC MDS are:

- Self-care;
 - Bathing or showering
 - Dressing
 - Eating
 - Using the toilet
- Mobility; and
 - Getting out of bed/ moving around
- Communication.
 - Understanding and being understood by others.

Those who answer 'No' to one or more of the questions about their functional capacity on these items would be categorised by the ABS as having a 'profound' (unable to do or always requires help) core activity limitation. Those answering 'yes, sometimes' to one or more of the same questions fall within the ABS category of 'severe'. By using the HACC MDS functional status data in this way, comparison can be made between the incidence of profound and severe core activity limitations in the HACC population and in the Tasmanian community. Identifying the proportion of HACC clients with profound and severe activity limitations is also relevant to the aim of distinguishing different sub-groups of HACC clients. Of course, the problem of missing data in the HACC MDS restricts the generalisability of such findings.

Unfortunately, the HACC MDS data has a number of significant limitations. Firstly, no data is collected on the health conditions and impairments leading to the functional limitations of the client. Secondly, the assessments of functional limitations are undertaken by a large number of service providers at different times and in different contexts. The HACC MDS User Guide provides broad guidelines for the assessment

of functional status (AIHW 2012: 32-36), but there is no way of knowing to what extent a uniform standard is actually applied across all assessments. Thirdly, not all HACC MDS questions are recorded in exactly the same way. Finally, the HACC MDS functional status data contains a high level of missing data which limits the capacity to generalise about all clients from the data that is available. These limitations must be considered when interpreting the summary statistics presented below.

The amount of missing data on functional status in the HACC MDS is considerable. Missing data is reported per item and per client. For all 14 functional status items, the percentages of missing data ranges from 44.1 per cent (toileting) to 36.2 per cent (medication, money). Missing data per client refers to the number and percentage of clients for whom there is complete, partial or no data. For the 5,178 HACC clients in the data set, complete data (14 items) is available for 2,780 (53.7 per cent) clients; no data is available for 1,807 (34.9 per cent) clients and partial data is available for 591 (11.4 per cent). Most of the analyses in this section are based on the 12 main functional status items, of which complete data is available for 2,802 (54.1 per cent) clients. Missing information on functional status raises the concern that the areas in which a person requires assistance with daily living may not be the same for these two sub-groups, that is, those with missing data on functional status and those with no missing data on these variables. To investigate this issue, statistical tests for comparing the two groups were undertaken to detect if, and describe how, the sub-group of HACC clients with complete data on the 12 functional status items differed to the sub-group of HACC clients with missing data on these items. Using chi squared and t-test statistics, the analysis compared the two sub-groups on a number of characteristics including age, length of time since commencing as a HACC client, sex and whether or not they were a client of Specialist Disability Services. The tests of significance showed that group membership was not independent of most of these characteristics. HACC clients with missing data were younger in age, shorter in length of time as a HACC client and less likely to be clients of Specialist Disability Services compared to HACC clients with complete data. Therefore, while it is not possible to determine how clients may have responded to the functional status items, it seems unlikely that the results reported for clients with complete data might reflect the capabilities in the respective activities for clients who have incomplete or no information.

To further investigate this, the data was linked with the survey data for 311 clients who consented. Using four core limitation variables that were comparable across the two datasets, namely mobility, bathing, showering and dressing, eating, and communication, the analyses on the missing data showed that between 54.2 per cent (mobility) and 84.3 per cent (eating) of the missing data was self-reported as not having a limitation in these activities. These results along with the statistical tests between the groups seem to suggest that the missing data on limitations may be largely due to service providers' not entering data for clients who have no activity limitations. However, there is still a group (approximately 15.7 to 45.8 per cent) that have activity limitations (as indicated through self-reports) that have not been reported on the HACC MDS and the analyses in section 4.3 examined patterns in the available data without making any assumptions about those clients for whom we do not have this data. The following analyses of the functional status data was undertaken and described in section 4.3. Firstly, the levels of functional dependency in the HACC population for all activities, including core activities as defined by the ABS, were calculated and compared. Secondly, the number and proportion of clients with multiple activity limitations were analysed. Thirdly, the types of activity restrictions were investigated further. Fourthly, the proportion of HACC clients with profound and severe core activity limitations were calculated.

ADDITIONAL DETAIL: ABS DATA USED FOR DEMAND PROJECTIONS

ABS 2011 Census

Description of data set: The ABS Census data is a descriptive count of every person in Australia on one night, and of all dwellings. A census is conducted every 5 years: the most recent Census of Population and Housing was conducted on 9 August 2011 (ABS 2011a).

Contribution to objectives: As with the SDAC 2012 data, information from the Census 2011 data was used to provide summary statistics describing the Tasmania population which were then compared to results from the HACC client survey. By comparing the Census and SDAC sources of data across similar items we have been able to develop reliable estimates of potential demand on HACC services in the future (up to 2061) in the light of demographic change in the Tasmanian community. Additionally, use was made of the Census data to compare the characteristics of HACC clients with the characteristics of the Tasmanian population.

Access and availability: Census data is maintained and controlled by the Australian Bureau of Statistics. We have received access to the 2011 Census Sample File which is a comprehensive 5 per cent sample unit record file containing census characteristics, for a random sample of person, family and dwelling variables.

Variables available: The Census contains a large number of variables concerning individuals, families and households in Australia. This includes data on need for assistance with core activities. The key items are:

- Does the person ever need someone to help with, or be with them for, self-care activities? For example: doing everyday activities such as eating, showering, dressing or toileting.
- Does the person ever need someone to help with or be with them for body movement activities? For example: getting out of bed, moving around at home or at places away from home.
- Does the person ever need someone to help with or be with them for communication activities? For example: understanding, or being understood by, others
Responses available are: Yes always, Yes sometimes, and No.
- What are the reasons for the need for assistance or supervision shown [above]?
Responses available are: 'No need for help or supervision', 'Short-term health condition lasting less than six months', 'Long-term health condition lasting six months or more', 'Disability lasting six months or more', 'Old or young age', 'Difficulty with English language', and 'Other cause'.

Data limitations: The 5 per cent Census 2011 data file is a random selection of the Australian Census data file and it is expected that there was no notable bias introduced by using the 5 per cent sample.

The census data was used to examine the questions on activity limitation, and reasons for the need for assistance or supervision, with self-care, communication, and mobility. These questions were then used to distinguish between short-term health condition lasting less than six months, long-term health condition lasting six or more months.

ABS Survey of Disability, Ageing and Carers (SDAC)

Description of data set: The SDAC is a national survey that is undertaken at regular intervals (1998, 2003, 2009 and 2012). SDAC is an ABS survey that collects information on people with disability, older people and carers. The aims of SDAC are to:

- Measure the prevalence of disability in Australia.
- Measure the need for support of older people and those with disability.

- Provide a demographic and socio-economic profile of people with disability, older people and carers compared with the general population.
- Estimate the number and characteristics of people who provide care to people with disability, long-term health conditions and older people.

The SDAC defines disability as any limitation, restriction or impairment which restricts everyday activities and has persisted, or is likely to persist, for at least six months. A summary report of the 2012 findings from SDAC is available online from the Australian Bureau of Statistics (2012a).

Contribution to objectives: The SDAC has been used as a resource for questions in the HACC client survey as well as a means of comparison (SDAC 2012) to results from this client survey. By comparing the two sources of data across similar items we have been able to develop reliable estimates of potential demand on HACC services in the future based on projected demographic change in the Tasmanian community.

An important aspect of SDAC is that it provides clear definitions of terms that are central to the client survey and this research: disability; long-term health condition; specific limitation or restriction; core activity limitation and levels of restriction; and the need for assistance.

Access: We have received the confidentialised unit record file data of the SDAC 2012 from ABS and have full access to this data for the purposes of this report.

Variables available: The SDAC data is comprised of numerous variables. People with disability were asked questions relating to:

- Help and assistance needed and received for mobility, self-care, communication, cognitive or emotional tasks, health care, household chores, property maintenance, meal preparation, reading and writing tasks, and transport activities.
- Use of aids and equipment.
- Schooling restrictions, for those aged 5 to 20 years.
- Employment restrictions, for those aged 15 to 64 years.
- Satisfaction with the quality of services received and range of services available.
- Computer and internet use.
- Self-perception of health and wellbeing.
- Access and barriers to health care.
- Social, community and civic participation.
- Feelings of safety.
- Experience of homelessness.

Data limitations: The SDAC is a national survey, carefully designed to select representative households in Australia. Every effort is made to ensure that the survey is representative of the population of Australia. The survey was conducted under the authority of the Census and Statistics Act 1905 and therefore cooperation of selected households and participants was maximized. This meant that the response was very high at around 90 per cent of all households selected to participate in the survey, ensuring that the survey results are largely representative of the population.

The most recent ABS Survey of Disability, Ageing and Carers (SDAC), undertaken in 2012, is the most important source of data for estimating the prevalence of disability and activity limitations in Tasmania. A number of publications are available from the ABS to facilitate use of the SDAC and to report on its major findings. The *User Guide* (ABS 2011a) outlines the underlying logic of the survey and includes a Glossary of Terms. The Household Questionnaire (2013d) includes all of the questions asked of households. All variables included in the Tables proposed below are identified in the guide to micro-data (ABS 2014b). There is also a list and classification of long-term health conditions (ABS 2013f). The main findings for

Australia (ABS 2014a) and for Tasmania (ABS 2013e) are conveniently summarised in publications. The Tables in the findings for Tasmania (ABS 2013e) provide a template for the Tables proposed below. All ABS publications referred to are available in the shared file.

