Homeshare
Victoria

Economic Evaluation of Homeshare Victoria

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Can an innovative community based aged care program give good value for money?

February 2003

Preface and Acknowledgements

This report has been prepared on behalf of the Ronald Henderson Research Foundation, for Homeshare Victoria, as part of an internship programme. The stated purpose of the Ronald Henderson Research Foundation Internship Programme is "to fund the participation of bright young scholars in research projects that combine social and economic analysis." The internship allows honours students in economics and social sciences to undertake research projects for community organisations to the benefit of both parties.

In fulfilling the requirements of the internship I have familiarised myself with Homeshare Victoria by attending monthly steering committee meetings, conducting research at Homeshare Victoria and accompanying the co-ordinator during the day-to-day operations of the program.

The report has benefited from supervision and advice from the following academic supervisors. Jeff Richardson and Terri Jackson of the Health Economics Unit, Centre for Health program evaluation. Peter Forsyth, of the Department of Economics, Monash University and Meg Montague, Social Policy and Research Consultant. I would like to express my thanks to them and also to Beris Campbell, Coordinator of Homeshare Victoria and the members of the Homeshare Victoria Steering Committee for their guidance and commitment during the internship. Finally I am grateful to Helen McDonald, Internship Supervisor and am indebted to the Ronald Henderson Research Foundation for the opportunity to participate in the internship.

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1. Executive Summary

Homeshare Victoria is a community based aged care program that involves matching a frail older person in need of some help around the house with a younger person who can benefit from low cost, reasonable accommodation. The Department of Veterans Affairs and the Department of Human Services - HACC have supported the program. The program also relies heavily on the donations and grants of philanthropic trusts.

Matches involve a formal agreement setting out the expectations of both parties. The homesharer (younger person) provides a notional 10 hours of help around the house. This has both a formal and informal nature. Formal tasks include bringing in rubbish bins, gardening, assistance with grocery shopping, paying bills and transport to medical appointments. However informal assistance such as companionship, friendship and having someone in the house at night have proven of most value to the householder (older home owner). In exchange for help the householder offers a rent free room in their home.

This report is a comprehensive economic evaluation using a methodology known as cost-benefit analysis. Data has been collected through telephone surveys of householders and their family, householder care workers or case managers and homesharers. In addition the report has made use of earlier research, a recent desk audit and Homeshare Victoria records. The program is in its infancy and has been operating for 29 months. During this time there has been 39 matches. At maturity the program is expected to have the capacity to maintain 32 matches in place. This will have an operating cost of $95,270 per annum.

Using the sample of 39 matches the impacts of two years of operation at maturity has been estimated. A two year analysis reflects the changing care needs of householders as well as the limitations of evaluating a pilot program. The program's impact on society can be categorised by seven main groups:

1. **Commonwealth Department of Health and Ageing (DHA)** – The DHA benefits from a reduction in the usage of subsidised residential care. This results in an expected saving of $119,347 per annum. This is not from homesharers providing the care equivalent to a nurse or trained care staff. Rather, a homesharer presence during the night and often during the day, usually combined with qualified community care maintains the householder in the community.

2. **Victorian Department of Human Services- (HACC).** The HACC program benefits from a reduction in the usage of subsidised units of HACC services. In addition HACC incurs a cost in re-current funding and community care received by clients who have avoided residential care because of the program. The HACC program incurs an expected net cost of $84,671 per annum.

3. **Commonwealth Department of Veterans Affairs (DVA)** – The DVA benefits from a reduction in the usage of subsidised units of community care. In addition the DVA incurs a cost from community care received by clients

who have avoided residential care because of the program. The final effect is an expected net saving of $4,961 per annum.

By combining community care and funding HACC incurs a net cost. This allows several householders to avoid residential care. Community care is less expensive than residential care and results in a net saving to the aged care system. The expected net saving is $39,637 per annum. If HACC reduces its funding or Homeshare Victoria fails to solve its current funding shortage this saving will be foregone.

4. **Victorian Hospitals** benefit through savings caused by early householders discharge. This is the result of hospital staff allowing the householder to return home due to homesharer presence and supervision. This is estimated at $10,585 per annum.

5. **Householders and their families** benefit from direct care, companionship and savings from avoiding residential care and other services. This represents an expected benefit of $681,317 per annum.

6. **Homesharers and their families** benefit from savings on accommodation, better quality accommodation and other savings. Homesharers also incur a cost from a commitment to provide reliable, supportive presence in the home and companionship. This generates an expected net benefit of $150,900 per annum.

7. **Philanthropists** also have a significant impact through donations to the program. This helps them to achieve their own philanthropic objectives at an expected cost of $30,000 per annum. The program will require additional funds of $30,270 per annum to continue operating. This will be an additional cost to the source of that funding.

The sum of the costs and benefits to the participants is the program's net benefit to society. The expected net benefit to society is $822,169 per annum.

The report has made two recommendations:

1. The program introduce a matching and/or monitoring fee for participants.
2. HACC continue funding and that Homeshare Victoria seek additional funding from the Commonwealth Department of Health and Ageing and Department of Veterans Affairs.

Homeshare Victoria delivers significant benefits to the community. By removing barriers to exchange the program offers older Australians a near substitute for the care provided by a live in carer. This is facilitated through barter rather than direct payment. When a match forms parties exchange private benefits and generate external social benefits in savings to the health and aged care system. Without the program, the health and aged care system could not receive these savings. Homeshare clients could not privately purchase live in carers. Rather they would initially remain in the community, at risk, eventually entering residential care and the savings would be lost.

2. Introduction

Homeshare Victoria is a community organisation that has been operating under the auspices of MECWA since May 2000. The program has received government funding from the Victorian Department of Human Services and Commonwealth Department of Veteran Affairs. It has also received financial support from philanthropic trusts. The Department of Human Services has reviewed Homeshare funding and it is hoped that this, a formal economic evaluation will inform this process and form the basis of submissions to state and federal governments for recurrent funding.

The vision of Homeshare Victoria is "to see older Australian householders maintaining a higher quality of life by remaining longer in their own homes and surroundings through a formalised arrangement with another person, a homesharer, this being of benefit to both parties"[1].

The concept of formal Homesharing was originally developed in the United States in the 1970's. Since then Homeshare programs have grown in popularity with formal programs operating in eight countries, with over 100 in the US, several in the UK and two formal programs in Australia. Homeshare Victoria is best described as agency assisted shared housing. The agency publicises, interviews, screens, matches, and monitors progress of matches but is not present within the home setting[2].

Crucial to the success of matches is a formal agreement setting out the expectations of both parties. The homesharer (younger person) provides a notional 10 hours of help around the house. This can be of both a formal and informal nature. Formal tasks include bringing in rubbish bins, gardening, assistance with grocery shopping, paying bills and transport to medical appointments. However companionship, friendship and having someone in the house at night have proven of most value to the householder (older home owner). Neither participant is currently charged for the program's services.

3. Other Literature

There is extensive international literature evaluating the homesharing programs from a social perspective. There have been two major evaluations of the Homeshare Victoria Pilot. The first is Montague (2001) *An evaluation of the Homeshare Victoria Pilot. Phase I: planning, implementation and the first year of matches*. This is best described as a feasibility and social evaluation, and reports that the program is both feasible and of significant social benefit to the participants.

The Department of Human Services has recently commissioned the report by Martin Bonato & Associates Pty Ltd and Pro-consult Management Advisory Pty. Ltd. The Status of the Homeshare Victoria Pilot Scheme as it relates to the Home and Community Care (HACC) Consideration of the costs and benefits, Department of Human Services – HACC. Hereafter referred to as the Martin Report. Despite its title

[1] Homeshare Victoria (2001) *Vision Statement*

[2] Jaffe, D & Howe, E (1988) "Agency Assisted Shared Housing: The nature of Programs and Matches", *The Gerontologist*, vol. 28, No. 3, pp318-324.

this is not a cost-benefit analysis. However there is occasional crossover between the Martin report and the work presented here. The Martin report referred to and retitled this report "a third Project to look at the Cost-effectiveness….with no clear methodology or scope established…will potentially look more broadly at the cost effectiveness of the service than this assignment, which focuses on the costs and benefits for the HACC Program". This statement is incorrect and the methodology of this report is described in section 4. In addition the estimated program size, contained in section 5.3 and the budgeted operating costs contained in section 5.5 differ from that of the Martin Report.

4. Methodology

4.1 Cost-Benefit Analysis

The method of evaluation is Cost-Benefit Analysis (CBA). CBA is a comprehensive tool of evaluation that identifies and attempts to measure all quantifiable impacts of a project. It is used for the social appraisal of projects and should not be confused with a profit and loss analysis or other accounting related measures. A key feature is that all impacts are measured in dollar terms. This allows all costs (resources consumed) to be subtracted from benefits (outcomes/savings) and a net value derived. A positive value suggests the program is worthwhile, and a negative value that the program is not.

A major strength of CBA is its conceptual foundations in welfare economics. As such, decisions based on the results of CBA should lead to an efficient allocation of resources. If all parties affected by a project gain, with no other party losing, the project is pareto efficient and society is better off. However, most projects consume scarce resources and there is a cost associated with the benefits that are generated. If the benefits to the gainers are greater than the costs of the losers the project is potentially pareto efficient. That is, the benefits of the winners could potentially compensate the losers and the net benefits would leave society in a better position. This is the case for most projects, including Homeshare Victoria.

In theory program outputs should be valued by the consumer's willingness to pay for them. Similarly, costs in the form of inputs such as labour and capital should be valued by the supplier of that labour or capital willingness to accept as compensation. This is not necessarily their market price, rather the area under their respective demand and supply curves. Many aspects of aged care and health outcomes in general are qualitative and cannot be purchased on a market. Outcomes that can be purchased offer only market prices for valuation not their true economic values. Strictly, the outputs of a Homeshare program aren't marketed. Homesharer help or homesharer sleepovers cannot be directly purchased; neither can other intangible benefits such as friendship or companionship.

The CBA literature suggests a number of ways to value non-marketed items. These include market based or revealed preferences approaches such as hedonic pricing or the travel cost method, both of which rely on finding markets that implicitly incorporate the non-market effects. Alternatively, stated preference techniques such as contingent valuation and experimental approaches can be used. Contingent valuation using willingness to pay surveys can be a valid method of evaluating consumer

surplus if used correctly[3]. This report originally attempted willingness to pay telephone surveys. A sample of the WTP survey is contained in appendix 3. Respondents were asked set questions about impacts from the project. The market prices of similar or contingent markets were suggested and respondents were then asked how much they value or would hypothetically be willing to pay for perceived benefits. To avoid causing undue stress on the often frail and elderly householders a close family member was expected to complete the survey on their behalf. Other researchers have used this method[4]. After several attempts using this method it was discovered respondents either did not understand, were not willing or struggled to reliably make a valuation. As a result the method of survey was altered to basic qualitative, set question interviews. These are contained in appendix 3 and are discussed in further sections.

In the light of the problems with the WTP survey, the paper has relied on hedonic pricing for valuing homesharer help, companionship and overnight support. This was done considering the close but not substitutable live-in carer market. The details of this are discussed in detail in section 12.2. Impacts such as savings to government departments are valued at their unit cost or cost to fund.

In theory, benefits and costs in the future are worth less then, than if they are received now. As a result, most studies discount future costs and benefits to represent their present values. Several matches have lasted longer than a year and the timing of benefits and costs becomes an issue. The householder's health may deteriorate or fluctuate and the associated care needs and costs to fund change. Currently, the maximum length of a match has been two years and following from this the analysis will be based on a two-year program. The second year of results will be discounted at 6%. This is recommended in the Department of Finance *Handbook of Cost-Benefit Analysis*[5]. The assumptions surrounding a two-year program are discussed in section 5.4 and 7.0.

4.2 Data Collection

Using a 'do nothing' comparator five main groups are affected by the program. They are the householders and their families, the homesharers and their families, the Victorian Department of Human Services, the Commonwealth Department of Veteran Affairs and the Commonwealth Department of Health and Ageing. Outcomes relating to hospitals and the aged care system were determined through telephone interview of available case managers. These were combined with a recent DHS desk audit[6], Homeshare Victoria matching and monitoring records, staff consultation and earlier research[7]. Impacts on householders, homesharers and respective families were

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[3] Olsen J, Smith R & Harris A, (1999), Economic theory and the monetary valuation of health care: An overview of the issues as applied to the economic evaluation of health care programs, Centre for Health Program Evaluation.
[4] Donaldson, C (1990) Willingness to pay for publicly provided goods: A possible measure of benefit? *J. Health Economics*, 6, p103-18.
[5] Department of Finance (1991), *Handbook of Cost-Benefit Analysis*, AGPS.
[6] Bayside Community Options (2002), *Desktop Audit of Homeshare Householders*. Department of Human Services – HACC.
[7] Montague, M (2001), *Increasing Housing and Support Options for Older People An evaluation of Homeshare Victoria Pilot, Phase I: planning, implementation and the first year of matches*.

determined through telephone interviews, applications, matching and monitoring records, and earlier research[8].

Telephone interview participants were asked questions relating to how the program has affected them and where they would be if not in the program. The survey then posed questions regarding what was most important to them. This included reasons for entering the program, a ratings scale and yes/no responses with follow up explanations. The details of survey respondents are given below.

