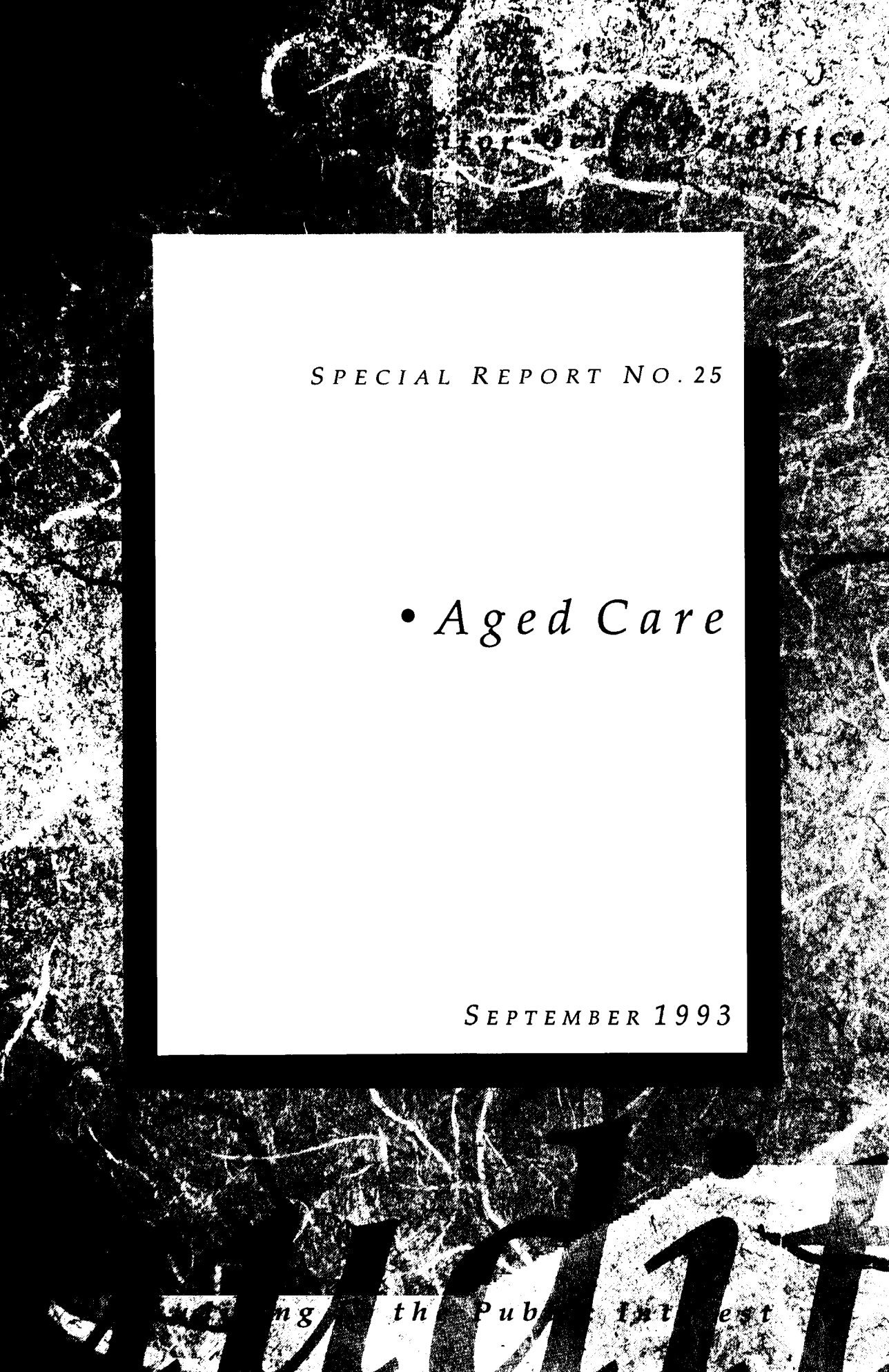

SPECIAL REPORT NO. 25

• Aged Care

SEPTEMBER 1993

VICTORIA

Auditor-General
of Victoria

SPECIAL REPORT No. 25

AGED CARE

Ordered by the Legislative Assembly to be printed

FOR PRESENTATION TO PARLIAMENT

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MELBOURNE
L.V. NORTH, GOVERNMENT PRINTER
1993

September 1993

The Honourable the Speaker
Legislative Assembly
Parliament House
Melbourne, Vic. 3002

Sir

Under the provisions of section 48A of the *Audit Act* 1958, I transmit the Auditor-General's Special Report No. 25 on Aged Care.