SDAC does not provide clear, unambiguous data on need and demand for the HACC program. There is no specific information on the HACC program in SDAC. Many factors impact on current and future demand for HACC including:

- The level and nature of activity limitations in the community;
- The aims, objectives and scope of the HACC program as they develop over time;
- The management and operation of the HACC program;
- The aims and scope of related programs such as Specialist Disability Services (NDIA);
- The extent to which assistance with activity limitations is met by informal sources (family and friends);
- Demographic changes impacting on the level and nature of activity limitations in the community; and
- Cultural issues relating to reliance on state funded services, caring, etc.

The only one of these factors that SDAC provides information on is the level and nature of activity limitations in the community. However, this is a fundamental factor and SDAC provides comprehensive information. The tables provided in the summary of SDAC findings relating to Tasmania provide a detailed picture of these issues for the overall Tasmanian population. However, the picture for the potential HACC population aged 15-64 (SDAC presents age in 5 or 10 year groupings) is quite different to the picture for the overall population due to the high levels of disability and activity limitation in the 65 and over population. It is therefore necessary to develop tables specific to the HACC context. In our analysis that follows, we obtained access to the Confidentialised Unit Record File (CURF) for SDAC 2012 and can use this file to build the tables required.

SDAC sampling, weighting and interpretation of results: A multi-stage sampling strategy is used to select individuals to participate in the SDAC survey and therefore it is important to apply statistical weights to the achieved sample to ensure that the results are representative of the Australian population. The sample of private and non-private dwellings was selected from a list of dwellings from each State and Territory. The first stage of sampling was to divide each State and Territory into geographically contiguous (neighbouring) areas called strata. The strata are formed by dividing Australia into regions within the state and Territory boundaries, and these divisions are known as statistical divisions (using the Australian Standard Geographical Classification). The next stage is to divide these regions into statistical local areas (SLAs). These areas are administrative divisions made of state capital city, major urban centres, minor urban centres and rural non-metropolitan areas. To account for the high population densities in major urban and capital cities, the selection of SLAs was made proportional to size of the population.

These smaller regions are then divided into even smaller groups called census collection districts (CCDs) so that based on the population density each CCD has on average 250 dwellings. The sample was then selected to ensure that each dwelling within each CCD was selected with equal probability. In an ideal world the sample should be a replica of the population of interest. The sample would be representative of the population with respect to the information collected from the survey. If a survey is conducted using simple random selection process then the assumption is that each sample unit is selected with the same probability. In most cases, as for the SDAC, a multistage stratified design is used and hence statistical weighting is used to adjust for the sampling design to ensure that the estimates derived from the sample are unbiased. A second problem related to representativeness is that of nonresponse. Not everyone who is selected to participate in the survey will respond to the survey. In addition, this nonresponse does not occur uniformly, with some groups, particularly young men, being under-represented, while others such as older women are over-represented. If this occurs, conclusions from the observed survey information are less reliable. By using statistical weights this lack of representativeness can be reasonably corrected.

In SDAC person weights are provided in the survey data files, and these have been used to 'weight' up the observed sample data to ensure that the results are representative of the population of Tasmanians aged 15-64. These weights assign a weighting adjustment to each survey respondent. In theory, a person with characteristics that are under-represented are assigned a larger weight, while those in over-represented groups are assigned a smaller weight. In the computation of statistics such as means, totals and percentages, these weighted values ensure that the resulting estimates are representative of the population.

The weighted estimates sometimes need to be interpreted with care, especially for cases with very small sample counts. For a population the size of Tasmania, there is a strong chance that some variables will have small counts due to the nature of the population, which leads to difficulties in obtaining a large enough sample to perfectly capture the variability in the incidence of disability and other characteristics across Tasmania. Therefore, weighted estimates with zero proportions need to be interpreted with care.

The Tables of SDAC estimates required for this analysis have been designed similarly to tables in the ABS publication of findings for Tasmania (ABS 2013e). This means that the results can be compared to results in the ABS tables. The tables are listed below with a brief description. Note that because SDAC is a survey with complex sample selection and nonresponse patterns, relative standard errors are reported for most statistics.

APPENDIX II: HACC CLIENT SURVEY METHODS

SAMPLE FRAME

The sampling frame for the Client Survey needed comprehensive coverage of the population of HACC clients with accurate and detailed information for identifying a client by characteristics that allow for stratification. The sample frame needed to closely represent the population to be studied, in this case recent clients of the Tasmanian HACC program. The most appropriate sample frame was the list of all clients recorded in the HACC MDS as receiving at least one service type during the financial year 1st July 2013 to 30th June 2014. Obtaining informed consent from persons aged less than 18 to participate in the survey was beyond the scope of this study and clients 0-17 years of age were considered out of scope. A total of 5,191 HACC clients aged less than 65 (less than 50 for Indigenous clients) were in scope. This group comprised 5,080 non-indigenous clients aged less than 65 and 111 indigenous clients aged less than 50. Thirteen clients had invalid SLKs due to the non-provision of name structure, age, sex or a combination of these. The final sample frame consisted of 5,178 clients. To ensure that each client only received one invite to participate in the survey from a Service Provider (clients may use multiple Service Providers), SLKs were assigned to the Service Providers used most by the client. This resulted in 61 of the 68 Service Providers being assigned SLKs for the purpose of matching personal details and for distributing the invitation letters to these clients.

SAMPLING APPROACH

The appropriate choice of sample size underpins the valid inferences that can be drawn from a sample to the population and minimises bias in statistical estimates. To estimate a quantity, such as a mean or proportion for the entire HACC population, a sample size that is sufficient to produce a sample estimate that is within an acceptable range of the true value of the quantity in the total population (for a specified level of confidence) is needed. An acceptable range from the true population value is often considered to be 5 per cent and this should be achievable with a 95 per cent level of confidence or greater. For this Client Group Analysis, this degree of accuracy requires a minimum sample size of 384 survey respondents. To obtain this from a population size of 5,178 requires a minimum response rate of 7 per cent. Other factors such as deaths and the occurrence of duplicate clients with alternate SLKs in the sampling frame also need to be considered as this potentially reduces access to the client population further.

To maximise the chances of achieving the desired sample size, all clients recorded in the HACC MDS for the period 1 July 2013 to 30 June 2014 inclusive (n=5,178) were sent an invitation to participate in the study via their Service Provider in mid-December 2014. The research team collated the invitation to participate packs and sent these to the Service Providers to add personal contact details and post to their clients. Prior to sending the invitations, service Providers were asked to remove clients who were deceased. Each invitation pack contained an invitation letter, an information sheet, a consent form, and a reply-paid envelope. Through the consent form, the client gave the research team their personal contact details and permission to contact them, a preferred mode of contact (email, telephone, or face-to-face), and permission to link their survey data to administrative data collected by DHHS. Each invitation pack was assigned a unique SLK to the consent form and also printed on the envelope for easy reference for Service Providers.

Due to a slow response rate, a second round of recruitment was undertaken in mid-January 2015. This involved contacting the Service Providers with comparatively lower response rates to request them to send a reminder to their clients to consider taking part in the study. As part of this process, the consent forms were revised to include date of birth and gender to enable the research team to generate an SLK and link the participant to the sample frame. This resulted in some consent forms being returned (n=18) from people who were outside the desired age range. Additionally, two clients who were not in the original 5,178 extraction completed the survey, as they turned 65 during the 2013-2014 time period. However, because

they did receive services while still under 65 during 2013-2014, they were retained in the survey data set. Therefore, the sampling frame increased to 5,180.

A total of 514 consent forms, 8 return to senders, and 9 refusals were received. Of the 514 consent forms, 18 were out of scope (as discussed above), 5 were duplicates (same client but different SLKs) and 4 were deceased, which left 487 in scope for the study. Reviewing the consent forms within scope, the research team identified 188 that had partially complete information (e.g. missing information, conflicting information etc.) and participants were contacted via email or phone to obtain the data needed. A total of 478 consent forms were complete and uploaded to the sample, of these 5 dropped out during the study period, and 84 were not contactable or unable to participate due to personal circumstances (e.g. one client was admitted to hospital the night prior to the face-to-face interview). The final survey sample available for analysis consisted of 389 Tasmanian HACC clients.

The response rate is based on the number of completed surveys divided by the size of the in-scope sample frame. The size of the sample frame, prior to this calculation, should be adjusted for out of scope participants, which include participants who have moved with no known forwarding address, those that are deceased, and duplicates. Based on the proportion of out of scope clients identified (which may be conservative), it is estimated that at least one per cent (52 SLKs) of the sampling frame has duplicate SLKs for the same client. However, feedback from four Service Providers identified 27 clients who were out of scope from the 301 SLKs they received (9.0 per cent), either because their address was unknown, they were deceased or SLKs were duplicated for the same client. Although this information was requested from all Service Providers, many felt this was asking too much over and above the invitation distribution. However, based on these figures, we can estimate that 9 per cent of the sampling frame was out of scope. Based on these estimates, the sampling frame would be reduced to 4,714, which would yield a survey response rate of 8.2 per cent. If we use the 5,180 sampling frame without adjusting for out of scope clients, the survey response rate was 7.5 per cent.