Table 1. Survey Respondents

	Householder	Householder Family	Care worker	Homesharer
Matches	n=10	n=6	n= 8	n = 8

All survey respondents were current matches in place. The sample selection was restricted to participants who were receptive and willing to be interviewed and/or could physically participate without causing unnecessary stress. As a result, it was not a random sample and it is possible that characteristics allowing them to participate were related to their responses. However, information that is likely to be biased is information such as the rating scale, which although useful in determining client feelings is independent of results such as savings to the aged care system. Because of the small sample size its purpose is to help validate a range of different data sources. It is likely that those householders who have had good experiences and wish to participate receive care from their homesharer more suited to their needs. In addition homesharers who are happy and settled in the homesharing arrangement and interested in the program are more likely to participate and less likely to have over demanding or difficult householders and consequently stay in the program for longer. These results are contained in sections 13, 14 and appendix 2.

All accessible case managers were interviewed. They represented several local service providers including council, DVA and private organisations. Case managers were asked three set questions:

1. How has Homeshare Victoria impacted upon your client?
2. Have you reduced or delayed services due to Homeshare Victoria?
3. Do you think Homeshare Victoria will delay future usage of services?

The results of these surveys are contained in sections 8,9 and 10.

4.3 Applying the data to the health and aged care system

Due to the variation in the length of matches and the associated impacts on the health and aged care system a two-period analysis has been used. There have been 32 householders over the 29 months of operation. This is also the estimated program capacity and the care status and associated costs and savings of the actual 32 householders will be applied to the 32 matches of a representative program. Matches that have lasted the full two years have been applied across the entire two-year analysis. Matches that have ended and have lasted less than the entire two-year period have been annualised and are assumed to be replaced with a match of similar characteristics. This gives a constant flow of costs and savings weighted according to

[8] ibid

the changing care needs and the length of match. The exception is matches that lasted a short period and were assessed as saving significant amounts of overnight respite. There is a maximum amount of overnight respite available to clients. As a result it has been conservatively assumed that no more than the maximum is used per client in any one year. For example, a match that lasts 2 months and reduced usage of 10 units of overnight respite during the match is not treated as recurrent. Otherwise, if annualised would represent an unrealistic saving of 60 units of overnight respite.

5. The Program

5.1 Client Characteristics

Since beginning in May 2000 up until mid November there have been 39 matches made and18 were in place on the 17th November 2002. Of the 39 matches made, 1 involved a householder couple, and 6 were householders who have been rematched, one 4 times. Hence a total of 32 householders. There has been 1 homesharer rematch and 1 homesharer couple. This represents 39 individual homesharers.

Table 2. Summary of Client Characteristics

Householder						Homesharer					
Gender		Age		Status		Gender		Age		Status	
Male	7	50-59	1	CACPS	7	Male	5	20-29	12	Intl Student	14
Female	25	60-69	2	HACC	9	Female	34	30-39	15	Cntry Student	7
		70-79	7	DVA	7			40-49	2	Mature Aged	15
		80-89	17					50-59	7	Other	3
		90+	5					60+	3		

n=39 matches
n= 32 (includes 1 couple and 6 rematches)

n=39 matches
n = 39 (includes 1 couple and 1 rematch)

The majority of the participants have been female. Most householders are aged over 70 and typically live in areas of high home ownership and offer good quality accommodation. The age of homesharers ranged between 20 to 73, the majority being between 20-40 and varied from country or international student, middle aged, employed or even older members of the community.

5.2 Cessation of matches

From a welfare economics perspective, a match will continue until the point where the benefits as measured by willingness to pay are less than the costs. Many matches have ended due to the homesharer having some change in circumstances leading to them not being able to fulfil their requirements. That is the opportunity cost of their time foregone has become too great for them to remain in the program.

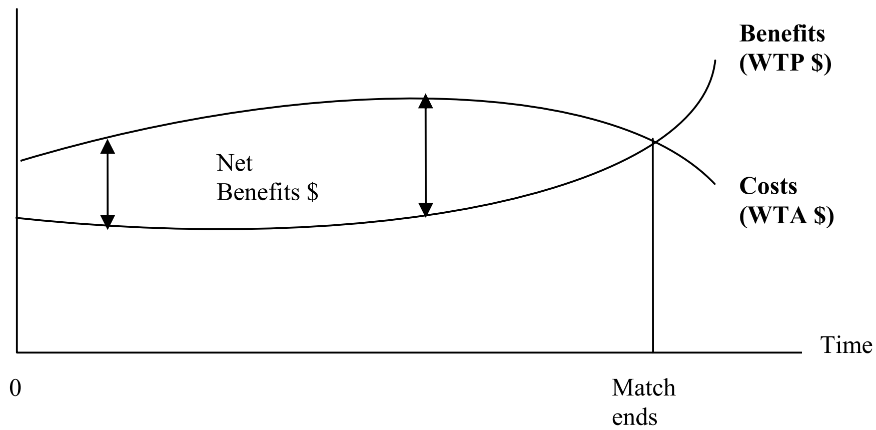


Figure 1. Match cessation

The report assumes a match ends when it reaches the point of zero benefit and as such no participant incurs a negative net benefit. This is not unreasonable given the considerable coordinator effort spent interviewing and screening participants and their families. Of the three matches that have lasted less than a month, one was a temporary match while the regular homesharer was away and the other two became unworkable due to excessive householder or householder family demands on the homesharer. In addition, it cannot be argued that short matches have little benefit to participants or the health and aged care system. This is highlighted by a match lasting 11 weeks which allowed a 91 year old householder additional time at home before later dying of lung cancer, see section 12.

Table 3. Match Duration

Match	Start	Finish	Total weeks	Reason for cessation
1	15-Jul-00	4-Jul-02	103	HH died
2	28-Aug-00	2-Dec-01	66	HS purchased own unit
3	9-Nov-00	20-May-01	27	Brought to end HS not present at night
4	16-Dec-00	7-Sep-01	38	HH entered nursing home
5	18-Feb-01	15-Nov-01	39	HS returned to country
6	13-Feb-01	2-Sep-01	29	HH died
7	5-Mar-01		89	
8	9-Mar-01	24-Mar-02	54	HH increasing care needs
9	16-Apr-01	14-Oct-01	26	HS could no longer fulfil commitment
10	29-May-01		77	
11	20-Jul-01	2-Jul-02	50	HH moved
12	31-Jul-01		68	
13	3-Aug-01		67	
14	15-Aug-01	16-Jan-02	22	HS moved campuses
15	15-Sep-01	27-Jul-02	45	HS moved overseas
16	31-Oct-01		55	
17	1-Nov-01	19-Jan-02	11	HS returned to overseas
18	15-Nov-01	29-Nov-01	2	Temporary match
19	2-Dec-01		50	
20	5-Dec-01		50	
21	10-Dec-01	21-Apr-02	19	HS could no longer fulfil commitment
22	6-Jan-02		45	
23	12-Feb-02	18-Jun-02	18	HH health deteriorate- mental issues
24	2-Mar-02	2-Jun-02	13	HS could no longer fulfil commitment
25	3-Mar-02	23-Mar-02	3	Excessive family demands on HS
26	27-Apr-02	15-May-02	3	Excessive demands on HS
2 & 27	30-Apr-02		29	
28	26-May-02		25	
29	9-Jun-02		23	
30	10-Jul-02	17-Aug-02	5	Temporary match
31	17-Jul-02	24-Oct-02	14	HS became ill had to return home
15 & 32	28-Jul-02		16	
33	30-Jul-02		16	
34	5-Aug-02	17-Oct-02	10	HH went into hospital
35	2-Sep-02		11	
36	14-Sep-02		9	
37	7-Sep-02	27-Sep-02	10	HH returned from hospital, high care needs
38	5-Nov-02		2	
39	17-Nov-02		0	
Total			**1,239**	

5.3 Program Size and Program Output

In 29 months the program has averaged 1.34 matches made per month with an average of .72 matches ending each month. The matches in place have grown at an average rate of .62 per month. The majority of coordinator time is spent making matches and is not closely related to the number of matches in place. All new

organisations face a steep learning curve and the program has benefited from growing coordinator experience. The development of a procedures manual and information systems will continue to improve program efficiency. In addition, a new part-time coordinator represents a 31% increase in coordinator hours. As a result, it does not seem unreasonable that in future periods the program will exceed the historical average rate of growth. Assuming the additional 31% in coordinator hours is spent making matches the report anticipates higher growth of around 1.75 new matches per month with matches remaining in place growing at 1.03 per month.

Table 4. Historical and expected program growth

	Historical average		Expected future average	
	Per month	Per annum	Per month	Per annum
Average new matches	1.34	16.08	1.75	21
Average growth in matches in place	0.62	7.44	1.03	12.36
Average attrition rate	0.72	8.64	0.72	8.64

International experience indicates that a full-time coordinator can manage around 25-30 matches. The Homeshare London program has a target of maintaining 32 matches per coordinator. Homeshare London however is structured such that senior management undertakes activities such as promotion and advertising and is not directly involved matches. In contrast, the Homeshare Victoria coordinator undertakes these activities. Allowing for these additional tasks 25 matches per coordinator is expected. A program with costs reflecting 1.3 coordinators will have a capacity of 32 matches. Given the forecast growth rate the program will reach its capacity of around 32 matches by December 2003. Program output is measured by weeks in residence. During the growth period leading up to December 2003 the outputs will differ from when the program is operating at capacity.

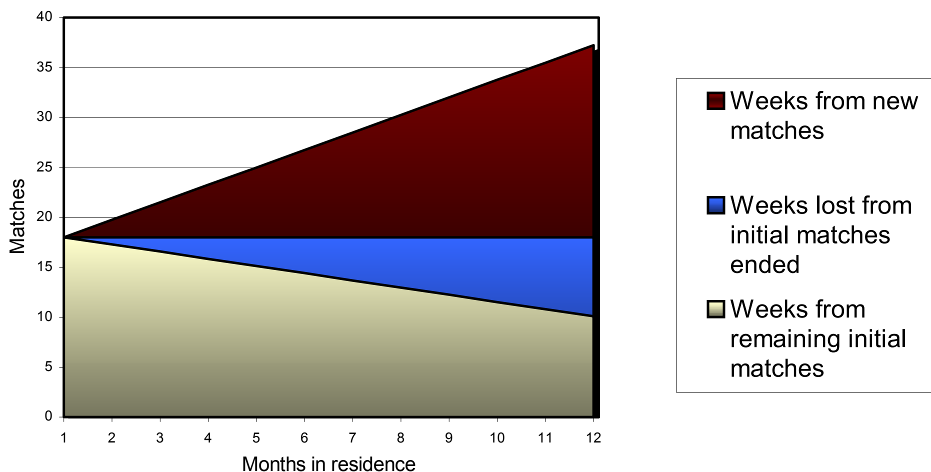


Figure 2. Program output during growth period

Table 5. Program output during growth period

Weeks from new matches	546
Weeks lost from initial matches ended	-225
Weeks from remaining initial matches	711
Total weeks in growth in year	**1,257**

Once the program reaches capacity, time constraints will restrict coordinator time available for new matches. This will lead to a slowing in the rate of growth of new matches to equal the rate of attrition. Hence, the program will maintain 32 matches with a constant flow of new matches replacing those that end. This report is based on a program that has reached maturity and is maintaining 32 matches. This is 1,664 weeks in residence per annum.

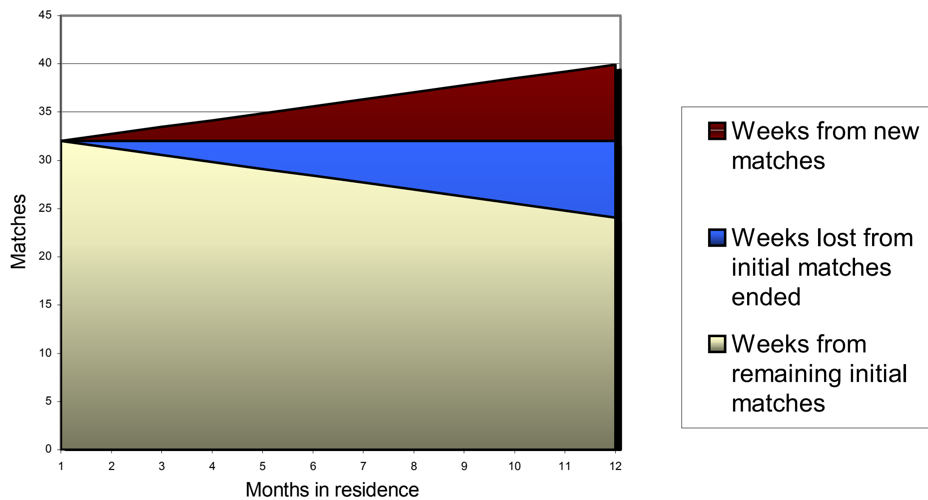


Figure 3. Program output at capacity

Table 6. Program output at capacity

Weeks from new matches	276
Weeks lost from initial matches ended	-276
Weeks from remaining initial matches	1,388
Total weeks in maturity year	**1,664**

In contrast to these results the Martin report projects that "the number of weeks of matches in residence in a typical year when the program attains "maturity" would be 1,300". This is not simply a difference in estimated program size. Rather it is the result of the Martin report calculating weeks in residence from a program described as at maturity as if the program was growing. Using the Martin reports own description, with 20 matches brought forward, 10 are expected to last the full year the other 10 matches will end during the year. This generates 780 weeks. The remaining 520 weeks are generated by the 20 new matches that begin over the year.