During the recruitment process, the sample was monitored according to key strata to ensure the sample was representative. The strata variables were attained from the HACC MDS, and comprise: age, gender, Indigenous status, region, service type, length as a client and use of disability services. Comparisons to the 5,180 client sample frame revealed that the survey sample is representative of the HACC client population for 2013-2014. Further comparisons using these strata, have shown that there are no obvious differences between those who returned their consent form and participated in the survey and those who returned their consent form but were not included in the survey analysis.

Participants who took part in the survey were eligible to go into the draw to win one of five \$100 Coles gift cards. Winners were randomly drawn from the survey sample of 389 people on the 18 March 2015 and all winners were notified by phone call on this day. The gift cards were then sent by registered post and the names and locations of the successful participants, who gave permission to do so, were posted on the project website.

SAMPLE REPRESENTATIVENESS

The representativeness of the client survey sample was analysed by comparing the characteristics of the sample with the characteristics of the sampling frame from which the sample was drawn, i.e. the 5,178 HACC clients aged 18-64 (18-49 for clients with Indigenous status) who were recorded as clients in the HACC Minimum Data Set (NMDS) for the period 1st July 2013 – 30th June 2014. Comparisons were made on variables drawn directly from the HACC MDS and with variables derived from the HACC MDS. The variables used for the comparison and the results of the comparison are set out in the tables below. In summary: Tables summarised below were:

- *Age group.* Younger age groups (15-49) are slightly under-represented in the sample and the 60-64 age group is somewhat over-represented.
- *Sex.* Women are slightly over-represented in the sample and men are slightly under-represented.

- *Indigenous status.* The sample is broadly representative of the population in terms of Indigenous status.
- *Living arrangements.* The sample is broadly representative of the population in terms of living arrangements.
- *Accommodation setting.* The sample is broadly representative of the population in terms of accommodation setting.
- *Presence of Carer.* The sample is representative of the population in terms of presence of carer.
- *Language.* The sample is broadly representative of the population in terms of language.
- *Pension received.* The sample is broadly representative of the population in terms of pension received.
- *Region.* The North region is slightly over-represented and the North West and South regions are slightly under-represented in the sample.
- *Remoteness.* Inner regional areas are slightly over-represented in the sample and outer regional areas are slightly under-represented.
- *First service used.* The sample is broadly representative of the population in terms of first service used. Domestic ass slightly over-represented and home nursing is slightly under-represented in the sample.
- *Length of time as a HACC client.* The sample is broadly representative of the population in terms of length of time as a HACC client. Short-term not continuing is somewhat under-represented in the sample.
- *Use of Disability Services:* The sample appears to be broadly representative of the population in terms of use of disability services (some data unavailable due to data linking permission not being given).

Table 167 HACC client survey sample compared to HACC population based on age group

Age Group	Sample		Population	
	No.	%	No.	%
15-19	4	1.0	78	1.5
20-24	4	1.0	177	3.4
25-29	11	2.8	181	3.5
30-34	4	1.0	208	4.0
35-39	16	4.1	289	5.6
40-44	23	5.9	446	8.6
45-49	27	6.9	511	9.9
50-54	64	16.5	704	13.6
55-59	79	20.3	1,059	20.5
60-64	155	39.8	1,525	29.4
65-69	2	0.5	2	0.0
<i>Total</i>	388	100.0	5,180	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 168 HACC client survey sample compared to HACC population based on sex

Sex	Sample		Population	
	No.	%	No.	%
Male	134	34.4	2,080	40.2
Female	255	65.6	3,100	59.8
Total	389	100.0	5,180	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 169 HACC client survey sample compared to HACC population based on Indigenous status

Indigenous Status	Sample		Population	
	No.	%	No.	%
Aboriginal but not Torres Strait Islander	4	1.0	98	1.9
Torres Strait Islander but not Aboriginal	0	0.0	6	0.1
Both Aboriginal and Torres Strait Islander	3	0.8	13	0.3
Neither Aboriginal or Torres Strait Islander	364	93.6	4,673	90.2
Not stated	18	4.6	390	7.5
Total	389	100.0	5,180	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 170 HACC client survey sample compared to HACC population based on living arrangements

Living Arrangements	Sample		Population	
	No.	%	No.	%
Lives alone	149	38.3	1,743	33.6
Lives with family	202	51.9	2,671	51.6
Lives with others	21	5.4	461	8.9
Missing	17	4.4	305	5.9
Total	389	100.0	5,180	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 171 HACC client survey sample compared to HACC population based on accommodation setting

Accommodation setting	Sample		Population	
	No.	%	No.	%
<i>Owned/purchasing</i>	219	56.3	2,521	48.7
<i>Private rental</i>	62	15.9	754	14.6
<i>Public rental</i>	71	18.3	929	17.9
<i>Retirement village - Independent Living</i>	2	0.5	19	0.4
<i>Boarding house/private hotel</i>	2	0.5	15	0.3
<i>Crisis or emergency or transitional accommodation</i>	0	0.0	11	0.2
<i>Supported accommodation .or supported living facility</i>	8	2.0	200	3.9
<i>Institutional setting</i>	0	0	11	0.2
<i>Public place/temporary shelter</i>	0	0	12	0.2
<i>Private rental in Aboriginal community</i>	0	0	7	0.1
<i>Other</i>	1	0.3	88	1.7
<i>Not stated/inadequately described</i>	24	6.2	609	11.8
<i>Total</i>	389	100.0	5,180	100

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 172 HACC client survey sample compared to HACC population based on presence of carer

Carer present	Sample		Population	
	No.	%	No.	%
<i>Yes</i>	109	28.0	1,353	26.1
<i>No</i>	264	67.9	3,604	69.6
<i>Not stated/inadequately described</i>	16	4.1	223	4.3
<i>Total</i>	388	100.0	5,180	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 173 HACC client survey sample compared to HACC population based on language

Language	Sample		Population	
	No.	%	No.	%
<i>English</i>	379	97.4	5,012	96.8
<i>Other</i>	2	0.5	38	0.7
<i>Missing</i>	8	2.1	130	2.5
<i>Total</i>	389	100.0	5,180	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 174 HACC client survey sample compared to HACC population based on pension received

Pension received	Sample		Population	
	No.	%	No.	%
<i>Aged pension</i>	21	5.4	213	4.1
<i>DVA pension</i>	3	0.8	17	0.3
<i>Disability support pension</i>	205	52.7	2,821	54.5
<i>Carer payment</i>	13	3.4	147	2.8
<i>Unemployment related benefits</i>	3	0.8	62	1.2
<i>Other Government pension/benefit</i>	20	5.1	182	3.5
<i>No government pension/benefit</i>	20	5.1	330	6.4
<i>Missing</i>	104	26.7	1,408	27.2
<i>Total</i>	389	100.0	5,180	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 175 HACC client survey sample compared to HACC population based on Region

Region	Sample		Population	
	No.	%	No.	%
<i>Interstate</i>	0	0.0	7	0.1
<i>North</i>	133	34.2	1,362	26.3
<i>North West</i>	102	26.2	1,518	29.3
<i>South</i>	152	39.1	2,288	44.2
<i>Missing</i>	2	0.5	5	0.1
<i>Total</i>	389	100.0	5,180	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 176 HACC client survey sample compared to HACC population based on remoteness

Remoteness	Sample		Population	
	No.	%	No.	%
<i>Inner Regional Australia</i>	260	66.8	3,194	61.7
<i>Outer Regional Australia</i>	117	30.1	1,834	35.4
<i>Remote Australia</i>	8	2.1	121	2.3
<i>Very Remote Australia</i>	2	0.5	18	0.4
<i>Interstate</i>	0	0.0	7	0.1
<i>Missing</i>	2	0.5	6	0.1
<i>Total</i>	389	100.0	5,180	100

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 177 HACC client survey sample compared to HACC population based on first service used

Service1	Sample		Population	
	No.	%	No.	%
<i>Assessing your need for services</i>	11	2.8	132	2.5
<i>Care by a health worker like a Physiotherapist</i>	26	6.7	465	9.0
<i>Group activities in a day centre</i>	5	1.3	125	2.4
<i>Help coordinating your services</i>	67	17.2	696	13.4
<i>Help managing your care</i>	8	2.0	157	3.0
<i>Help with everyday self-care tasks such as dressing</i>	25	6.4	227	4.4
<i>Help with everyday tasks provided by a companion</i>	22	5.7	208	4.0
<i>Help with housework</i>	111	28.5	899	17.3
<i>Help with maintaining and repairing your house</i>	15	3.9	174	3.4
<i>Home nursing</i>	23	5.9	699	13.5
<i>Information, counselling and/or advice</i>	14	3.6	255	4.9
<i>Linen laundry services</i>	0	0	2	0.0
<i>Meals</i>	14	3.6	242	4.7
<i>Modifications made to your house such as grab rails and ramps</i>	0	0	8	0.2
<i>Respite care</i>	3	0.8	76	1.5
<i>Transport to community activities or medical appointments</i>	45	11.6	811	15.7
<i>Missing</i>	0	0	4	0.1
<i>Total</i>	389	100.0	5,180	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 178 HACC client survey sample compared to HACC population based on length of time as a HACC client (long/short)

Long/Short	Sample		Population	
	No.	%	No.	%
<i>Short not continuing</i>	21	5.4	532	10.3
<i>Short continuing</i>	49	12.6	705	13.6
<i>Long</i>	247	63.5	3,106	60.0
<i>Missing</i>	72	18.5	837	16.1
<i>Total</i>	389	100.0	5,180	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

Table 179 HACC client survey sample compared to HACC population based on use of Disability Services

Use of Disability Services	Sample		Population	
	No.	%	No.	%
Yes	44	11.3	778	15.0
No	269	69.2	4,326	83.5
No permission to link data	76	19.5	76	1.5
Total	389	100.0	5,180	100.0

Source: Extraction of data from HACC MDS for Tasmania for July 2013-June 2014 inclusive

INSTRUMENT DEVELOPMENT AND ADMINISTRATION

Seven core areas relating to the use of HACC services were identified as needing further investigation and these areas provide the conceptual framework for the client survey. In developing the survey instrument, a rigorous approach was taken to ensure relevance to the central objectives of the survey and high quality in terms of validity and reliability of the questions. As part of the instrument development process, existing surveys were reviewed to identify items that measure the core areas of interest to DHHS Tasmanian HACC program. The literature on the measurement of disability and health was used to refine the questionnaire. To ensure validity and comparability of the survey data to existing data on disability and health, survey items from previous studies were used where possible. A draft of the survey instrument was submitted to an expert review process which included the project reference group in DHHS and regional representatives.

Because of the complex needs of a proportion of the HACC clients, three different modes for completing the survey (online, telephone or face-to-face) were offered. Of the 389 who completed the survey, 38.0 per cent completed online, 42.2 per cent completed via telephone and 19.8 per cent completed via face-to-face interview.

Two weeks prior to the start of fieldwork, a pilot was conducted on 48 clients from the sample, using the telephone mode to test the items and the survey length. Based on the pilot, the survey questions were reduced and some of the responses within a question were collapsed.

QUALITY ASSURANCE

All investigators, associates, and fieldwork teams involved in the project were bound by confidentiality agreements. All interviewers were well trained and had experience in working with diverse population groups that includes people with special needs.

For the face-to-face and telephone interviews, all interviewers were briefed and debriefed on the project. Quality control checks were conducted throughout the duration of the fieldwork. A minimum of 10 per cent of phone contacts by each interviewer were randomly audited by a supervisor to ensure that call procedures were followed and telephone interviews were conducted professionally. Similarly, 10 per cent of face-to-face interviews were monitored by a senior researcher.

All three modes of data collection included computer program checks and prompts that were executed while the data were being collected. For example, if a participant did not answer a question and tried to skip to the next question, cues were included to prompt them to provide an answer. Logic checks were also incorporated to ask for verification where answers appear to be incorrect.

Following closure of the survey on the 16 March 2015, the data was extracted from the data collection software and de-identified. An additional dataset was created that included variables from the HACC MDS using a linkage procedure via the SLK variable, for the participants who had consented to their data being

linked (n=311). Questions asked in the pilot but not in the revised version of the survey were dropped from the data set.

DATA ANALYSIS

The analysis of the survey data used a range of exploratory statistical techniques to describe the clients. These provide basic descriptive statistics and tabular displays for the various questionnaire items, and give appropriate summary statistics for the responses, including frequencies, means, medians, modes, ranges and other indicators of central tendency and dispersion. This exploratory analysis serves as a basis to investigate characteristics of subsets of the population, in particular the age, sex, and regional and functional limitation profile. Where the sample size permits and there is sufficient variability within a question, cross-tabulations of these characteristics was conducted. An analysis of the survey data linked with the secondary sources (HACC MDS, Disability service data, and Health Central data) was conducted using the 311 clients who have given permission to do so. Findings from these analyses and aligned with the seven core areas are discussed in the body of the report.

APPENDIX III: SURVEY QUESTIONNAIRE

The format of the survey was slightly different for each of the modes of delivery: on-line, telephone interview and face-to-face interview.

Introduction

Thank you for agreeing to participate in this survey that the University of Queensland is conducting on behalf of the Tasmanian Department of Health and Human Services or DHHS Home and Community Care Program.

You recently agreed to take part in the survey by sending us the consent form {on [INSERT NAME]'s behalf}.

Your responses to these questions will help us to better understand your need for services to help and support you. OR

We would like to ask you some questions that will help us to better understand INSERT NAME]'s need for services to help and support him/her.

Your participation will help the Tasmanian DHHS to work out what services need to be provided In the future. Your participation is voluntary and you may withdraw at any time.

The survey will take 20 to 30 minutes to complete and all your answers will be anonymous. You will not be individually identifiable in any way.

If you experience any technical difficulties with the survey, please phone Jenny Povey on (07) 33467474 OR email Jenny on THCS@uq.edu.au.

Please press 'Start' to commence the survey.

MONITOR

For quality assurance purposes, we would like to collect some basic information about how you access the survey, such as the internet browser (e.g. Internet Explorer, Mozilla Firefox) and operating system (e.g. Windows, OS X) you are using and whether you are completing the survey using a tablet, mobile phone or on a computer. This helps us to deliver high quality online surveys. We may only collect this information with your permission, please can you indicate below if you give The University of Queensland permission to collect this information for quality assurance purposes.

	Yes	No
Do you give The University of Queensland permission to collect information on the internet browser, operating system and device that you use to access the survey for quality assurance purposes only?	<input type="checkbox"/> 1	<input type="checkbox"/> 2

Q1A Are you aged 18 or over?

[IF SAMPLE=2 (PERSON RESPONSIBLE) PIPE: "Please *answer this according to your own age and not [CLIENT NAME]*"]

[SINGLE]

- (i) Yes GO TO Q1
- (ii) No GO TO INT98
- (iii) Don't know GO TO INT98

Q1 Which ONE of the following, if any, best describes [you /IF PERSON RESPONSIBLE: INSERT NAME]?

[SINGLE]

- (i) A carer of a person with a disability or health condition
- (ii) A person with a disability or health condition
- (iii) Both
- (iv) None of these
- (v) Don't know

If Q1 = (i) or (iii) INSERT TEXT: Please answer the questions thinking about yourself and your own perspective and needs, not the person you are, or have been, caring for.

Q2 We would like to know if you will be answering these questions on your own or if someone will be helping you. We encourage you to seek help if you need it. Will you be ...?

[SINGLE]

- (i) Answering the questions on your own GO TO Q5
- (ii) Answering the questions yourself with someone helping
- (iii) Don't know

Section 1: Health conditions, disabilities and functional dependencies

[IF SAMPLE=2 (Person Responsible) PIPE: **"Please answer the questions thinking about [CLIENT NAME] and not yourself."**

There are no Qs 3 or 4

Q5 Since July 2013, which, if any, of the following health conditions or disabilities that has lasted, or is likely to last, for six months or more do you have or have you had? Please select all that apply.

Do you have ...?

[MULTI]

- (i) An acquired brain injury or ABI
- (ii) Autism
- (iii) Cancer
- (iv) Diabetes
- (v) Digestive disorders
- (vi) Down's syndrome
- (vii) Heart disease including heart failure
- (viii) An intellectual disability
- (ix) Joint, bone, muscle diseases
- (x) Mental health problem, for example, anxiety or depression
- (xi) A neurological condition or conditions, for example, Parkinson's, Multiple Sclerosis, Motor Neurone Disease ,epilepsy or dementia
- (xii) A physical disability
- (xiii) A respiratory disease or difficulty breathing
- (xiv) A sensory disability, for example, hearing or vision
- (xv) Effects from a stroke
- (xvi) Was there anything else? (please specify):
- (xvii) I do not have a health condition or disability *GO TO Q10*
- (xviii) Don't know *GO TO Q10*

IF Q5>1, ASK Q6

Q6 Which **one** of these health conditions or disabilities causes you the most problems in your everyday life? If difficult to choose, choose the health condition or disability that you have had the longest.

If you are finding it difficult to choose one, then think about which one causes you the 'most problems'. If you are still finding it difficult, then choose the first answer in alphabetical order.

[SINGLE] [INSERT SELECTED ITEMS FROM Q5 LIST]

- (i) An acquired brain injury or ABI
- (ii) Autism
- (iii) Cancer
- (iv) Diabetes
- (v) Digestive disorders
- (vi) Down's syndrome
- (vii) Heart disease including heart failure
- (viii) An intellectual disability
- (ix) Joint, bone, muscle diseases
- (x) Mental health problem
- (xi) A neurological condition or conditions, for example Parkinson's, Multiple Sclerosis, Motor Neurone Disease or epilepsy
- (xii) A physical disability
- (xiii) A respiratory disease or difficulty breathing
- (xiv) A Sensory disability for example hearing or vision
- (xv) Effects from a stroke
- (xvi) <Q5: o> (Q5 open end)

Q7 How long have you had [ANSWER FROM Q5/6]? Would you say ...?

[SINGLE]

- (i) Since birth
- (ii) For 10 years or longer
- (iii) For between 1 and 9 years
- (iv) For less than 1 year
- (v) Don't know

Q8 Over the next two years, do you expect the [ANSWER FROM Q5/6] to ...?

[SINGLE. READ OUT]

- (i) Get better
- (ii) Stay the same
- (iii) Get worse
- (iv) Don't know

There is no Q 9

ASK ALL:

We will now ask some questions about different types of disability. Please select all the disabilities that you have. For each disability we will ask you about the impact it has on your everyday activities.

Q10 Do you have any of the following? Please select all that apply.