However, for the 20 matches that are described as beginning evenly over the year to generate 520 weeks they must have not ended. Hence at the end of the year there will be 30 matches. Using that trend the program will grow to 35 by the end of the next year and continue to grow. Hence, that calculation actually reflects a program that is growing rather than at maturity.

5.4 Timing

There is large variation in the length of matches. The longest match lasted just on two years while the shortest was a 2-week temporary match. The probabilities of different match lengths are given below.

Table 7. Probability of match length

Duration of matches that have ended	**Probability**
Greater than a year and finished	14%
Duration between 52 and 26 weeks and finished	29%
Duration between 26 and 13 weeks and finished	29%
Duration less than 13 weeks and finished	29%
Duration of matches currently in place	
Greater than a year and in place	28%
Duration between a 52 and 26 and in place	22%
Duration between 26 and 13 weeks and in place	22%
Duration less than 13 weeks and in place	28%

The probability of a match lasting greater than a year is significantly higher for existing matches at 28% compared with earlier matches that have ended at 14%. Benefits and costs are not independent of match length. Savings to the aged care system change with level of care otherwise required over the match. In modelling the impacts to the aged care system the report will assume that when a match ends a match of similar characteristics will replace it. The savings, benefits and costs from sample of 39 householders have been applied to the representative 32 match program on a proportionate basis over the two year period of analysis. This is also explained in section 7.

5.5 Financial Analysis

Cost-benefit analysis is not an accounting exercise. Although it is worthwhile to know the breakdown of expenditures in determining program size and operating costs. The financial years up until 30th June 2002 have involved many one off costs. At maturity, the Martin report has budgeted for the program to cost $105,400 per annum. However, this includes salaries of $80,000 from a "current staffing level of 1.5 FTE coordinator/caseworker"[9]. This cost is overstated. The program currently and will continue to operate with 50 hours of combined coordinator time. This represents 1.31 coordinators. Adjusting the above-mentioned budgeted staffing costs to 87.3% and ignoring differences in pay rates the program is expected to cost $95,270.

Table 8. Budgeted operating costs

	Actual 01/02	Actual excluding establishment expenses 01 / 02	Normal Maturity
Cost category	**$**	**$**	**$**
Salaries & Related	56,950	56,950	69,870
Travelling	1,780	1,780	3,400
Property related	1,140	1,140	1,200
Equipment related	2,260	2,260	2,300
Office overheads	3,370	3,370	6,500
IT development	3,080	-	-
Marketing & Promotion	2,320	-	-
Consulting fees	23,290	-	-
MECWA admin charge	8,000	8,000	12,000
Total	**102,180**	**73,500**	**95,270**

Source: Homeshare Victoria budget, Mecwa, Pro-consult Management Advisory Pty. Ltd.

[9] Martin Bonato & Associates Pty Ltd/ Pro-consult Management Advisory Pty. Ltd. (2002) *The Status of the Homeshare Victoria Pilot Scheme as it relates to the Home and Community Care (HACC) Consideration of the costs and benefits,* Department of Human Services – HACC.

6. Program Impacts

The parties directly affected by the existence of the Homeshare Victoria can be categorised by five main groups. These parties and the program's impacts are summarised below:

1. The aged care system. This incorporates the Commonwealth Department of Health and Ageing, Commonwealth Department of Veterans Affairs and the Victorian Department of Human Services – Home and Community Care:
    - 1.1 Savings - Substitution for community care services
    - 1.2 Savings – Deferral of residential care entry
    - 1.3 Outcomes – Care and support generated by homesharers to the target population, as measured by direct benefits to the householders
    - 1.4 Effectiveness- Deferral of residential care that could not otherwise be achieved by traditional care. Already represented in savings to the DHA but also relevant to HACC and DVA.
    - 1.5 Cost- Both DVA and HACC currently provide funding
    - 1.6 Cost- Both DVA and HACC continue to provide community care for those clients that would otherwise have been in residential care or hospital.

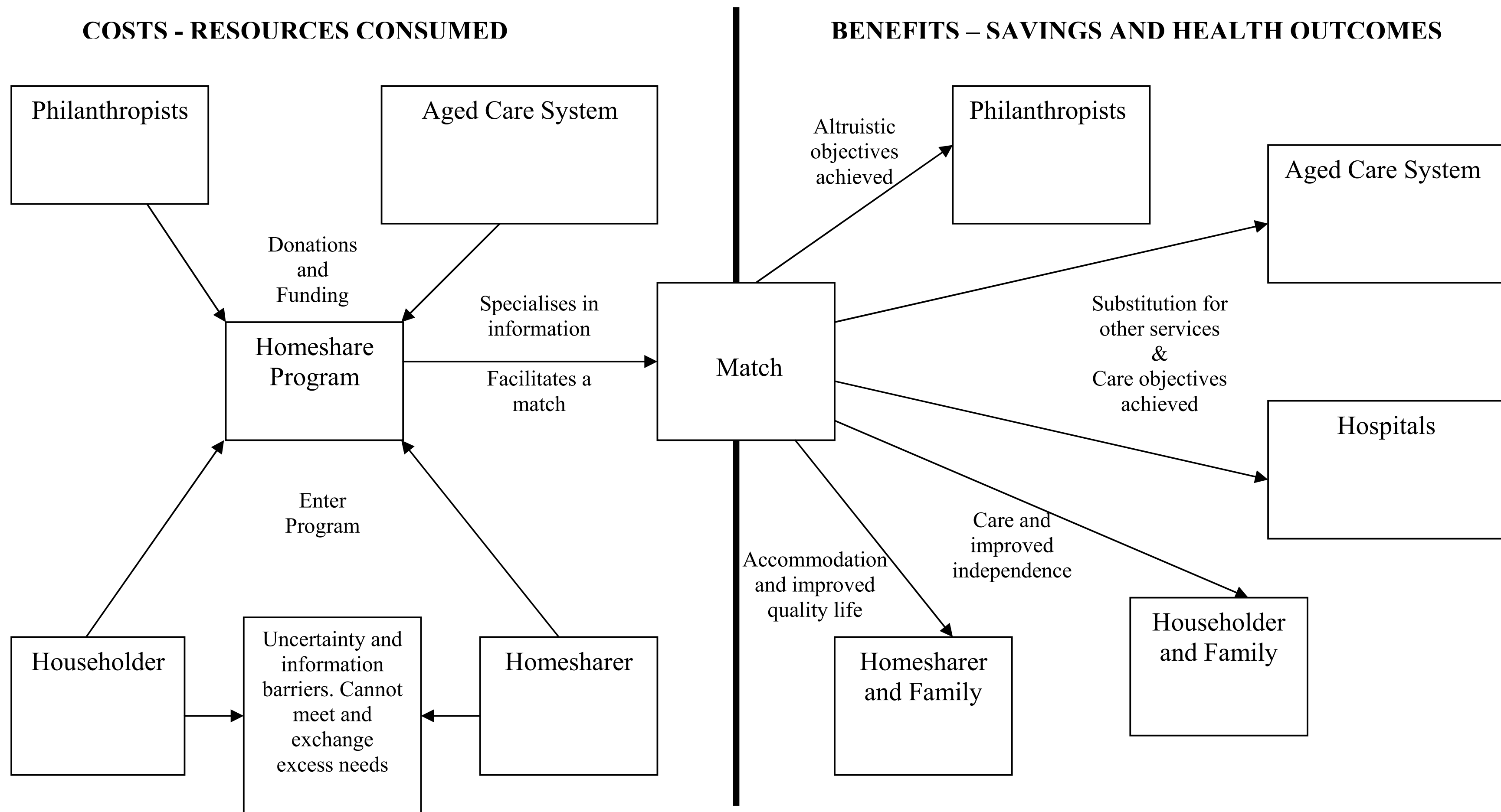
2. Victorian Hospitals:
    - 2.1 Savings – Allowing early discharge due to the presence and supervision of a homesharer.
    - 2.2 Effectiveness – Achieving goals of HACC by preventing inappropriate hospital admission. Already represented by the savings to hospitals.

3. Householders and their families. The impacts are as follows:
    - 3.1 Benefits- Measured by the value of care and support received
    - 3.2 Savings – Measured by amounts otherwise spent
    - 3.3 Costs- Room in house foregone - if it would have otherwise been rented

4. Homesharers and their families:
    - 4.1 Savings- Measured by the cost of accommodation otherwise rented
    - 4.2 Outcomes- Intangible quality of life improvements
    - 4.3 Costs- Time spent helping and lost independence.

5. Philanthropists:
    - 5.1 Cost- Measured by funding and support received
    - 5.2 Outcomes- Measure by the benefits generated to householders and the rest of society.

Figure 4. Impacts of the Homeshare Victoria program



7. The Australian Aged Care system

Australia has a two-tiered aged care system offering residential and community care. Residential care includes nursing home (high level) and hostel (low level) care. Community care can be provided for people with complex care needs through packages such as Community aged care packages (CACPS) or Linkages. Most community care is provided by the Home and Community Care program (HACC). HACC offers a range of services including home care, personal care, domestic maintenance, meals on wheels and centre based group activities. Funding is not uniform between state and federal governments. Residential care and CACPS are funded by the Commonwealth Department of Health and Ageing (DHA). HACC is administered at the state and local council level but is funded jointly between DHA 60% and Victorian Department of Human Services (DHS) 40%. Veterans and war widows receive community care services that are paid for by the Commonwealth Department of Veterans Affairs (DVA).

Before entering residential care or receiving CACPS, assessment is made by an Aged Care Assessment Team. ACAT teams are made up of doctors, nurses, social workers and other health professionals[10]. HACC services are often received "first come, first served"[11] after assessment of needs by a local assessment officer. Assessing the aged care status of the elderly householders and determining the impacts on clients with limited information is a complex task. As mentioned in section 4.2 all available case managers or associated care workers have been surveyed as to their opinion of the impact of the program. These surveys were combined with match records, coordinator assessment, the desk audit undertaken for DHS and the opinions of family members and the householders themselves. The results are applied to a two-year analysis, refer to section 4.3.

[10] Department of Health and Ageing (2002) *ACAT assessment information sheet*

[11] National Ageing Research Institute and Bundoora Extended Care Centre*, Targeting in the Home and Community Care program*, No.3: Aged and Community Care Service Development and Evaluation Reports, Commonwealth Department of Health and Aged Care, 1999.

8. Department of Health and Ageing

8.1 About residential care and CACPS

Using a scoring and classification scale ACAT teams assess applicants between low level hostel care, level 8 to level 5 to high-level nursing home level 4 to level 1. Providers receive a subsidy in accordance with this classification. The subsidies as at July 2002 are given below.

Table 9. Assessed category & Government subsidy

Level	Subsidy per day ($)	
1	118.14	
2	106.83	High Care
3	91.96	(Nursing Home)
4	65.14	
5	38.11	
6	31.58	Low Care
7	24.24	(Hostel)
8	0	

Subsequently residents are further categorised into groups according to dependence levels. In addition to residential care, applicants may also be eligible for CACPS packages.

8.2 Savings to the Department of Health and Ageing

The program has had an impact on 19 householders relevant to the DHA through either CACPS or residential care. Nine of those householders were also HACC clients and 6 were DVA clients.

Table 10. Savings to the Department of Health and Ageing

	Year 1			Year 2		
Category of Care	**Weighted units PA**	**Subsidised cost per annum ($)**	**Saving Per annum ($)**	**Weighted units PA**	**Subsidised cost per annum ($)**	**Saving Per annum ($)**
CACPS - Value added	5.00	-	-	5.00	-	-
CACPS	0.50	10,700.00	5,350.00	1.00	10,700.00	10,700.00
Nursing Home - Level 1	-	43,121.10	-	-	43,121.10	-
Nursing Home - Level 2	1.00	38,992.95	38,992.95	1.00	38,992.95	38,992.95
Nursing Home - Level 3	-	33,565.40	-	-	33,565.40	-
Nursing Home - Level 4	0.25	23,776.10	5,944.03	1.25	23,776.10	29,720.13
Hostel - Level 5	1.00	13,910.15	13,910.15	-	13,910.15	-
Hostel - Level 6	2.50	11,526.70	28,816.75	3.00	11,526.70	34,580.10
Hostel - Level 7	3.00	8,847.60	26,542.80	3.00	8,847.60	26,542.80
Hostel - Level 8	-	-	-	-	-	-
Residential respite- High	10.00	91.96	919.60	-	91.96	-
Residential respite - Low	-	31.58	-	-	31.58	-
Total savings	-		**119,556.68**			**140,535.98**

Five clients received CACPS and were assessed as would not otherwise have been in residential care in both years. The program added value to their existing care package. One of these assessments was made by the client's case manager

In year 1, two clients were assessed as avoiding high-level residential care, one client only 25% of that year. In year 2 an additional client who avoided low level care in year 1 was reassessed as avoiding high-level care in the year 2. These assessments were made by the clients' caseworkers in each of the three cases.

Seven clients were assessed as avoiding low-level residential care in year 1, one of those clients for only the last half of the first year. The match of another of those clients ended and the client ceased to avoid low-level care. Another client avoided low level care only in year 2. Hence, six clients avoided hostel level care in year 2. One of these clients was concurrently receiving a CACPS package. Three of these assessments were made by the clients' care workers.