[MULTI] [RANDOMISE]

- (i) Loss of sight. *If you can see normally using contact lenses or glasses, then don't select this option*
- (ii) Loss of hearing. *If you can hear normally using hearing aids, don't select this option*
- (iii) Speech problems
- (iv) Limited use of arms, fingers, feet or legs
- (v) None of these [EXCLUSIVE] [FIXED] GO TO Q11

Q10_1 Which of the following statements best describes the impact of **loss of sight** on your everyday activities? Would you say it ...?

[SINGLE RESPONSE] [SKIP IF NOT Q10=1]

- (i) Severely restricts
- (ii) Somewhat restricts
- (iii) Does not restrict
- (iv) Not applicable

Q10_2 Which of the following statements best describes the impact of **loss of hearing** on your everyday activities? Would you say it ...?

[SINGLE RESPONSE] [SKIP IF NOT Q10=2]

- (i) Severely restricts
- (ii) Somewhat restricts
- (iii) Does not restrict
- (iv) Not applicable

Q10_3 Which of the following statements best describes the impact of **speech problems** on your everyday activities? Would you say it ...?

[SINGLE RESPONSE] [SKIP IF NOT Q10=3]

- (i) Severely restricts
- (ii) Somewhat restricts
- (iii) Does not restrict
- (iv) Not applicable

Q10_4 Which of the following statements best describes the impact of **limited use of arms, fingers, feet or legs** on your everyday activities? Would you say it ...?

[SINGLE RESPONSE] [SKIP IF NOT Q10=4]

- (i) Severely restricts
- (ii) Somewhat restricts
- (iii) Does not restrict
- (iv) Not applicable

Q11 Do you have any of the following? Please select all that apply.

[MULTI] [RANDOMISE]

- (i) Breathing difficulty or shortness of breath
- (ii) Chronic or recurrent pain or discomfort
- (iii) Blackouts, seizures or loss of consciousness
- (iv) A mental health problem
- (v) Difficulty learning or understanding things
- (vi) None of these [EXCLUSIVE] [FIXED]→ Q12A_1

Q11_1 Which of the following statements best describes the impact **breathing difficulty or shortness of breath** has on your everyday activities? Would you say it ...?

[SINGLE RESPONSE] [SKIP IF NOT Q11=1]

- (i) Severely restricts
- (ii) Somewhat restricts
- (iii) Does not restrict
- (iv) Not applicable

Q11_2 Which of the following statements best describes the impact **chronic or recurrent pain or discomfort** has on your everyday activities? Would you say it ...?

[SINGLE RESPONSE] [SKIP IF NOT Q11=2]

- (i) Severely restricts
- (ii) Somewhat restricts
- (iii) Does not restrict
- (iv) Not applicable

Q11_3 Which of the following statements best describes the impact **blackouts, seizures or loss of consciousness** has on your everyday activities? Would you say it ...?

[SINGLE RESPONSE] [SKIP IF NOT Q11=3]

- (i) Severely restricts
- (ii) Somewhat restricts
- (iii) Does not restrict
- (iv) Not applicable

Q11_4 Which of the following statements best describes the impact **a mental health problem** has on your everyday activities? Would you say it ...?

[SINGLE RESPONSE] [SKIP IF NOT Q11=4]

- (i) Severely restricts
- (ii) Somewhat restricts
- (iii) Does not restrict
- (iv) Not applicable

Q11_5 Which of the following statements best describes the impact **difficulty learning or understanding things** has on your everyday activities? Would you say it ...?

[SINGLE RESPONSE] [SKIP IF NOT Q11=5]

- (i) Severely restricts
- (ii) Somewhat restricts
- (iii) Does not restrict
- (iv) Not applicable

The next questions are about the amount of help you may, or may not, need from another person or people to do some everyday activities because of your disability or health condition.

Q12A Which of the following best describes how much help you need, if any, to do the following everyday activities because of your disability or health condition? Help here means any type of help from another person or people. If you need help with more than one of the items listed in a single question, think about the one you need the most help with. Please indicate how much help you need for each of the following using the scale 'A lot of help', 'A little help', 'No help needed', 'Don't know', or 'Not applicable':

[SINGLE] *RANDOMISE*

- (i) Getting in or out of bed or moving around the home
- (ii) Moving around outside the home
- (iii) Bathing or showering or dressing
- (iv) Eating
- (v) Cooking, cleaning, doing the shopping, or doing jobs around the home or yard
- (vi) Remembering or taking your medications

Q12B Which of the following best describes how much help you need, if any, to do the following everyday activities because of your disability or health condition? Help here again means any type of help. If you need help with more than one of the items listed in a single question, think about the one you need the most help with.

Please indicate how much help you need for each of the following using the scale 'A lot of help', 'A little help', 'No help needed', 'Don't know', or 'Not applicable':

[SINGLE] *RANDOMISE*

- (i) Understanding and being understood by other people
- (ii) Understanding, remembering and learning new things
- (iii) Coping with feelings and emotions
- (iv) Joining in community activities or hobbies such as church, sporting clubs or cultural associations
- (v) Getting or keeping a paid or voluntary job

There are no Qs 13-22

Q23 Do you use any aids or equipment to help you with everyday activities and tasks? These include walking frames, wheelchairs, scooters, lifting machines, audio-tapes, special computers, or grab rails, but there are also many others.

[SINGLE]

- (i) Yes
- (ii) No
- (iii) Don't know

There is no Q 24

Section 2: Short-term health circumstances

We would now like to ask some more questions about your health and your use of health services since July 2013.

Q25 Between July 2013 and today, have you had any of the following?

[MULTI] Please select all that apply.

- (i) An illness *GO TO Q26*
- (ii) An injury *GO TO Q26*
- (iii) Surgery *GO TO Q26*
- (iv) Don't know [EXCLUSIVE] *GO TO Q30*
- (v) Not applicable [EXCLUSIVE] *GO TO Q30*

Q26_SELECT

- (i) Illness
- (ii) Illness and injury
- (iii) Illness and surgery
- (iv) Illness, injury and surgery
- (v) Injury
- (vi) Surgery

Q26 What kind of <Q26_SELECT> was it? If you had more than one, please tell me the one you consider the most serious or required the most help since July 2013. For example, you were diagnosed with pneumonia or you broke a bone.

[OPEN]

Q27 Did you get any help at home, or a change in help provided at home, **as a result of this** <Q26_ANSWER> [SINGLE]?

- (i) Yes GO TO Q28x
- (ii) No GO TO Q30
- (iii) Don't know GO TO Q30

Q28x Who provides or provided this additional help? Please select all that apply.

[MULTI].

- (i) Someone who usually lives with you or other family members or friends GO TO Q30

- (ii) An organisation that provides help to people in their homes or nurses or other health workers GO TO Q29_4x
- (iii) Was there anyone else? (Please specify):
..... GO TO Q30
- (iv) None of these [EXCLUSIVE] GO TO Q30
- (v) Don't know [EXCLUSIVE] GO TO Q30

Q29X_4 **As a result of this <Q26_ANSWER>**, which of the following types of help is or was provided by **an organisation that provides help to people in their homes or nurses or other health workers?** Please select all that apply.

[MULTI] [SKIP IF NOT Q28x=2]

- (i) Help with housework
- (ii) Nursing care in the home
- (iii) Help with personal care, such as dressing, bathing, eating, or using the bathroom
- (iv) Provision of meals
- (v) Help with shopping
- (vi) Transport to medical appointments
- (vii) Transport elsewhere
- (viii) Was there any other type of help? (Please specify): [OPEN END]
- (ix) None of these [EXCLUSIVE]
- (x) Don't know [EXCLUSIVE]

Q30 Between July 2013 and today, how many times have you stayed at hospital for at least one night? Please give your best guess if unsure. Would you say ...?

Please answer this according to a stay at hospital due to [SAMPLE=1 "your own", SAMPLE=2 "<CLIENTNAME>'s"] illness, etc., and not someone else's.

[SINGLE]

- (i) None GO TO Q38
- (ii) Once GO TO Q31
- (iii) Twice GO TO Q31
- (iv) 3 times GO TO Q31
- (v) 4 times or more GO TO Q31
- (vi) Don't know GO TO Q38

Q31 What were the reasons you stayed in hospital for at least one night since July 2013? Please include all the reasons if you had more than one stay.

[OPEN]

Q32 Did you get any help at home or a change in the help provided at home, **whilst waiting for any of your appointments to go into hospital?**

[SINGLE. READ OUT]

- (i) Yes GO TO Q33x
- (ii) No GO TO Q35
- (iii) Don't know GO TO Q35
- (iv) Not applicable as you did not have to wait for your hospital appointment GO TO Q35

Q33x Who provides or provided this additional help? Please select all that apply.

[MULTI]

- (i) Someone who usually lives with you or other family members or friends GO TO Q35
- (ii) An organisation that provides help to people in their homes or nurses or other health workers GO TO Q34_4x
- (iii) Was there anyone else? (Please specify): [OPEN END] GO TO Q35
.....
- (iv) None of these [EXCLUSIVE] GO TO Q35
- (v) Don't know [EXCLUSIVE] GO TO Q35

Q34x_4 Which of the following types of help was provided by **an organisation that provides help to people in their homes or nurses or other health workers** while waiting to go into hospital? Please select all that apply.

[MULTI] [SKIP IF NOT Q33x=2]

- (i) Help with housework
- (ii) Nursing care in the home
- (iii) Help with personal care, such as dressing, bathing, eating, or using the bathroom
- (iv) Provision of meals
- (v) Help with shopping
- (vi) Transport to medical appointments
- (vii) Transport elsewhere
- (viii) Was there any other type of help? (Please specify): [OPEN END]
- (ix) None of these [EXCLUSIVE]
- (x) Don't know [EXCLUSIVE]

Q35 During any of the times you were **recovering at home after being in hospital**, did you get any help at home, or a change in the help provided at home?