One client is known to have continued to avoid a referral to CACPS with several rematches over the period. Savings from reduced usage of residential respite was estimated in two separate cases. In one case this occurred when a client returned from hospital admission. In another case, the client was known to rely on residential respite when family or the homesharer were not available. Most householders have a strong desire to remain at home. As such, no clients were assessed as category 8 hostel care. It is expected that they would not avoid residential care until their care needs are higher.

8.3 Costs to the Department of Health and Ageing

The DHA do not currently fund the program. However it does incur a cost from CACPS packages still received by clients who have been able to remain at home.

Table 11. Costs to the Department of Health and Ageing

		Year 1			Year 2	
	Weighted units per annum	**Subsidised unit cost ($)**	**Cost per annum ($)**	**Weighted units per annum**	**Subsidised unit cost ($)**	**Cost per annum ($)**
Funding						
Recurrent funding	-	-	-	-	-	-
Total funding			**-**			**-**
Community care still received						
CACPS	1.00	10,700.00	(10,700)	1.00	10,700.00	(10,700)
Total cost of care still received			**(10,700)**	-		**(10,700)**
Total cost			**(10,700)**			**(10,700)**

One client was receiving a CACPS package that would have otherwise been in residential care. Hence the cost to DHA is $10,700 in each year.

8.4 Net result – Department of Health and Ageing

The savings to the DHA increase over the two year period. This reflects the changing care needs of clients. Often clients were assessed as spending up to 75% of their time not avoiding residential care. However, as the clients' health deteriorates they could

not remain in the community without the Homeshare program. The homesharer does not provide the care equivalent to a nurse or trained care staff. Rather, a homesharer presence during the night and often during the day, and often combined with qualified community care, maintains the householder in the community.

Table 12. Net result – Department of Health and Ageing

	Year 1	Year 2	Expected average
Total saving from reduced services	119,557	140,536	130,046
Total cost from funding and care still received	(10,700)	(10,700)	(10,700)
			-
Net result	**108,857**	**129,836**	**119,346**

The net saving to the DHA is $108,857 in year 1 and $129,836 in year 2. The expected annual saving is $119,346.

9. Department of Human Services – Home and Community Care

9.1 About the HACC program

HACC services are provided by local government and other organisations.[12] HACC services are important in preventing high cost service usage through hospitalisation and premature residential care entry. Service providers receive fixed funding allocations paid quarterly on a HACC unit cost basis. The savings below are actual known reductions in services. Where available the results of care worker interviews have been used. The savings are not hypothetical and are not assessed care needs that would not actually be provided. HACC has previously funded the pilot on a non-recurrent basis and has recently committed funding on a recurrent basis of $35,000 beginning in the financial year of 2003/04.

9.2 Savings to the Department Human Services – HACC

Fourteen householders were assessed as being relevant to the HACC program. All 14 already received some form of HACC service.

Table 13. Savings to the Victorian HACC program.

	Year 1			Year 2		
	Weighted units per annum	Subsidised unit cost ($)	Savings per annum ($)	Weighted units per annum	Subsidised unit cost ($)	Savings per annum ($)
HACC Value added	13.00	-	-	9.50	-	-
RDNS – Medication prompting	-	55.84	-	-	55.84	-
Delivered meals	-	1.10	-	-	1.10	-
Home care	84.50	22.75	1,922	-	22.75	-
Property maintenance	-	34.00	-	-	34.00	-
Linkages	-	10,700.00	-	-	10,700.00	-
Personal Care	-	26.01	-	-	26.01	-
Respite - In Home	-		-	-		
Respite - In Home	11.00	111.47	1,226	11.00	111.47	1,226
Community based activity	-	1,500.00	-	-	9.50	-
Centre based activity	-	9.50	-	-		
Total saving	-		**3,149**			**1,226**

[12] Department of Health and Ageing (2002) *Home and Community Care information sheet*, p.2.

There were two known cases of reduction in HACC services due to the Homeshare program. Both householders were subsequently assessed by their care workers as likely to be in residential care if not for the program. As a result, both clients were assessed as reducing HACC services by the known reduction in services for half of the first year. The other half of year 1 and all of year 2 would have otherwise been spent in residential care. Two clients were assessed as reducing their usage of overnight respite. Both clients are rematches and considered to have incurred equivalent savings in both years.

Users of this report should also refer to section 10.2 with several DVA clients known to reduce their usage of community care. The saving to HACC is $3,149 per annum in year 1 and $1,226 per annum in year 2.

9.3 Costs to Department of Human Services - HACC

There are two costs to the Department of Human Services - HACC program. The first is the recently committed recurrent funding of $35,000 per annum. The second is that by better achieving HACC objectives and keeping clients out of residential care those clients are still receiving HACC services. Therefore Homeshare shifts costs from DHA back onto HACC. This additional cost to HACC is less than the saving to the DHA and the net effect is a saving to the aged care system. This is further explained in section 9.4 and 17.2

Table 14. Costs to the Department of Human Services – HACC

	Year 1			Year 2		
	Weighted units per annum	**Subsidised unit cost ($)**	**Cost per annum ($)**	**Weighted units per annum**	**Subsidised unit cost ($)**	**Cost per annum ($)**
Funding						
Recurrent funding	1.00	35,000.00	(35,000)	1.00	35,000.00	(35,000)
Total funding			**(35,000)**			**(35,000)**
Community care still received						
RDNS - Medication prompting	-	55.84	-	-	55.84	-
Delivered meals	1,638.00	1.10	(1,802)	2,106.00	1.10	(2,317)
Home care	468.00	22.75	(10,647)	572.00	22.75	(13,013)
Property maintenance	-	34.00	-	-	34.00	-
Linkages	-	10,700.00	-	-	10,700.00	-
Personal Care	573.30	26.01	(14,912)	700.70	26.01	(18,225)
Respite - In Home	-	111.47	-	-	111.47	-
Community based activity	-	1,500.00	-	-	1,500.00	-
Centre based activity	-	9.50	-	-	9.50	-
Personal Alarm	-		-	-		-
Max amount of community care	2.00	10,700.00	(21,400)	2.00	10,700.00	(21,400)
Total cost of care still received			**(48,760)**	-		**(54,955)**
Total cost			**(83,760)**			**(89,955)**

Over the two year period nine clients were still using HACC services while avoiding residential care due to the program. Where the clients current usage of HACC services was known those units were applied as a cost to HACC. If the usage was not known those clients, assessed as being kept out of high-level residential care, were assumed to be using the maximum amount of HACC services. This was approximated as equivalent to a linkages packages at a cost of $10,700 per annum. Those clients who were assessed as avoiding low-level residential were assumed to be using a typical

care plan[13]. This typical care plan was 7 subsidised meals, 2 hours of home care and 2.45 hours of personal care per week. The costs to the HACC program increase with the level of care and number of clients avoiding residential care. The cost to the HACC program is $83,760 per annum in year 1 and $89,955 per annum in year 2.

9.4 Net Result to the Department of Human Services - HACC

With funding of $35,000 per annum the net cost to HACC is $80,612 in year 1 and $88,629 in year 2. The expected net cost is $84,670 per annum.

Table 15. Net result – Department of Human Services - HACC

	Year 1	Year 2	Expected average
Total saving from reduced services	3,149	1,226	2,188
			-
Total cost from funding and care still received	(83,760)	(89,955)	(86,858)
			-
Net result	**(80,611)**	**(88,729)**	**(84,670)**

These results do not suggest that HACC should not support the program. Rather they reflect that Homeshare Victoria shifts costs back on to HACC by better achieving its goal of avoiding premature residential care entry. It is not the aim of Homeshare Victoria to be a substitute for HACC services such as personal care and nursing. Rather, it is the program's aim to maintain householders longer in their homes through offering a service type that could not be otherwise provided. It is not feasible for HACC to subsidise an equivalent level of support through overnight respite. Homeshare Victoria is achieving the objectives of HACC more effectively by maintaining people in their homes when traditional services could not. This is not reflected in direct savings to HACC but in the savings to the DHA and the benefits received by the householders themselves. By not supporting the program, HACC would be essentially shifting costs to the DHA with a net loss to the aged care system and society.

[13] Bayside Community Options (2002), *Desktop Audit of Homeshare Householders*. Department of Human Services – HACC.

10. Department of Veterans Affairs - Veterans Home care

10.1 About DVA - Veterans home care

As part of a range of service to veterans and their widows the DVA provides subsidised community care. The DVA, through its community grants provided $25,000 in June 2000 towards the establishment of Homeshare Victoria. It has also provided approximately $32,000 for a promotional video. Seven of the 32 householders have been DVA clients and the impact on them is similar to all clients.

10.2 Savings to DVA- Veterans home care

Seven householders were DVA clients, one of whom was receiving a CACPS package. The care staff of 6 DVA clients were surveyed and all clients were assessed as otherwise in residential care during some part of their time in the program. One client was known to have significantly reduced services including high cost services such as RDNS nursing. This client was also assessed to be otherwise in high level residential care for the later 25% of match duration.

Table 16. Savings to the Department of Veterans Affairs

	Year 1			Year 2		
Category of care	**Total weighted units**	**Subsidised unit cost ($)**	**Savings per annum ($)**	**Total weighted units**	**Subsidised unit cost ($)**	**Savings per annum ($)**
RDNS – Medication prompting	78	55.84	4,356	78	55.84	4,356
Delivered meals	273	1.10	300	273	1.10	300
Home care	97.5	22.75	2,218	97.5	22.75	2,218
Property maintenance	0	34.00	-	0	34.00	-
Linkages	0	10,700.00	-	0	10,700.00	-
Personal Care	0	26.01	-	0	26.01	-
Respite- DVA entitlement	76	111.47	8,472	20	111.47	2,229
Community based activity	0	-	-	0	-	-
Centre based activity	0	9.50	-	0	9.50	-
Personal Alarm	0	-	-	0	-	-
Total savings			**15,346**			**9,103**

10.3 Costs to DVA - Veterans home care

The program has contributed to keeping several DVA clients out of residential care. However in a similar manner to HACC clients this results in the continuation of subsidised care. This cost would have otherwise been shifted to DHA. It is not known whether DVA will continue to fund the program and it will be assumed that they will not.

Table 17. Costs to DVA home care

	Year 1			Year 2		
	Weighted units per annum	Subsidised unit cost ($)	Cost per annum ($)	Weighted units per annum	Subsidised unit cost ($)	Cost per annum ($)
Community care still received						
RDNS - Medication prompting	-	55.84	-	-	55.84	-
Delivered meals	182.00	1.10	(200)	416.00	1.10	(458)
Home care	52.00	22.75	(1,183)	104.00	22.75	(2,366)
Property maintenance	-	34.00	-	-	34.00	-
Linkages	-	10,700.00	-	-	10,700.00	-
Personal Care	63.70	26.01	(1,657)	127.40	26.01	(3,314)
Respite - In Home	-	111.47	-	-	111.47	-
Community based activity	-	1,500.00	-	-	1,500.00	-
Centre based activity	-	9.50	-	-	9.50	-
Personal Alarm	-		-	-		-
Max amount of community care	0.25	10,700.00	(2,675)	0.25	10,700.00	(2,675)
Total cost	-	10,700.00	**(5,715)**	-		**(8,812)**

The cost to DVA from care still received is $5,715 in year 1 and $8,812 in year 2.

10.4 Net results to Department of Veterans Affairs – Home Care

The net result to DVA home care is a saving $9,631 in year 1 and $291 in year 2. The expected annual saving is $4,961. Between year 1 and year 2 the savings fall and costs increase. This highlights that as the program helps sustain higher care needs the saving from reduced community care falls while the cost of care still provided to clients otherwise in higher levels of residential care increases.

Table 18. Net result for the Department of Veterans Affairs

	Year 1	Year 2	Expected average
Total saving from reduced services	15,346	9,103	12,225
			-
Total cost from funding and care still received	(5,715)	(8,812)	(7,264)
			-
Net result	**9,631**	**291**	**4,961**

11. Victorian Hospitals

Hospitals are funded and administered by the state government with federal/state tax sharing arrangements. Hospitals receive funding on a case-mix or DRG basis. AR-DRG or Australian Related - Diagnosis Related Group is a character patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital[14]. It is not known if admissions were to private or public hospitals and as their costs differ the report will assume that all admissions were to public hospitals.

The program impacts upon the Hospital system by allowing householders to be discharged early. In many cases doctors have allowed the householder to return home because of the presence and supervision of a homesharer. This early discharge generates savings by reducing the hospital days per admission. When a householder returns home, they do so during their recovery period. As such the average cost per DRG would overstate the savings by including all relevant costs rather than those relating to the last days of admission. To allow for this the following adjustments were made. Firstly the costs of pathology, imaging, critical care, operating rooms, emergency departments, specialist procedure suites and prostheses were removed from the total average per DRG cost. The remaining sum of long stay costs was then taken as a percentage of the total costs. That weighting was then applied to the DRG cost per day (average total DRG cost divided by the average length of stay). Due to the limited information it was not known whether the admission involved catastrophic or severe complications. As a result an average long stay cost for different types of admission was calculated. This involved weighting the DRG's by the proportionate number of separations, thus deriving a weighted average cost of long stay day saved[15].