[SINGLE]

- (i) Yes GO TO Q36x
- (ii) No GO TO Q38
- (iii) Don't know GO TO Q38
- (iv) Not applicable as you did not have a recovery period at home after spending the night in hospital GO TO Q38

IF Q35 = (i) ASK Q36x

Q36x Who provides or provided this additional help? Please select all that apply.

[MULTI. READ OUT]

- (i) Someone who usually lives with you or other family members or friends GO TO Q38
- (ii) An organisation that provides help to people in their homes or nurses or other health workers GO TO Q37x_4
- (iii) Was there anyone else? (Please specify): [OPEN END] GO TO Q38
.....
- (iv) None of these [EXCLUSIVE] GO TO Q38
- (v) Don't know [EXCLUSIVE] GO TO Q38

Q37x_4 Still thinking about **recovering at home after being in hospital**, which of the following types of help was provided by **an organisation that provides help to people in their homes or nurses or other health workers**? Please select all that apply.

[MULTI] [SKIP IF NOT Q36x=2]

- (i) Help with housework
- (ii) Nursing care in the home
- (iii) Help with personal care, such as dressing, bathing, eating, or using the bathroom
- (iv) Provision of meals
- (v) Help with shopping
- (vi) Transport to medical appointments
- (vii) Transport elsewhere
- (viii) Was there any other type of help? (Please specify): [OPEN END]
- (ix) None of these [EXCLUSIVE]
- (x) Don't know [EXCLUSIVE]

Section 3: Pattern of use of HACC services

We would now like to ask you about some of the services that you have been receiving from funded organisations since July 2013, such as:

- (i) <SERVICE1>
- (ii) <SERVICE2>
- (iii) <SERVICE3>

Q38 Which of the following triggered your need for [TEXT SUBSTITUTION: Q38_SELECT: "this service" / "these services"]? Please select all that apply.

[MULTI]

- (i) An illness
- (ii) An injury
- (iii) Surgery
- (iv) A long-term health condition/disability
- (v) A short-term health condition/disability
- (vi) A mental health problem
- (vii) Is there any other reason not mentioned? (Please specify): [OPEN END]
- (viii) Don't know

Q38B Thinking about when you first needed [TEXT SUBSTITUTION: this service / these services], did any of the following people tell you about, or help you to get in touch with, [TEXT SUBSTITUTION: this service / these services]? Please select all that apply.

[MULTI RESPONSE]

- (i) Your doctor
- (ii) A nurse or other person working in a hospital
- (iii) A community nurse
- (iv) Someone from a community service organisation
- (v) A family member
- (vi) A friend or neighbour
- (vii) Someone else (please specify): [OPEN END]
- (viii) No one else (found out about it myself) [EXCLUSIVE]
- (ix) Someone from the community organised it on my behalf
- (x) Don't know. [EXCLUSIVE]

Q39 Are you still receiving [TEXT SUBSTITUTION: <Q39_SELECT>:"a home and community care service" or "home and community care services" like those mentioned just before?

[SINGLE RESPONSE]

- (i) Yes GO TO Q40x
- (ii) No GO TO Q41
- (iii) Don't know GO TO Q41

IF Q39 = (i) ASK Q40x

Q40x Which of the following best describes the reason or reasons you are still receiving the <Q40_SELECT>: "service"/"services"?

[SINGLE RESPONSE]

- (i) I still have the health condition or disability that triggered my use of the services
- (ii) I have a new health condition or disability that I need services for
- (iii) My services have continued even though I have recovered from my health condition or disability
- (iv) Don't know

We would like you to now think about a specific service you received between July 2013 and now. We understand you received [SERVICE 1] (*name service type using the informal term agreed on*) during 2013 or 2014. This may have been once, a few times or over a longer period.

Q41 Are you still receiving [SERVICE 1] now? You may have only received this service once or twice

[SINGLE]

- (i) Yes
- (ii) No
- (iii) Never received this service even though I may have registered for it GO TO Q48
- (iv) Don't know GO TO Q46B

Q42 To what extent *does or did* [SERVICE 1] meet your needs?

[SINGLE]

- (i) Completely
- (ii) Mostly
- (iii) Somewhat
- (iv) Not really
- (v) Not at all
- (vi) Don't know

Q43 Do you expect to use [SERVICE 1] in the future?

[SINGLE]

- (i) Yes GO TO Q44
- (ii) No GO TO Q46A or B depending on whether answered Q41 =(i) or (ii) or (iii)
- (iii) Don't know GO TO Q46A or B depending on whether answered Q41 =(i) or (ii) or (iii)

Q44 How often do you expect to use [SERVICE 1]? Is it...

[SINGLE]

- (i) As needed, for example, when you are ill
- (ii) On a regular basis, for example, every week
- (iii) Don't know

If Q41= (ii) then skip Q45

Q45 Which of the following best describes how much longer you expect to use [SERVICE 1]?

[SINGLE]

- (ii) For six months or less
- (iii) For more than six months and up to two years
- (iii) For over two years, but not for the rest of your life
- (iv) For the rest of your life
- (v) Don't know

IF Q41 = (i) YES, ASK Q46A

Q46A Thinking about the [SERVICE 1] you receive, do you need more, or less, or is the service about right for your needs?

[SINGLE]

- (i) Need more
- (ii) About right
- (iii) Need less
- (iv) Don't know
- (v) Not applicable

IF Q41 = (ii) NO or (iv) DON'T KNOW, ASK Q46B

Q46B Thinking about the [SERVICE 1] you received since July 2013. Did you need more, or less, or was the service about right for your needs?

[SINGLE]

- (i) Needed more
- (ii) About right
- (iii) Needed less
- (iv) Don't know
- (v) Not applicable

Q47 Thinking about the [SERVICE 1] you received since July 2013, what suggestions do you have as to how this service could help/could have helped and support/supported you better?

- (i) [OPEN]
- (ii) No suggestions

If Q41= (ii) then get the past tense wording

Respondents who only used one service type GO TO Q62.

IF > 1 VARIABLE IN SAMPLE FOR NAME OF SERVICE TYPE, ASK Q48

We understand you also received [*name service using the informal term agreed on*] during 2013 or 2014. This may have been once, a few times or over a longer period.

Q48 Are you still receiving [SERVICE 2] now? You may have only received this service once or twice.

- (i) Yes
- (ii) No
- (iii) Never received this service even though I may have registered for it GO TO Q62
- (iv) *Don't know GO TO Q53B*

Q49 To what extent *does or did* [SERVICE 2] meet your needs?

[SINGLE]

- (i) Completely
- (ii) Mostly
- (iii) Somewhat
- (iv) Not really
- (v) Not at all

Q50 Do you expect to use [SERVICE 2] in the future?

[SINGLE]

- (i) Yes GO TO Q51
- (ii) No GO TO Q53A or B depending on whether answered Q48 = (i) or (ii) or (iii)
- (iii) Don't know GO TO Q53A or B depending on whether answered Q48 = (i) or (ii) or (iii)

Q51 How often do you expect to use [SERVICE 2]? Is it ...?

[SINGLE]

- (i) As needed, for example, when you are ill
- (ii) On a regular basis, for example, every week
- (iii) Don't know

If Q48= (ii) then skip Q52

Q52 Which of the following best describes how much longer you expect to use [SERVICE 2]?

[SINGLE]

- (i) For six months or less
- (ii) For more than six months and up to two years
- (iii) For over two years, but not for the rest of your life
- (iv) For the rest of your life
- (v) Don't know

IF Q48 = (i) YES, ASK Q53A

Q53A Thinking about the [SERVICE 2] you receive, do you need more or less or is the service about right for your needs?

[SINGLE]

- (i) Need more
- (ii) About right
- (iii) Need less
- (iv) Don't know
- (v) Not applicable

IF Q48 = (ii) NO or (iv) DON'T KNOW, ASK Q53B

Q53B Thinking about the [SERVICE 2] you received since July 2013. Did you need more or less or was the service about right for your needs?

[SINGLE]

- (i) Needed more
- (ii) About right
- (iii) Needed less
- (iv) Don't know
- (v) Not applicable

Q54 Thinking about the [SERVICE 2] you received since July 2013, what suggestions do you have as to how this service could help/could have helped and support/supported you better?

- (i) [OPEN]
- (ii) No suggestions

If Q48 = (ii) then get the past tense wording

Respondents who only used two service types GO TO Q62

There are no Qs 55-61

Q62 In addition to the services already mentioned, what other services do you need to help and support you?

If you need additional support you may wish to contact TasCarepoint on 1300 769 699 or by fax 1300 721 611 or email mail@tascarepoint.net

If you need someone to talk to further about this, please contact Lifeline [13 11 14](tel:131114).

- (i) [OPEN]
- (ii) None
- (iii) Don't know

Section 4: Personal support

We would now like to ask you about family, friends or neighbours who help you with your day to day activities.

This does not include people who are from service organisations as volunteers or paid workers.

Q63 Do you have family, friends or neighbours who help you with any everyday activities and tasks, such as helping you with household chores (such as laundry & vacuuming); preparing meals; shopping; getting to appointments or social events; gardening; or reading and writing tasks (such as writing letters or filling in forms)?

[SINGLE RESPONSE]

- (i) Yes
- (ii) No GO TO Q68

Q65 During the last **four weeks**, have any of your family, friends or neighbours telephoned or visited you to see if you were ok?

[SINGLE]

- (i) Yes
- (ii) No
- (iii) Don't know

Section 5: Personal characteristics

We would now like to ask you some general questions about your life at the present time.

Q68x Which ONE of the following best describes your **current** involvement in paid work?

[SINGLE]

- (i) I am working and have a full-time paid job
- (ii) I am working and have a part-time or casual paid job
- (iii) I am currently unemployed
- (iv) I am retired
- (v) I am not in the paid work force for another reason
- (vi) Was there something else? (Please specify): [OPEN END]

-
- (vii) Don't know

Q69x What is the highest level of education you have **completed**?

[SINGLE]

- (i) University degree or higher
- (ii) TAFE trade certificate or diploma
- (iii) Year 12 or equivalent
- (iv) Year 11 or equivalent
- (v) Year 10 or equivalent
- (vi) Year 9 or below
- (vii) No formal education
- (viii) Don't know

Q71 What is the approximate total annual income of your household? Your household income is the combined income of you and your partner (if any) and other members of your family (if any) who live with you.

If you are living in shared accommodation and you all contribute to expenses and 'eat from the same pot' then you are considered a household for this purpose. As a guide, the full Single Rate of the Disability Support Pension is about \$22,000 per year and the full Couple Rate is about \$33,000 per year.

[SINGLE]

- (i) Over \$80,000 a year (more than \$1530 per week)
- (ii) Over \$40,000 and up to \$80,000 a year (over \$770 and less than \$1530 per week)
- (iii) Over \$25,000 and up to \$40,000 a year (over \$475 and less than \$770 per week)
- (iv) \$25,000 or less a year (\$475 or less per week)
- (v) Don't know
- (vi) Refused

Q72 Are you an Australian citizen or permanent resident?

[SINGLE]

- (i) Yes
- (ii) No
- (iii) Don't know

Q73 In general, would you say that your health is ...?

[SINGLE]

- (i) Excellent
- (ii) Very good
- (iii) Good
- (iv) Fair
- (v) Poor
- (vi) Don't know

Q74 How would you rate your quality of life? Would you say ...?

[SINGLE]

- (i) Very good
- (ii) Good
- (iii) Neither poor nor good
- (iv) Poor
- (v) Very poor
- (vi) Don't know

Section 6: Other service use

We would also like to ask you about your use of some other services that are available in the community.

Q76x Since July 2013, approximately how many times have you visited a GP for your own health? Please give your best guess if unsure. Would you say ...?

[SINGLE]

- (i) None
- (ii) 1-5 times
- (iii) 6-20 times
- (iv) More than 20 times
- (v) Don't know

Q77x Since July 2013, approximately how many times have you visited a hospital emergency department for your own health? Please give your best guess if unsure. Would you say ...?

[SINGLE]

- (i) None
- (ii) 1-5 times
- (iii) More than 5times
- (iv) Don't know

Q78x Since July 2013, approximately how many times have you visited a hospital to use other health services, for example, to see a specialist, physiotherapist, etc., for your own health? This does not include specialist appointments outside of hospital.

Please give your best guess if unsure. Would you say ...?

[SINGLE]

- (i) None
- (ii) 1-5 times
- (iii) More than 5 times
- (iv) Don't know

Q79 Do you get funding from Tasmania Disability Services, for example, an Individual Support Package, Community Access or Respite Package?

[SINGLE]

- (i) Yes
- (ii) No
- (iii) Don't know

Q79B Do you get funding from the National Disability Insurance Scheme?

[SINGLE]

- (i) Yes GO TO Q81
- (ii) No
- (iii) Don't know

IF Q79B = (2) NO or (3) DK, ASK Q80

Q80 Do you expect to be eligible for the National Disability Insurance Scheme or NDIS when it is fully established?

[SINGLE]

- (i) Yes
- (ii) No
- (iii) Don't know

Q81 Are you covered by any of the following concession cards? Please select all that apply.

[MULTI]

- (i) Health Care Card
- (ii) Pensioner Concession Card
- (iii) Commonwealth Seniors Health Card
- (iv) Department of Veteran Affairs Card
- (v) None of the above [EXCLUSIVE]
- (vi) Don't know [EXCLUSIVE]

Q82 Are there any other comments you would like to make about any of the services you receive or about this survey?

- (i) [OPEN END]
- (ii) No further comments

Conclusion

Q83 If you would like to contact TasCarepoint regarding any of the services you receive, please contact them on the following:

TasCarepoint: 1300 769 699 or by fax 1300 721 611 or email mail@tascarepoint.net.

If you would like to contact a support service then Lifeline can be contacted on 13 11 14.

Q84 Would you be interested in receiving a summary of the survey findings by email when the information is available?

[SINGLE RESPONSE]

- (i) Yes
- (i) No → INT99

(IF <EMAIL> = BLANK then SKIP)

A summary of the findings will be provided to your Service Provider and will also be uploaded on the project website <http://issr.uq.edu.au/THCS>.

Q85 Is this the best email address to send the summary findings to?

[SINGLE RESPONSE]

Recorded email: <EMAIL>

- (i) Yes → INT99
- (ii) No

Q86 What is the best email address to send the summary findings to?

[INPUT FIELD – EMAIL MASK]

INT98

Unfortunately we can only interview people over 18 years of age. Thank you for your time today. Please press 'Close' to exit from the survey.

[SKIP IF NOT Q1A=1]

NQ Continue GO TO END

INT99

That is the end of the interview. Thank you very much for your time. Please press 'Submit' to finalise your responses.

CO Complete

CLOSE

Thank you, your responses have been submitted. Please press 'Close' to be redirected to the study webpage.

1 Close GO TO END

Direct to project website <http://issr.uq.edu.au/THCS>

Conversion chart for HACC service types

Formal term	Informal term to be used
<i>Domestic assistance</i>	<i>Help with housework</i>
<i>Social support</i>	<i>Help with everyday tasks provided by a companion</i>
<i>Nursing care</i>	<i>Home nursing</i>
<i>Allied health care</i>	<i>Care by a health worker [such as podiatrist, physiotherapist, occupational therapist, speech pathologist or dietician].</i>
<i>Personal care</i>	<i>Help with everyday self-care tasks [such as dressing, bathing, eating, using the bathroom, taking medications]</i>
<i>Centre-based day care</i>	<i>Group activities in a day centre</i>
<i>Meals</i>	<i>Meals</i>
<i>Other food services</i>	<i>Help with cooking</i>
<i>Respite care</i>	<i>1Respite care</i>
<i>Assessment including screening - client</i>	<i>Assessing your need for services</i>
<i>Assessment including screening - carer</i>	<i>Assessing your need for services</i>
<i>Case management</i>	<i>Help managing your care</i>
<i>Client care coordination - client</i>	<i>Help coordinating your services</i>
<i>Client care coordination - carer</i>	<i>Help coordinating your services</i>
<i>Home maintenance</i>	<i>Help with maintaining and repairing your house</i>
<i>Home modification</i>	<i>Modifications made to your house [such as grab rails, ramps, alarms, shower rails]</i>
<i>Provision of goods and equipment</i>	<i>Equipment [such as walking frames, wheelchairs, commodes]</i>
<i>Formal linen service</i>	<i>Linen laundry services</i>
<i>Transport - client</i>	<i>Transport [to community activities, medical appointments, services]</i>
<i>Transport - carer</i>	<i>Transport [to community activities, medical appointments, services]</i>
<i>Counselling, support, information and advocacy - carer</i>	<i>Information, counselling or advice</i>
<i>Counselling, support, information and advocacy - client</i>	<i>Information, counselling or advice</i>

APPENDIX IV: CONCEPTS AND DEFINITIONS

A report of this kind necessarily involves the use of specialised terms and concepts that are given a particular meaning and used in particular ways. Several such terms have already been used in the report and it is necessary to define these terms at the outset to ensure consistency throughout the report. The main terms requiring explanation and definition are:

- Disability
- Long-term or chronic health condition
- Restriction (impairment)
- Functional (activity) limitation
- Core activity limitation.

The meanings given to these terms, the links amongst them, and the ways in which they are used in the report are briefly described. In general, the use of these terms in the report is consistent with the ways that the terms are used by the ABS in the *Survey of Disability, Ageing and Carers (SDAC)*. The ABS's description of these terms can be found in the *SDAC User Guide* (ABS 2011a: 9-13).

DISABILITY

The concept of disability is central to the Tasmanian HACC program, with the client group of the program since 2012 being defined as 'younger persons with a disability and their carers' (section 1.1). However, the concept of disability is difficult to define in part because the nature of disability is highly contested (Marks 2000). The traditional medical view is that disability involves damage to a person's body or mental functioning requiring diagnosis, care and support and professional treatment. The social model of disability, by contrast, argues that the focus should be on the disabling environment and its role in excluding and marginalising disabled people. Psychological perspectives on disability draw attention to the ways that disability is experienced by both disabled and non-disabled people. Increasingly, it is recognised that there is a 'complex relationship between physiological, social and psychological dimensions of disability' (Marks 2000: 93).