Table 19. Average long stay day savings over entire 29 month life of program

Weighted AR DRG by case	No. of days	Average cost per long stay day saved $	Total	% otherwise in RC	Weighted saving
Other after care	14	432.33	6,053	100%	0
Average heart related	7	433.19	3,032	25%	2,274
Bronchial related	7	492.82	3,450	25%	2,587
Other after care	21	432.33	9,079	75%	2,270
Other after care	7	432.33	3,026	75%	757
Angina related	7	417.43	2,922	0%	2,922
Lung disease related	28	473.48	13,257	0%	13,257
Other after care	7	432.33	3,026	75%	757
Other after care	7	432.33	3,026	75%	757
Total saving			**46,872**		**25,580**
Savings applied to two year analysis			**38,790**		**21,170**
Savings per annum			**19,395**		**10,585**

At least 7 clients were known to have been able to return home early due to a homesharer presence. Most admissions were heart related with one client returning

[14] Department of Health and Ageing (2002), National Hospital Cost Data Collection Hospital Reference Manual Round 5 (2000-01).

[15] I am indebted to the help of Terri Jackson of the Health Economics Unit, Centre for Health Program Evaluation for her guidance in this area.

home after surgery. Other clients were known to have lung cancer and bronchial related problems. In cases where the details of the clients admission was not known in sufficient detail a reduction in the lower cost weighted DRG of other after care is assumed. Over the 29 months of operation the savings were conservatively estimated as $46,872. Many householders, assessed as reducing hospital usage were also assessed as otherwise in residential care. It is reasonable to expect that if in residential care, those clients would have been able reduce hospital time. Hence, the estimated savings per case has been weighted and reduced by the amount of time otherwise spent in residential care. The weighted saving over 29 months is $25,580. Applied proportionately over the two-year analysis is $21,170 or $10,585 in net savings per annum.

12. Case studies reflecting health outcomes

12.1 High level DVA client

This client suffered from lung cancer and was able to return from hospital when the match began. It is likely that this client was kept out of hospital the entire 11 weeks of the match. Eventually care needs became too great. Arrangements were made for the householder to return to Hospital the day the homesharer left. Being at home to celebrate her birthday was very important to this client and the program allowed her to spend an additional 11 weeks at home. She later died in hospital five months after the match ended. A conservative estimate is that the client avoided a minimum of 4 weeks in hospital, 28 days of DVA subsidised overnight respite and 10 days of high-level residential respite. In total this represents 66 days of care saved. The remaining 11 days would have otherwise been spent at home at risk. Inconsistent with the methodology applied to other matches these saving were not applied across the two-year period. Subsidised overnight or residential respite would not have continued for a sustained period. Hence the savings are limited to what would have normally been provided. Matches involving such high care needs are an exception. Hence the evaluation has included one match lasting 11 weeks and occurring once every two-year period.

12. 2 HACC/Residential care client with deteriorating health

This match is still in place and has lasted 50 weeks. The client entered the program with problems such as sleeping difficulties, safety issues and a heavy reliance on family members. The client was receiving 2 hours of home care per week. After the match began the client first reduced home care to 1.5 hours per fortnight and subsequently cancelled all usage. Over the length of the match the client's health has deteriorated and was eligible for low to high level residential care. The report has conservatively assessed the client as follows: Reducing 2 hours of home care for 50% or 26 weeks of year 1. For the remaining 50% of year 1 and 100% of year 2 the client is assessed as otherwise in category 7 - hostel care. It is assumed that as the client's health deteriorated they would once again require HACC services. This is assumed to be a typical care plan of 2 hours home care, 2.45 hours personal care and 7 meals a per week. This client is also known to have reduced a hospital admission by a week. The reason for admission was not known in detail and was estimated as 7 days of other after care saved. This client has recently purchased a daily carer from 10am to

4pm Monday to Friday. Accordingly, the cost to HACC from a typical care still received will be overstated. This cost has not been removed and highlights the conservative methodology applied to the evaluation. In addition, the purchase of a daily carer does not imply the client is not avoiding residential care. The homesharer remains an important aspect of this clients care providing an overnight and weekend presence. Without the homesharer the burden on family members would be too great and the client would enter residential care.

12.3 HACC relevant client with high care needs- not reducing service usage

This client has been involved in the program for 28 months with two matches. The first match lasted for 66 weeks and the second current match has been in place for 29 weeks. This client suffers from Parkinson's Disease and also employs a live in carer on weekdays. The main reason for entering the program was companionship and the need for weekend carer respite. The client has used HACC services in the past but currently does not. It is difficult to determine if this is due to the live in carer or homesharer. It seems reasonable to assume that the client would have used additional carer respite if not for the homesharer. However, as this is not known it has been conservatively assumed that it has not. This case exemplifies that even where householders do not reduce usage of HACC services or avoid residential care the homesharer presence has a significant impact on their ability to maintain independence at home and not rely on family support.

13. Householders and their Families

13.1 About householders

All survey participants stated that their quality of life had improved from being in the program. Respondents stated an average rating scale improvement of 8.75 (see survey questionnaire in appendix). Several householders described heart problems and anxiety about being left alone. As such, having someone in the house overnight was most important. Second in importance was the informal care provided by the homesharer. Domestic help, gardening, shopping, cooking and assistance with health issues were identified as important. Equally important was the householder's family being reassured of their safety. All but one survey respondent had a family member actively involved in arranging the match.

Table 20. Summary of householder survey results

Category of Benefit/Cost	Yes	No	Total or Amount ($)
Rating Scale			8.75
Current usage of HACC	7	1	
Otherwise in residential care	5	3	
Otherwise rented room	1	7	$80
Homesharer Service	8	0	
Gardening	4	4	
Shopping	2	6	
Domestic help	6	2	
Cooking	3	5	
Assistance with health issues	2	6	
Overnight support	7	1	
Improved Health & Nutrition	2	6	
Family reassurance	7	1	

Montague (2001) has described the motivation and precipitating factor for application and highlights other social benefits to participants [16]

Primary reason for interest		Precipitating factor for application	
Concern about security or safety	14	Steady decline in health	15
Desire for companionship	13	Health crisis/hospital admission	17
Need for assistance with household tasks	8	Breakdown of existing support	8
Family pressure/family concern	7	Incapacity of death of spouse/carer	3
Desire to stay in/return to own home	7	Increasing family concern	4
Desire for live-in help	6	No clear factor	5
Desire to maintain independence	2	Other	2
Other	3	Not specified	8
Not specified	2		

Source: Montague, 2001 n=62

[16] Montague, M , *op.cit.*

13.2 Benefits for householders

There is no market for homesharer presence and care, and its valuation must be estimated. However, other markets offer some guidance of a consumer's willingness to pay. Private service providers offer HACC services on a full fee basis at $79.50 and $110 for 8 and 10 hour sleepovers and $292 for a 24 hour live in. Personal and domestic care can be purchased for $26.50 per hour. This market reflects care that is provided by trained and qualified support staff and is not a substitute. The closest market for homesharer care and presence is that for an unqualified live in carer. An unqualified live in carer can be purchased through privately run matching and screening agencies. The quoted prices for an unqualified live in carer who has been matched and screened through an agency were as follows:

Agency 1 provided carers who have separate part-time jobs during the day. They offered the security of having someone overnight as well as a few hours care per day paid at an hourly rate. This would cost $300- $350 per week for presence in the home and $16-17 per hour for direct work. This does not include a once off fee paid directly to the agency. Agency 2 provided carers who would be available most of the time. The quoted rates were between $80 to $100 per day. This does not include a fee paid directly to the agency. The flat fee payable to the agency for arranging the match was $280. Both offered temporary stays at much higher rates of between $80 to $150 per night.

It is not the objective of the Homeshare program to be a substitute for the live in carer market or the qualified support services market. However, a full time live in carer is the next best alternative to a homesharer. At $350 per week for presence in the home without directly providing any care the expectations of a live in carer would be greater than that of a homesharer. Therefore, a higher level of care than that from homesharer presence can be purchased for $350 per week. Hence, $350 per week or $50 per day is the maximum willingness to pay for a homesharer's presence. At that price a householder could receive a higher level of care from a live in carer. Conversely, householders are currently receiving a week of homesharer presence for $0. This represents the minimum willingness to pay. Hence, the market demand for homesharer presence can be estimated and is shown diagrammatically below.

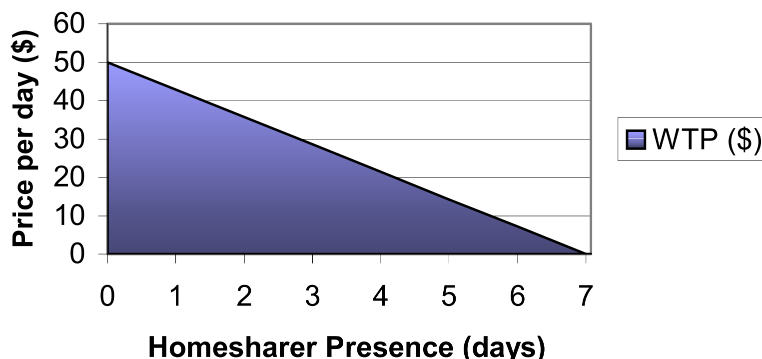


Figure 5. Market for homesharer presence (not including direct care)

The area under the demand curve is the householder's willingness to pay for a day of homesharer presence and represents its economic value. The value of a week of

homesharer presence is $175. This represents $9,100 per client per year and $291,200 per program.

Homesharer help comprises a number of services such as cleaning, gardening, care of pets, shopping, short trips and direct health related assistance. Research has shown that the notional 10 hours of help around the home is a combination of the direct care and companionship in the form of sharing meals, watching TV etc. It is estimated that the notional 10 hours is divided 50/50 between direct care and companionship. The 50% spent in companionship is implicitly incorporated in the already measured value of homesharer presence. The remaining 5 hours of direct care can be valued in a similar manner to that of homesharer presence. However, in contrast to homesharer presence the direct care provided by a homesharer is the equivalent to direct hours of care provided by a live in carer. Both homesharers and live-carers are unqualified and provide the same care types and can be purchased for $16 per hour. The next better alternative to an unqualified live in carer or homesharer is directly purchasing qualified care workers. The quoted rate for private purchases from service providers is $26.50 per hour. This is the maximum willingness to pay and represents the price where a consumer would not purchase live in carer or homesharer hours. Rather the consumer would be better off purchasing a qualified care worker from a service provider. Householders currently pay $0 and consume 5 hour of direct care per week. This is a minimum willingness to pay. (Some householders actually pay through providing accommodation. This is discussed in section 13.4) Using this information the market demand for direct homesharer care can be estimated and is shown diagrammatically below.

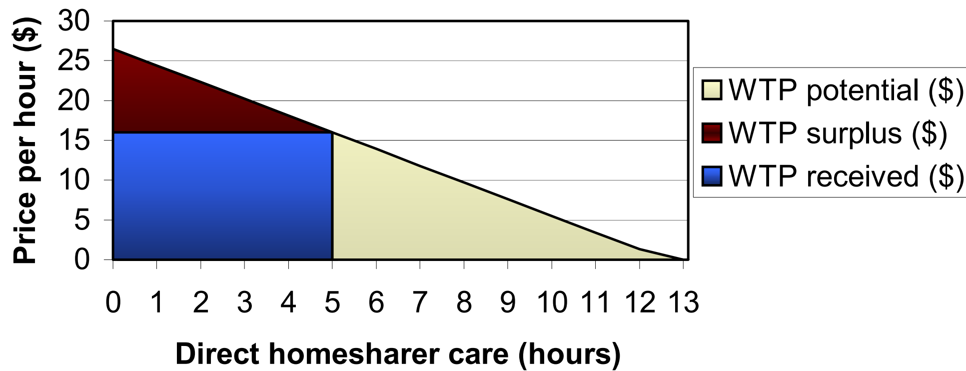


Figure 6. Market demand for direct homesharer care hours

The willingness to pay surplus and willingness to pay received represents the economic value to householders. Willingness to pay potential represents the economic value if additional units were received and is not relevant to the evaluation. The value to householder is the WTP received of $80 plus the surplus WTP of $66.25. The total value per week is $146.25. This represents $7,605 per annum and $243,360 per 32 match year of operation.

Most aged care services attract user fees and by deferring or reducing their usage householders benefit from significant savings. The majority of householders receive a

full or part aged pension and own their own homes. Hence, in estimating their savings all are assumed to be asset rich, full aged pensioners. The costs of entering low level residential care as at 30th June 2002 is as follows[17]:

A full aged pensioner would typically pay a daily care fee of $24.63 per day. If they provide an accommodation bond greater than $105,500 the basic daily care fee would increase to the non-pensioner rate of $30.76 per day. Householders typically own their homes or apartments and it is assumed that all pay an accommodation bond greater than $105,500. Providers take from this accommodation bond the maximum retention amount of $246 per month or $2,952 per annum for up to five years. Therefore, householders who defer entry to low-level hostel care would save $14,180 per annum. In year 1, 6.5 clients were assessed as avoiding hostel level care. This represents a saving of $92,170. In year 2, 6 clients were assessed as avoiding hostel level care representing a saving of $85,080.

The fees for a full pensioner entering high-level nursing home care also include a daily care fee of $24.63 per day. However no accommodation bond is paid. Clients with net assets greater than $51,000 pay an additional accommodation charge of $13.45 per day. This is a total cost of $38.08 per day or $13,890 per annum. In year 1, 1.25 clients were assessed as avoiding high-level care and saved $17,363. In year 2, 2.25 clients were assessed as avoiding high-level care, which represented a saving of $31,253

The usage of HACC and DVA community care also attracts user fees. The savings to HACC clients are $448 in year 1 and $110 in year 2. The savings to DVA clients were $2,885 in year 1 and $2,325 in year 2.