Debates concerning the nature of disability have had an impact on the ways that disability is defined in the policy and service context. Two examples from social policy in Tasmania illustrate this point. The Tasmanian *Disability Services Act 2011* which came into operation on 1st January 2012 explicitly adopted a human rights view of disability in line with the United Nations Conventions on the Rights of Persons with Disabilities. This involved amending the definition of disability to give greater emphasis to the impact of a person's impairment on their everyday life and participation and on the need for significant and continuing support (Tasmania DHHS n.d.). Similarly, the 'disability requirements' for participation in the Tasmanian NDIS pilot reflect the social as well as physiological dimensions of disability. These eligibility requirements include all of the following:

- A permanent intellectual, cognitive, neurological, sensory or physical impairment or an impairment attributable to a psychiatric condition;
- Substantially reduced ability to take part effectively in activities (i.e. communication, social interaction, learning, mobility, self-care or self-management) or perform tasks or actions;
- Reduced capacity for social and economic participation; and
- A requirement for support under the NDIS for life (NDIA 2014).

The definition of arriving at an agreed definition of disability is also complicated by the approach to this issue in the research context, where the imperative is to define disability in a way that can be measured. In the Australian context, the most widely recognised approach to measuring disability is that developed by

the ABS for the *Survey of Disability, Ageing and Carers* (SDAC) (ABS 2011a: 9-10). The ABS accepts the rather loose definition of disability set out in the *International Classification of Functioning, Disability and Health* (WHO 2001) as 'an umbrella term for any impairment of body structure or function, limitation of activities, or restriction in participation' (Bowling 2005: 4). Within this broad concept, the ABS states that a person has a disability if they have, 'a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities' (ABS 2011a: 9). In the national survey, households are asked whether there are any individuals who have various types of impairments or limitations such as loss of sight, speech difficulties, etc. which have lasted (or are likely to last) six months or more (ABS 2013a). Households are asked about 17 different impairments or limitations. Broadly speaking, all answering 'yes' are counted as having a disability. On this basis, 18.5 per cent of the Australian population was reported as having a disability in 2012 (ABS 2013b) and 24.6 per cent of the Tasmanian population (ABS 2014a). This is far higher than the number of persons deemed to have a disability for purposes of eligibility for Specialised Disability Services or the NDIS.

In this report, the term 'disability' is used in different ways in different contexts. Sometimes the word is used in the context of the eligibility requirements for a particular program: a client of Specialist Disability Services is a person deemed to have a disability as defined by those Services. In other places the term is used to refer to those meeting the ABS's criterion for disability for data collection purposes. The particular meaning given to the term in different places in this report will be specified or will be apparent from the context.

Given the variable meanings given to the term 'disability', limited use is made of the term in this report in profiling clients of the HACC program. Instead, the terms primarily used for profiling purposes are 'long term or chronic health condition', 'restrictions' or 'impairments', 'functional or activity limitations' and 'core activity limitation'. These terms are interlinked. Long-term or chronic health conditions may lead to restrictions or impairments and to functional or activity limitations, including core activity limitations. Each of these terms, and their use in the report, is briefly described below.

LONG-TERM (CHRONIC) HEALTH CONDITION

The ABS Survey of Disability, Ageing and Caring defines a long-term health condition as 'a disease or disorder which has lasted, or is likely to last, for six months or more' (ABS 2011a: 10). This includes conditions resulting from accidents or injuries, lasting at least six months. A concordance of the major types of long-term health conditions, organised by 20 main groupings, is provided by the ABS (ABS 2013c). Many types of long-term health conditions are referred to as 'chronic diseases', meaning that they are long-lasting conditions that can be controlled but not completely cured. Chronic diseases are increasingly prevalent in the population due to longevity and improvements in treatment and management. Chronic illnesses often (but not always) lead to impairments or restrictions and to functional (activity) limitations. For example, SDAC notes that speech impairments or restrictions can be caused by a wide range of health conditions including autism, cerebral palsy, dyslexia, head injury, hearing loss, intellectual disability, speech impediment and stroke. The ABS SDAC survey asks respondents to identify the long-term health conditions that have resulted in impairments, restrictions and functional (activity) limitations.

IMPAIRMENT AND RESTRICTION

The concept of impairment was central to conceptualisations of disability in the 1980s when it was defined as 'any loss or abnormality of psychological, physiological or anatomical structure or function' (Bowling 2005: 3). This emphasis on deviation from the norm in an individual's biomedical status was for many years widely perceived as reflecting a narrow and stigmatising view of disability. However, recent conceptualisations of disability in both policy and research contexts use the concept of impairment in recognition of the biomedical dimension of disability. For example, eligibility for the NDIS requires proof of 'a permanent intellectual, cognitive, neurological, sensory or physical impairment or an impairment attributable to a psychiatric condition'. In a research context, the ABS SDAC identifies a person with a disability by whether they have 'a limitation, restriction or impairment' lasting for six months and restricting

everyday activities. The emphasis on 'restriction' as well as on the biomedical factors signified by the term impairment reflects the multifaceted understanding of disability referred to earlier.

FUNCTIONAL OR ACTIVITY LIMITATION

The concept of functional status is widely seen as more meaningful than biomedical measures of disability. Whether or not a person can perform a particular task or activity unaided or without difficulty is a direct indicator of capacity to function and participate in society. Measures of functional ability or limitation are integral to all definitions of disability in policy and research. The terms 'function', 'activity' and 'task' tend to be used interchangeably. In this report we follow the ABS in referring to 'activities' (e.g. self-care) and 'tasks' (e.g. washing, dressing).

The delineation of activities varies amongst data sets. A Table of Activities and Tasks identifying 12 types of activities is set out in the SDAC User Guide (ABS 2011a: 12-13). The HACC MDS identifies 15 activity types and these are used to determine program eligibility as well as for research purposes. The Specialist Disability Services National Minimum Data Set (NMDS) identifies nine broad types of activities (AIHW 2014a: 70):

- Self-care (e.g. washing, dressing, eating, toileting);
- Mobility (e.g. getting in and out of bed, moving around the home, moving outside the home);
- Communication (e.g. making oneself understood and understanding others);
- Interpersonal interactions (e.g. making and keeping friends, coping with feelings, behaving acceptably);
- Learning and applying knowledge (e.g. understanding new ideas, problem solving, following routines);
- Education (e.g. activities and tasks involved in performing in school or other educational settings);
- Community and economic life (e.g. recreation, leisure, handling money);
- Domestic life (e.g. organising meals, cleaning, housekeeping, shopping); and
- Working (e.g. activities and tasks involved in participating in paid employment).

Activity limitations can be thought of as the consequences of impairments, the social and physical environment and psychological factors. (Bowling 2005: 3). The ABS identifies people who have activity limitations by determining if they cannot do a task under any circumstances or 'if they needed assistance, had difficulty, or used aids or equipment to do ... tasks' (ABS 2011a: 11).

CORE ACTIVITY LIMITATION

Finally, it is necessary to define the concept of 'core activity limitation'. Of the nine broad types of activities listed above, the ABS identifies three as 'core activities': self-care, mobility and communication. A person's capacity to undertake tasks in these three activity areas are used by the ABS to identify four levels of core activity limitation¹³:

- *Profound*. The person is unable to do, or always needs help or supervision with a core activity task.
- *Severe*. The person sometimes needs help or supervision with a core activity task.
- *Moderate*. The person needs no help or supervision but has difficulty with a core activity task.
- *Mild*. The person needs no help and has no difficulty with any of the core activity tasks but uses aids or equipment (ABS 2011a: 11).

¹³ These are summaries of the full descriptions which can be found at ABS 2011a: 11.

These terms are often used to refer to levels of 'disability' in the community, even though technically they refer to levels of core activity limitation. In the 2012 SDAC, the ABS found that 14.9 per cent of the Australian population had core activity limitations comprising profound (3.2 per cent of the population), severe (2.9 per cent), moderate (2.8 per cent) and mild (6.0 per cent) (ABS 2013b). The comparable figures for Tasmania were 19.7 per cent comprising profound and severe (7.7 per cent of the population) and moderate and mild (12.0 per cent) (ABS 2104a).

USE OF CONCEPTS IN THE STUDY

The concepts described above are used throughout the study to refer to disability-related factors underpinning use of HACC services. Interpretation of the data presented in this study requires an appreciation of these concepts, their definition and significance.

The client profiling of HACC clients undertaken for this study aimed to identify the *chronic or long-term health conditions* of the HACC client population. This information is not collected in the HACC Minimum Data Set (MDS). The main source of this information was the client survey, together with matched data from Health Central, the data repository of the Tasmanian Department of Health and Human Services.

As with health conditions, data on *impairments and restrictions* is not collected in the HACC MDS. The main source of information on impairments and restrictions in the HACC client profile is the client survey where respondents are asked about specific impairments and the extent to which they restrict everyday life. The approach used to collect this information is based on the ABS SDAC. The population-level data for Tasmania reported in chapter 5 uses the ABS SDAC as one of two main sources and is thus reliant on the ABS operational definition of disability which relies on the concepts of limitations, restrictions and impairments.

The HACC MDS is a major source of data on *activity limitations* of HACC clients and this data is examined in detail. Unfortunately, there is considerable missing data in the HACC MDS and therefore further data on activity limitations was obtained through the client survey.

Finally, analysis of the HACC MDS data on activity limitations is undertaken to determine the approximate proportion of HACC clients who meet the ABS definition of having *profound and severe core activity limitations*. The ABS Census data is used to provide population-level data on core activity limitations in the Tasmanian population.