Most participants, estimated at 90% benefited from sharing utility bills. Survey participants estimated savings of around $25 per week or $1,300 per annum for utilities. This represents a saving of $37,700 for a 32 match program. Less matches, 20% or 6 clients benefited from reduced food expenses. Survey participants estimated $5 per week or $260 per annum from saved food expenses. This represents $1,560 for a 32 match program.

13.3 Intangible benefits to householders

Most householders have family members who benefit from the reassurance of knowing someone is with their elderly parents. In essence family reassurance is an external benefit accruing to family members from the householders own usage of care. However, family members often take an active role in facilitating a match. As such some of the benefit to family members may be implicitly incorporated in the householders benefit. Attempting to directly measure the family benefit would risk double counting.

Benefits such as increased independence and the ability to remain at home are very important quality of life improvements from participation. Benefits of this nature are a result of receiving homesharer care and presence. They are represented in the demand

[17] Department of Health and Ageing (2002) – *Residential care fees and charges information sheets*, p.10-18.

and willingness to pay for those services and separate measurement would lead to double counting.

13.4 Costs to householders

Most participants stated that they would not have otherwise rented out the room in the house. As a result giving up a room is not a true cost. The room is effectively an unemployed resource and there is not an associated cost from its consumption. Those householders who would have otherwise rented a room are incurring a cost because they forego rent by having a homesharer. Two householders were known to fit this category. The householder who participated in the survey stated foregone rent of $80 per week. This represents a cost of $4,160 per annum. Assuming an equivalent cost for the other householder it represents a cost for 32 match program of $8,320 per annum.

13.5 Net result to householders

The program generates net benefits to the householders of $678,366 in year 1 and $684,268 in year 2. This is significantly higher than that of the homesharers and is reflected by a large waiting list of potential householders compared with an undersupply of homesharers. This result is consistent with the ratings scale average of 8.75 with all householders describing improved quality of life.

Table 21. Benefits and costs to householders

	Year 1			Year 2		
Category of Cost or Benefit	**Clients**	**Unit value per annum ($)**	**Total year 1 ($)**	**Clients**	**Unit value per annum ($)**	**Total year 2 ($)**
Benefits						
Homesharer presence during the day and overnight	32	9,100	291,200	32	9,100	291,200
Direct homesharer care	32	7,605	243,360	32	7,605	243,360
Saving from not entering high level residential care	1.25	13,890	17,363	2.25	13,890	31,253
Saving from not entering low level residential care	6.5	14,180	92,170	6	14,180	85,080
Saving from non-contribution to HACC	1	448	448	1	110	110
Saving from non-contribution to DVA community care	1	2,885	2,885	1	2,325	2,325
Saving from shared utilities	29	1,300	37,700	29	1,300	37,700
Saving from shared food expenses	6	260	1,560	6	260	1,560
Total Benefits			**686,686**			**692,588**
Costs						
Foregone rent on room	2	4,160	(8,320)	2	4,160	(8,320)
Total Costs			**(8,320)**			**(8,320)**
						-
Net Benefit			**678,366**			**684,268**

14. Homesharers

14.1 About homesharers

There is large variation in homesharer characteristics. The sample of 39 homesharers can be grouped into four main categories.

International Student	37%
Country student	16%
Mature aged person	38%
Older homesharer	8%

Survey participants indicated friendship and savings on accommodation as the most important benefits from participation. Four respondents stated that their quality of life had improved and the other three that their quality of life was about the same. The average rating scale was 6.5 (see appendix 3 for rating scale). All respondents emphasised that although they had benefited from participation they also lost some independence and provided 10 hours of notional care.

Table 22. Homesharer survey results

Category of Benefit/Cost	Yes	No	Average or Amount ($)
Rating Scale			6.5
Otherwise in student accommodation	0	7	
Otherwise in shared accommodation	2	5	$90 pw
Otherwise renting private accommodation	5	2	$130 pw
Opportunity to save	2	5	
Reduced independence	7	0	
Direct care	7	0	
Cultural and language assistance	2	5	
Friendship	6	1	
Family environment	5	2	
Stability during personal/financial hardship	2	5	
Health and nutrition	1	6	
Family reassurance	4	3	

For detailed research in social aspects of homesharing see Montague (2001). The primary reason for interest in homesharing was taken from 116 telephone interview records[18].

Desire to assist older people and enjoy the company of older people	28
Financial benefit	27
Need for housing	25
Desire for companionship in a shared or family like environment	16
Opportunity to provide community service	6
Other	4
Not specified	10

Source: Montague (2001)

Homesharer experiences vary between matches. Those with similar characteristics tend to value the same things. International students benefit from free, reasonable

[18] Montague, M, *op cit*.

quality accommodation, cultural and language assistance, quiet and friendly family environment and family reassurance of their safety. Country students also identified free, reasonable quality accommodation, quiet and friendly family environment, and family reassurance of their safety. Mature aged homesharers identified free, reasonable quality accommodation, and opportunity to save for own home, stability during financial instability or personal hardship, and a friendly family environment. For older homesharers consistent factors were financial instability and a need for companionship.

14.2 Benefits to homesharers

The main reason for homesharers entering the program is accommodation related. This includes savings on rent, reasonable quality and conveniently located accommodation. Most international students would have lived in student accommodation, rented an apartment or lived in shared housing. Adjusting for meals and utilities the average rent saved was $95. Country students would have lived in similar accommodation but were more likely to share housing with an average rent of $87.50. Mature aged homesharers would not otherwise share and typically rented one or two bedroom apartments or town houses. Their average rent saved was $172 per week. The weighted average rent saved is $130 per week. This represents savings per homesharer of $6,760 per annum and $216,320 for a 32 match program.

Table 23. Savings on rent and higher quality accommodation premium

Category	% of HS	Accommodation	Av. Rent saved ($)	Average value of accommodation across matches	Quality premium ($)
International Student	37%	Student/Renting/Shared	95	120	25
Country Student	16%	Student/Shared/Renting	87.5	120	32.5
Mature Aged/ Older	47%	Renting	172	120	-52
		Weighted average	**130**		**14.45**

In assessing the suitability of accommodation the Homeshare co-ordinator considers not only the number of bedrooms but also the quality of facilities, size of living areas and layout. Householder homes tend to be of a higher quality than what would have otherwise been rented. As such the average (or per person) value of the accommodation is higher than the rent saved. The difference between average or per person value of accommodation and rent saved is best described as a quality premium.

The majority of matches have been in the MECWA serviced areas of Stonnington, Port Phillip and Glen Eira. A few matches have also been made in the areas of Monash, Bayside and Melbourne City. The 31 homes or units that have been offered by householders are summarised by four main groups. Three bedroom in Stonnington, Port Phillip, Glen Eira or Bayside. Two bedroom in Stonnington, Port Phillip, Glen Eira or Bayside. Three bedroom in Monash and two bedroom other.

Table 24. Accommodation offered to homesharers

Type of accommodation	Number	Average rent per dwelling ($)	Rent per resident ($)
Stonnington, Port Phillip, Glen Eira or Bayside - 3 bedroom	14	260	130
Stonnington, Port Phillip, Glen Eira or Bayside - 2 bedroom	12	240	120
Monash - 3 bedroom	3	230	115
Other - 2 bedroom	1	230	115
Other (Public housing)	1		
Average across matches			**120**

The average rent per dwelling was based on equivalent quoted rental vacancies on <**http://www.domain.com.au** >.

With an average saving of $95 per week international students enjoy a quality premium of $25 per week. Country students with an average rent saving of $87.50 benefit from a quality premium of $32.50. Mature aged homesharers have an effective negative premium as the rent saved is less than the value of accommodation received. This does not reflect lower quality homesharer accommodation rather benefits from scale where the average cost or cost per person of sharing a large house is less than the average cost or per person cost of renting a small apartment. As such the premium for mature aged homesharers is assumed to be zero. The weighted average quality premium including a zero mature aged premium is 14.45 per week across all matches. This is equivalent to $751 per annum or $24,032 for a 32 match program.

Several mature aged homesharers identified the opportunity to save for their own home was important. This was conservatively estimated as six homesharers, half of the mature aged homesharers. This benefit is measured by the interest earned on those savings. This was calculated using a standard annuity formula with an interest rate of 4.5% per annum, compounding monthly on $350 of rent savings added to savings per month. The interest on these savings is $86 per annum and $516 per program.

While householders saved from sharing utilities most homesharers would have otherwise shared accommodation anyway. It is assumed that those homesharers most likely to be renting alone are mature aged, which is 47% or 15 clients. Survey participants estimated savings of around $25 per week, $1,300 per annum for utilities. This represents a saving of $19,500 from the 19 clients. Fewer matches, 10% or 3 clients benefited from reduced food expenses.. Survey participants estimated $5 per week, $260 per annum from saved food expenses. This represents $780 for a 32 match program.

14.3 Intangible benefits to homesharers

Most homesharers improved some intangible aspect of their quality of life. Some of these intangible benefits are listed below:

- Friendly family environment
- Quiet accommodation when studying

- Cultural and language assistance
- Secure accommodation during financial difficulty
- Stability during personal hardship
- Health and nutrition

A good example of an intangible benefit is international students benefiting from cultural and language assistance. This assistance varied between helping with uni assignments to learning Australian colloquialism such as "G'day" and "bloke".[19]

Ideally all of these benefits could be measured reliably through stated preferences techniques. It is the view of this report that such methods cannot provide reliable valuations and including them may mislead the users of the report. Intangible benefits are important aspects of the program and should not be ignored simply because they cannot be reliably valued in monetary terms. Indeed the matching of international, regional and other homesharers with the frail elderly contributes to an improvement in social wellbeing.

14.4 Costs to homesharers

All survey participants stated that although they benefit from savings on accommodation they do so in exchange for their time, care and independence. As outlined in section 13.2 what the homesharer provides is a combination of companionship, presence in the home and direct care. The notional 10 hours homesharer help tends to be split between 5 hours of direct care and 5 hours of companionship. The market price of an hour of homesharer care is $16 per hour as seen in the unqualified live in carer market. This represents supply of homesharer time as determined by willingness to accept in compensation. The supply of this homesharer time is assumed to be perfectly horizontal and shown diagrammatically below.

[19] Homeshare Victoria (2002) *Homeshare Victoria Video*

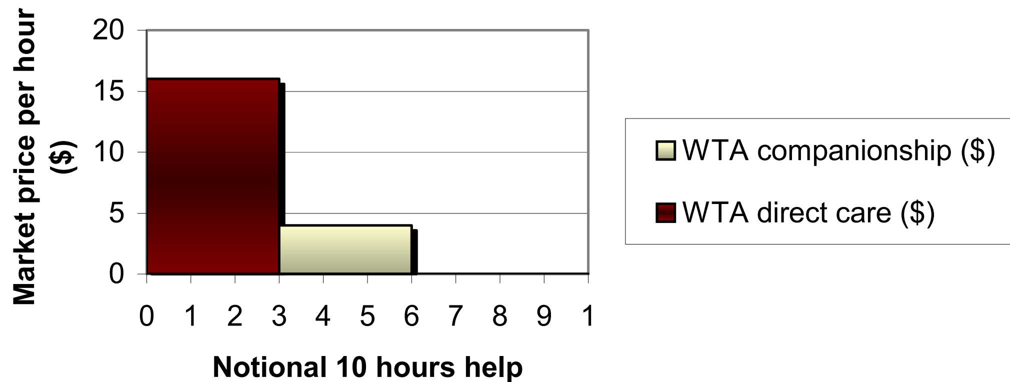


Figure 7. Supply and cost of the notional 10 hours of homesharer help

Although homesharers offer an average notional 10 hours of service per week most have stated they would have done most of these tasks anyway. Therefore, two hours of the direct care received by the householder are assumed to be tasks such as vacuuming and other domestic help that the homesharer would have done anyway. This is not a cost to the homesharer. In addition two of the five hours of companionship are assumed to be doing things such as watching TV that the homesharer also would have done anyway. Therefore, there are actually 6 additional hours given up, 3 in direct care and 3 in additional companionship. Companionship incurs no direct cost apart from reduced leisure time. The literature on valuing leisure time suggests savings or losses of leisure time should be valued at 40% of earnings[20]. Assuming that the market for unqualified care reflects homesharer earnings capacity the reduction in leisure time due to additional companionship is worth $6.40 per hour. This represents $19 per week, $998 per annum and $31,948 per year of 32 match program. The 3 hours spent in direct care that would not have otherwise been incurred is valued at the market rate for unqualified care of $16 per hour. This is the equivalent to $48 per week, $2,496 per annum and $79,972 per year of 32 match program.

[20] Layard and Glaister (eds), *Cost Benefit Analysis*, 2nd edn, Cambridge University Press.

14.4 Net result to homesharers

The program generates a net benefit to homesharers of $182,836 in both years. This is significantly less than the net benefit to householders and is not unexpected. Householders provide an asset which would not otherwise have been used while homesharers provide a notional 10 hours of help, giving up an additional 3 hours direct care and 3 hours of leisure time. This result is also consistent with the rating scale given by survey participants.

Table 25. Benefits and costs to the homesharer

		Year 1			Year 2	
Category of Cost or Benefit	**Clients**	**Unit value per annum ($)**	**Total year 1 ($)**	**Clients**	**Unit value per annum ($)**	**Total year 2 ($)**
Benefits						
Savings on accommodation	32	6,760	216,320	32	6,760	216,320
Quality premium	32	751	24,032	32	751	24,032
Interest on savings	6	86	516	6	86	516
Savings from shared utilities	15	1,300	19,500	15	1,300	19,500
Savings from shared food expenses	3	780	2,340	3	780	2,340
Total Benefits			**262,708**			**262,708**
Costs						
Direct homesharer care	32	2,496	- 79,872	32	2,496	- 79,872
Foregone leisure time	32	998	- 31,936	32	998	- 31,936
Total Costs			**- 111,808**			**- 111,808**
						-
Net Benefit			**150,900**			**150,900**

15. Philanthropists

Philanthropists are an important contributor to all community organisations. Homeshare Victoria is not an exception with philanthropic funding accounting for a significant proportion of program income. It is hoped this funding will continue in the future. Approximately $30,000 per annum will be sought.

Most philanthropic trusts have their own objectives and target groups. Those target groups reflected in Homeshare clients relevant to one such trust are:

- Persons over 60 years of age
- Those in need of companionship, advice, transport or entertainment
- Those unable to meet their needs from their own resources
- Aged support groups

Table 26. Benefits and costs to philanthropists

	Year 1			Year 2		
Category of Cost or Benefit	**Clients**	**Unit value per annum ($)**	**Total year 1 ($)**	**Clients**	**Unit value per annum ($)**	**Total year 2 ($)**
Benefits						
Philanthropic objectives achieved	32	-	-	32	-	-
Costs						
Donations and Grants	32	30,000	**(30,000)**	32	30,000	**(30,000)**

16. Net benefit to society

If the program receives HACC funding of $35,000 and $30,000 from philanthropists per annum it will have a funding shortage of $30,270. Homeshare Victoria intends to seek this at least from the Department of Health and Ageing as well as participant fees. This deficiency will be referred to as a cost from other sources.

Homeshare Victoria generates a net saving to the Health and Aged care system of $48,461 in year 1 and $51,983 in year 2. The expected annual saving is $50,222. DHS-HACC is a net loser in both periods and DHA, DVA and Victorian hospitals are net gainers. Refer to section 18 for further discussion.

Participants are the major beneficiaries of the program. Each householder receives a net benefit of $21,198 in year 1 and $21,383 in year 2. The expected annual benefit is $21,291 per householder or $681,317 per program. Homesharers receive an annual benefit of $150,900 per program. This equates to $4,716 per homesharer.

The program will continue to rely on grants and donations from philanthropists. The remaining operating costs will be funded from other sources. The cost of covering operating costs not funded by HACC is $60,270 per annum.

The program's impact on society is the sum of benefits and costs accruing to the different parties. This is $817,457 in year 1 and $826,881 in year 2. The expected annual benefit to society is $822,169. The two years have a net present value of $1,553,378.

Table 27. Net benefit to society

	Net Result Year 1	Net result Year 2	Expected average	Per Match	Two year NPV @ 6%
DHA	108,857	129,836	119,347	3,730	224,411
HACC	(80,612)	(88,729)	(84,671)	(2,646)	(159,580)
DVA	9,631	291	4,961	155	9,890
Aged Care total	**37,876**	**41,398**	**39,637**	**1,239**	**74,720**
Hospital	10,585	10,585	10,585	331	20,006
Health and Aged total	**48,461**	**51,983**	**50,222**	**1,569**	**94,726**
Householder	678,366	684,268	681,317	21,291	1,287,362
Homesharer	150,900	150,900	150,900	4,716	285,200
Participants total	**829,266**	**835,168**	**832,217**	**26,007**	**1,572,563**
Philanthropists	(30,000)	(30,000)	(30,000)	(938)	(56,700)
Other sources	(30,270)	(30,270)	(30,270)	(946)	(57,210)
Philanthropists & Other total	**(60,270)**	**(60,270)**	**(60,270)**	**(1,883)**	**(113,910)**
Net Benefit to Society	**817,457**	**826,881**	**822,169**	**25,693**	**1,553,378**

17. Recommendations and Conclusions

17.1 Recommendation 1 – Introduction of participant fees

- Homeshare Victoria should introduce fees to participants. This could include a once off matching fee, monitoring fee or a combination of both.

Currently, the biggest beneficiaries of the program are the participants. Participants pay each other through barter but do not pay the program for facilitating or monitoring the match. Benefits have been measured by willingness to pay and the program should be able to charge fees up to that amount. The present value of two years of benefits accruing to a householder is $40,594. The present value of two years of match in residence to a homesharer is $10,896. If the program could guarantee a workable two year match this would represent a maximum once off matching fee. Householders benefit 3.72 times more than homesharers. Therefore, fees to homesharers should be 3.72 times less or 27% of that charged to householders.

If no additional funding is received and philanthropists maintain donations, the program has a funding shortage of $30,270 per annum. If the program introduces a monitoring fee at capacity a minimum of $945 per match would need to be charged. To avoid distorting incentives for entering the program, the fees should be split according to benefits. Homesharers should be charged a monitoring fee of $255 per annum or $22 per month in residence. Householders would pay a monitoring fee of $690 per annum or $58 per month. Prior to reaching capacity a monitoring fee to cover costs between December 2002 and December 2003 is $1,187 per match. Split according to benefits homesharers should pay a monitoring fee of $320 per annum or $27 per month. Householders should pay a monitoring fee of $867 per annum or $72 per month.

At capacity the growth in new matches will slow to 8.64 new matches per annum. If the program chooses to introduce a once off matching fee, $3,504 per new match would need to be charged in order to cover costs. Split according to benefits this represents a once off matching fee of $946 per homesharer and $2,558 per householder. During the year leading up to capacity, the program is expected is make 21 new matches. To cover costs $1,442 per new match would need to be charged. Split according to benefits this represents a once off matching fee of $389 per homesharer and $1,053 per householder.

The program generates value by allowing participants to meet and benefit from exchange. Participants are dependent on the program in achieving their goals. If clients could meet, screen and match themselves these fees could not be charged and the program would have no reason for existing. However risk, uncertainty and imperfect information means that participants cannot do this and reflects the reason why the program exists.

17.2 Recommendation 2 – Funding

- HACC continue to fund the program.

All traditional HACC funded community care is a cost to HACC that generates savings to the DHA. Community care is less expensive than residential care and the net effect is savings to the aged care system. The Homeshare program is no exception. It generates negligible savings to HACC or DVA community care. The main reason for this is that case managers and care workers make care decisions independent of the Homeshare program and do not expect homesharers to replace their own trained care workers. Case managers provide a maximum amount of care based on the needs of clients, subject to their constraints of limited funds. This however does not mean that the Homeshare program is not meeting its own or HACC's objectives. The stated aim of HACC is to "assist people to be more independent at home and in the community… preventing inappropriate admission to long term residential care and to enhance the consumers quality of life.[21]" Homeshare is achieving that aim in a way that the existing service system cannot.

The program has been criticised for giving householders greater than equitable share of HACC funding[22]. It is true that householders indirectly receive additional HACC but in doing so they are generating a net saving to the aged care system. Without the program this saving will be foregone. This represents a reduction in other services that would otherwise have been provided. If the program ceased to exist HACC would save by reducing its costs. However, in doing so the Department of Health and Ageing would face increased costs, as would the Department of Veterans Affairs and Victorian hospitals. The net effect would be increased costs to the overall system.

- Homeshare Victoria should pursue additional funding from the Commonwealth Department of Health and Ageing and Department of Veterans Affairs.

The evaluation has highlighted that while HACC incurs a cost, the DHA and DVA are saving. These savings to the DHA are derived from householders avoiding residential care. This is not a result of the program offering the equivalent to high-level care, rather constant low-level supervision.

Homeshare Victoria intends to pursue funding from both departments. The benefit to the aged care system, net of HACC funding, is an expected saving of $50,222 per annum. This represents the maximum amount of funding before the aged care system becomes a net loser. If participant fees are not introduced, the program will have a deficit of $30,270 per annum. Split according to benefits this is $29,060 from the DHA and $1,210 from the DVA.

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[21] Department of Human Services (1998) *Victorian HACC Program Manual*, Aged Care Branch, Aged, Community & Mental Health Division.

[22] Martin

17.3 Conclusion

Homeshare Victoria delivers significant benefits to the community. The program generates expected annual benefits worth $832,317 to participants and net savings of $50,222 to the health and aged care system. By removing barriers to exchange the program offers older Australians a near substitute for the care provided by a live in carer. This is facilitated through barter rather than direct payment. When a match forms parties exchange private benefits and generate external social benefits in savings to the health and aged care system. Without this program, the health and aged care system could not receive these savings. Homeshare clients could not privately purchase live in carers. Initially they would remain in the community, at risk, and eventually enter residential care and the savings would be lost.

Appendix 1 – Sensitivity Analysis

Table 28. Sensitivity analysis

	Aged Care	Hospitals	Participants	Philanthropists & Other	Net Benefit to Society
Base run	39,637	10,585	832,217	(60,270)	822,169
Variations:					
1) Reduction in savings from reduced residential care usage of 10%	26,632	10,585	820,924	(60,270)	797,871
2) Reduction in savings from reduced residential care usage of 20%	13,627	10,585	809,630	(60,270)	773,572
3) Reduction in savings from reduced HACC/DVA community care usage of 10%	38,196	10,585	831,929	(60,270)	820,440
4) Reduction in savings from reduced HACC/DVA community care usage of 20%	36,754	10,585	831,641	(60,270)	818,710
5) Costs according to Martin Report	39,637	10,585	832,217	(70,400)	812,039
6) 20% cost blow out	39,637	10,585	832,217	(79,324)	803,115
7) Program capacity according to Martin Report	30,917	8,256	649,129	(60,270)	628,032
8) Combine variations 2); 4); 6) and 7) for pessimistic scenario	8,380	8,256	631,062	(79,324)	568,374

Appendix 2. Detailed results

Note: The aged care status row code is as follows. D = DVA, C = CACPS, R = Residential care, VA= value added. For example D-R 25% represents DVA client otherwise in residential 25% of that year.

Appendix 2.1 Savings and Costs to the Department of Health and Ageing

Table 29. Savings to the Department of Health and Ageing in Year 1

Match No.	**13**	**15/32**	**23**	**25**	**28**	**19**	**8**	**5/18/36**	**14/24/31/38**	**4**	**20**	**22**	**1**	**12**	**7**	**17**	**6**	**34**	**35**	**Weighted units PA**	**Subsidised cost of unit Per annum ($)**	**Saving Per annum ($)**
Aged Care Status	C - VA 100%	C - VA 100%	C - VA 100%	C - VA 100%	C - VA 100%	H - R 100%	D/C-R 100%	D 100%	H - C 50%	D - R 25%	H - R 50%	H - R 50%	H - R 100%	H - R 50%	D-R 50%	D 100%	H - R 100%	H - R 100%	H - R 50%			
CACPS - Value added	1	1	1	1	1															5	$ -	$ -
CACPS									0.5											0.5	$ 10,700.00	$ 5,350
Nursing Home - Level 1																				0	$ 43,121.10	$ -
Nursing Home - Level 2													1.00							1	$ 38,992.95	$ 38,993
Nursing Home - Level 3																				0	$ 33,565.40	$ -
Nursing Home - Level 4										0.25										0.25	$ 23,776.10	$ 5,944
Hostel - Level 5						1														1	$ 13,910.15	$ 13,910
Hostel - Level 6							1										1.00		0.50	2.5	$ 11,526.70	$ 28,817
Hostel - Level 7											0.50	0.50		0.50	0.50			1.00		3	$ 8,847.60	$ 26,543
Hostel - Level 8																				0	$ -	$ -
Residential respite-High																10.00				10	$91.96	$ 920
Residential respite - Low																				0	31.58	$ -
Total saving																						**$ 119,557**

Table 30. Savings to the Department of Health and Ageing in Year 2

Match No.	13	15/32	23	25	28	19	8	5/18/36	14/ 24	4	20	22	1	12	7	17	33	34	35	Units PA	Unit cost ($)	Saving PA ($)
Aged Care Status	C 100%	C 100%	D/C 100%	C 100%	C 100%	R 100%	D/C - R 100%	R 100%	C 100%	D - R 25%	R 100%	R 100%	R 100%	R 100%	D - R 100%	D - R 0%	H - R 100%	H - R 100%	H - R 50%			
CACPS - Value added	1	1	1	1	1															5	-	
CACPS									1											1	$ 10,700.00	$ 10,700
Nursing Home - Level 1																				0	$ 43,121.10	$ -
Nursing Home - Level 2													1.00			0.0				1	$ 38,992.95	$ 38,993
Nursing Home - Level 3																				0	$ 33,565.40	$ -
Nursing Home - Level 4										0.25					1.00					1.25	$ 23,776.10	$ 29,720
Hostel - Level 5																				0	$ 13,910.15	$ -
Hostel - Level 6						1	1	1									1		0.5	3	$ 11,526.70	$ 34,580
Hostel - Level 7											1.00	1.00		1.00				1		3	$ 8,847.60	$ 26,543
Hostel - Level 8																				0	$ -	$ -
Residential respite- High																				0	$91.96	
Residential respite - Low																				0	31.58	$ -
Total saving																				0		**$140,536**

Table 31. Costs to the Department of Health and Ageing – Year 1 and Year 2

Match No.	8	Weighted units PA	Subsidised cost of unit Per annum ($)	Saving Per annum ($)
Aged Care Status	D/C- R 100%			
Year 1				
CACPS	1	1	10,700	$ (10,700)
Total cost				
				$ (10,700)
Year 2				
CACPS	1	1	10,700	$ (10,700)
Total cost				**$ (10,700)**

Appendix 2.2 Savings and Costs to the Department of Human Services – HACC

Table 32. Savings and Costs to the Department of Human Services – HACC in Year 1

Match No.	12	2/27	6	9	11	21	29	26	3/10	16/30	14/24/31/38	20	35	37	39	Weighted units per annum	Subsidised unit cost ($)	Savings ($)	Contribution per unit ($)	Client contribution ($)
Aged Care Status	H - R 50%	H 100%	H 100%	H 100%	H 100%	H 100%	H 100%	H 100%	H 100%	H 100%	H 50%	H 50%	50%	H 0%	H 0%					
HACC Value added	0.5	1	1	1	1	1	1	1	1	1	0.5	0.5	0.5	1	1	13				
RDNS - Medication prompting																**0**	55.84	0.00	6.5	0
Delivered meals																**0**	1.10	0.00	4.5	0
Home care											52	32.5				**84.5**	22.75	1,922.38	4	338
Property maintenance																**0**	34.00	0.00	6	0
Linkages																**0**	10,700.00	0.00		0
Personal Care																**0**	26.01	0.00	3	0
Respite - In Home									10	1						**11**	111.47	1,226.17	10	110
Community based activity																**0**	1,500.00	0.00		0
Centre based activity																**0**	9.50	0.00	5	0
Personal Alarm																**0**		0.00		0
																0		0.00		0
Total Saving																		**3,148.55**		**448**

Table 33. Savings to the Department of Human Services – HACC in Year 2

Match No.		2/27	6	9	11	21	29	26	3/10	16	14/24/31/38	20	35	37	39*	Total weighted units	Unit cost ($)	Savings ($)	Contribution per unit ($)	Client contribution ($)
Aged Care Status		H 100%	H 100%	H 100%	H 100%	H 100%	H 100%	H 100%	H 100%	H 100%	H 0%	H 0%	H 50%	H 0%	H 0%					
HACC value added		1	1	1	1	1	1	1	1	1			0.5			9.5		0.00		0
RDNS - Medication prompting																**0**	55.84	0.00	6.5	0
Delivered meals																**0**	1.10	0.00	4.5	0
Home care																**0**	22.75	0.00	4	0
Property maintenance																**0**	34.00	0.00	6	0
Linkages																**0**	10,700.00	0.00		0
Personal Care																**0**	26.01	0.00	3	0
Respite - In Home									10	1						**11**	111.47	1,226.17	10	110
Community based activity																**0**	9.50	0.00		0
Centre based activity																**0**			5	0
Total Saving																		**1,226.17**		**110**

Table 34. Costs to the Department of Human Services- HACC from care still received in Year 1

Match No.	**19**	**14/24/31/38**	**20**	**22**	**1**	**12**	**6**	**34**	**35**	**Weighted units PA**	**Subsidised cost of unit Per annum ($)**	**Saving Per annum ($)**
Aged Care Status	H - R 100%	H - C 50%	H - R 50%	H - R 50%	H - R 100%	H - R 50%	H - R 100%	H - R 100%	H - R 50%			
Community care still received												
RDNS - Medication prompting										**0**	55.84	-
Delivered meals		182	182	182		182	364	364	182	**1638**	1.10	(1,802)
Home care		52	52	52		52	104	104	52	**468**	22.75	(10,647)
Property maintenance										**0**	34.00	-
Linkages										**0**	10,700.00	-
Personal Care		63.7	63.7	63.7		63.7	127	127	63.7	**573.3**	26.01	(14,912)
Respite - In Home										**0**	111.47	-
Community based activity										**0**	1,500.00	-
Centre based activity										**0**	9.50	-
Personal Alarm										**0**		-
Receives maximum care	1				1					**2**	10,700.00	(21,400)
Total cost of care received												**(48,760)**

Table 35. Costs to the Department of Human Services - HACC from care still received in Year 2

Match No.	19	14/ 24	20	22	1	12	33	34	35	Units PA	Unit cost ($)	Saving PA ($)
Aged Care Status	R 100%	C 100%	R 100%	R 100%	R 100%	R 100%	H - R 100%	H - R 100%	H - R 50%			
Community care still received										0		
RDNS - Medication prompting										0	55.84	-
Delivered meals		104	364	364		364	364	364	182	2106	1.10	(2,317)
Home care			104	104		104	104	104	52	572	22.75	(13,013)
Property maintenance										0	34.00	-
Linkages										0	10,700.00	-
Personal Care			127	127		127	127	127	63.7	700.7	26.01	(18,225)
Respite - In Home										0	111.47	-
Community based activity										0	1,500.00	-
Centre based activity										0	9.50	-
Personal Alarm										0		-
Receives maximum care	1				1					2	10,700.00	(21,400)
										0		
												(54,955)

Appendix 2.3 Costs and Benefits to the Department of Veterans Affairs – Veterans Home Care

Table 36. Savings to the Department of Veterans Affairs – Veterans Home Care in Year 1

Match No.	4	17	7	5/18/36	Total weighted units	Unit Cost ($)	Savings ($)	Client contribution	Saving ($)
Aged Care Status	D 75%	D 100%	D 50%	D 100%					
RDNS - Medication prompting	78				**78**	55.84	4,356	7	507
Delivered meals	273				**273**	1.10	300	5	1,229
Home care	97.5				**97.5**	22.75	2,218	4	390
Property maintenance					**0**	34.00	-	6	-
Linkages					**0**	10,700.00	-		-
Personal Care					**0**	26.01	-	3	-
Respite- DVA entitlement		20	28	28	**76**	111.47	8,472	10	760
Community based activity					**0**		-		-
Centre based activity					**0**	9.50	-	5	-
Personal Alarm					**0**		-		-
Total Saving							**15,346**		**2,886**

Table 37. Savings to the Department of Veterans Affairs – Veterans Home Care in Year 2

Match No.	4	17	7	5/18/36	Total weighted units	Unit Cost ($)	Savings ($)	Client contribution	Saving ($)
Aged Care Status	D 75%	D 100%	D 50%	D 50%					
RDNS - Medication prompting	78				**78**	55.84	4,356	6.5	507
Delivered meals	273				**273**	1.10	300	4.5	1,229
Home care	97.5				**97.5**	22.75	2,218	4	390
Property maintenance					**0**	34.00	-	6	-
Linkages					**0**	10,700.00	-		-
Personal Care					**0**	26.01	-	3	-
Respite- DVA entitlement		20			**20**	111.47	2,229	10	200
Community based activity					**0**		-		-
Centre based activity					**0**	9.50	-	5	-
Personal Alarm					**0**		-		-
Total Saving							**9,103**		**2,326**

Table 38. Costs to Veterans Home Care from care still received in Year 1

Match No.	5/18/36	4	7	17	Weighted units PA	Subsidised cost of unit Per annum ($)	Saving Per annum ($)
Year 1							
Aged Care Status	D 100%	D - R 25%	D-R 50%	D 100%			
Community care still received							
RDNS - Medication prompting						55.84	-
Delivered meals			182		182	1.10	(200)
Home care			52		52	22.75	(1,183)
Property maintenance						34.00	-
Linkages						10,700.00	-
Personal Care			63.7		63.7	26.01	(1,657)
Respite - In Home						111.47	-
Community based activity						1,500.00	-
Centre based activity						9.50	-
Personal Alarm							-
Receives Max care - Equivalent to CACPS		0.25			0.25	10,700.00	(2,675)
CACPS						10,700.00	-
Total							**(5,715)**

Table 39. Costs to Veterans Home Care from care still received in Year 2

Match No.	5/18/36	4	7	17	Weighted units PA	Subsidised cost of unit Per annum ($)	Saving Per annum ($)
Year 2							
Aged Care Status	R 100%	D - R 25%	D - R 100%	D - R 0%			
Community care still received							
RDNS - Medication prompting						55.84	-
Delivered meals	52		364		416	1.10	(458)
Home care			104		104	22.75	(2,366)
Property maintenance						34.00	-
Linkages						10,700.00	-
Personal Care			127.4		127.4	26.01	(3,314)
Respite - In Home						111.47	-
Community based activity						1,500.00	-
Centre based activity						9.50	-
Personal Alarm							-
Receives Max care - Equivalent to CACPS		0.25			0.25	10,700.00	(2,675)
CACPS						10700	-
Total cost							**(8,812)**

Appendix 3 – Participant surveys

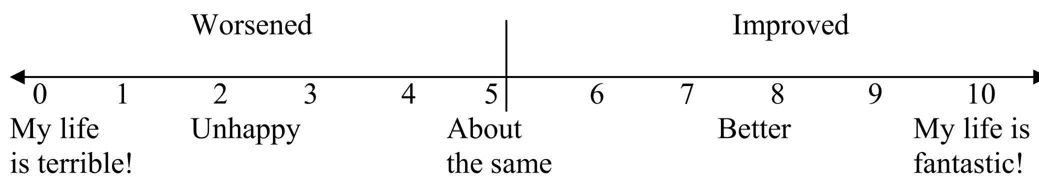
HOUSEHOLDER **MATCH NO.**

---

1. Reason for entering program:

2. How has impacted on your life?

3. Ratings Scale



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4. Current usage?
Do you currently attend or receive any aged care services
YES **NO**
What?

---

5. Otherwise doing?
If not in Homeshare what do you believe you would be doing? Nursing Home? Hostel? Need more HACC? Nothing changed?

---

6. Reduced Usage?
Have you stopped or reduced the usage of these services due to Homeshare?
Yes No

---

7. Foregone rent if would have rented room?
Would you have otherwise rented the room used by the Homesharer?
YES **NO**

Willing to accept as compensation?

---

8. Homesharer Service
Have you benefited from having a Homesharer provide help around the house?
YES **NO**

Typically a Homesharer does things such as cleaning, cooking meals, paying bills, gardening, walking the dog, medication prompting and being in the house when you shower?

---

9. Overnight Support
Have you benefited from having your Homesharer in the house overnight?
YES **NO**

---

10. Health, Nutrition and well being
Do you believe your health and nutrition and well being has improved from being in the program?
YES **NO**

---

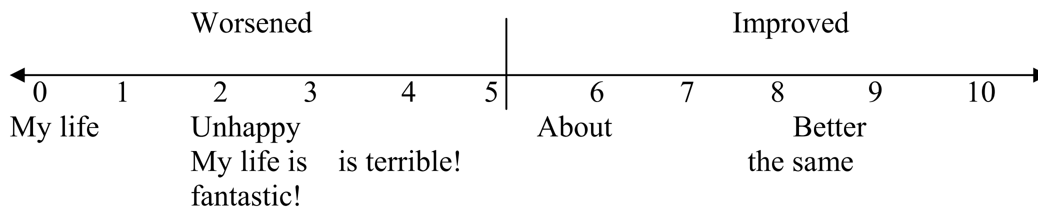
11. Family Reassurance
Do you believe you have benefited from your parent or loved one being in the program? **YES** **NO**

HOMESHARER SURVEY **MATCH NO.**

"We wish to find out what you think is important about the program and how much you value those things. Please note: We are asking these questions to find out how valuable these services are to you and not to ask for payment. Consider the options carefully and provide the most accurate answer possible."

1. Reason for entering program:

2. Ratings Scale How has your life changed from participation in Homeshare?



3. Type and Savings on accommodation

Where would you be living if not in the Homeshare program and what this would cost per week? (Does this include food, bills?)

4. How much do you save from sharing bills and meals?

5. Opportunity to save

Has the opportunity to save for own home been important to you? **YES** **NO**

How much of the savings on accommodation have been able to save per week?

6. WTA – Homesharer Service
How many additional hours do you give up as a Homesharer? (This is confidential and is simply for evaluating Homesharing as a program. It will not in anyway influence your agreement)
How much do you value these additional hours? What would you be willing to accept as compensation for these addition hours **per hour?**

---

7. Cultural and Language Assistance
Many international Homesharers have gained cultural and language assistance from living with the Householder. Have you received cultural and language assistance?
YES **NO**

---

8. Quality of life- Friendship, Family environment, Personal stability, Financial stability, Health and Nutrition
Have you benefited from friendship, a family home environment, stability during personal hardship or a better understanding of older people? **YES** **NO**

---

9. Family reassurance
Do you have a close family member or loved one who is concerned about your welfare and would benefit from being reassured of your safety from being in the program? **YES** **NO**

AGED CARE WORKER SURVEY **MATCH No.**

NAME AND PROVIDER OF CARE WORKER:

- My name is Ben Carstein and conducting research on Homeshare Victoria on behalf of Ronald Henderson Research Foundation.
- I am surveying aged care workers with clients who have participated in the Homeshare program and am wondering if you would be willing to answer a couple of quick questions?
- I am trying to quantify the impact of on the care status of participants of Homeshare Victoria.
- Particularly I aim to determine whether Homeshare has reduced usage of services or delayed future usage of services or delayed entry into residential care.

1. How has Homeshare impacted upon your client?

2. Have you reduced or delayed services due to Homeshare?

3. Do you think Homeshare will delay future usage of services?

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