Yours faithfully

C.A. BARAGWANATH
Auditor-General

PREVIOUS SPECIAL REPORTS
OF THE
AUDITOR - GENERAL

Report No.	*Title*	*Date issued*
1	· Works Contracts Overview - First Report	June 1982
2	· Works Contracts Overview - Second Report	June 1983
3	· Government Stores Operations · Department Cash Management	October 1984
4	· Court Closures in Victoria	November 1986
5	· Provision of Housing to Government Employees · Post-Project Appraisal Procedures within the Public Works Department	December 1986
6	· Internal Audit in the Victorian Public Sector	December 1986
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19	· Salinity	March 1993
20	· National Tennis Centre Trust · Zoological Board of Victoria	April 1993
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FOREWORD

In continuing my Office's program of performance auditing in the public interest which has in the past covered a diverse range of areas, I formed the view that the delivery of aged care services is a complex area of significance to the State which should be examined.

In terms of the ageing population and the substantial public funds consumed in caring for older people, it is essential that resources are efficiently and effectively used in meeting the challenges which face the Government in the provision of these services into the next century.

It is my view that the recent initiatives introduced by the Government provide a sound platform for significant public sector reforms to occur in an area which touches the lives of all Victorians.

The performance audit findings contained throughout the Report serve to illustrate areas where there is scope for the more effective delivery of services to older people and improved resource management.

PART 1

Executive Summary

1.1

OVERALL AUDIT CONCLUSION

1.1.1 There are in excess of 300 000 people over the age of 70, representing 7 per cent of the total Victorian population. Demographic projections indicate that the aged population will increase during the 1990s by approximately 40 per cent. With $1.7 billion spent annually by the State Government on aged care and 48 per cent of public hospital bed days accounted for by older people, **the demographic shift in population has significant social and economic implications for Victoria.**

1.1.2 The State Government is faced with a complex task of reconciling the need for appropriate, accessible and equitably distributed services with the requirement to provide these services at the lowest cost to the taxpayer. The physical structure of certain State operated centres, funding constraints and the fact that residents in public facilities have more demanding care needs, impact adversely on service delivery.

1.1.3 Audit acknowledges the challenges associated with the provision of aged care services. However, **the lack of strategic direction, needs-based planning and standard setting** provided by the Department of Health and Community Services in the past, and its inability to react to the changing demands for such services especially in a person's own home or local community rather than in large institutions, has contributed to the **inefficient and ineffective use of resources.** Specifically, the audit review revealed that:

- Although **the physical quality of residential care and short-term services was generally of a high standard, the overall quality of life** of residents in geriatric centres and public nursing homes **could be improved**. In forming this view, it is important to recognise that there was no evidence whatsoever of maltreatment of older people located in public facilities and the commitment of those dedicated staff involved in caring for the aged is to be commended;
- **Access to residential aged care services was restricted** by an uneven distribution of services and the concentration of significant resources in a small number of large geriatric centres;
- **The aged care needs of older people with specific needs were in some cases not adequately addressed,** particularly in relation to respite and dementia care; and
- **Inefficient and uneconomic practices**, particularly in relation to nursing and hotel services, resulted in a significant waste of taxpayers' funds. In particular, during 1991-92 the costs involved in providing nursing home services were more than $100 million higher than those that would have been incurred by the private and voluntary sectors while delivering the same level of services. In addition, some facilities were found to be holding substantial parcels of property surplus to their needs which, if sold, would generate funding for government to relocate existing nursing home services to more appropriate community-based nursing homes.

Overall audit conclusion - *continued*

1.1.4 In 1991, a 5 year time frame was set for the State to reach equivalent standards of care and accommodation to those required in the private sector and to meet the Federal Government's standards for nursing homes. In audit opinion, the delivery of quality services to older people is of paramount importance and the development of, and compliance with, standards of care similar to those that apply to the private and voluntary sectors would ensure that this aim is achieved. The audit confirmed the need for attention to be given to this important aspect of service delivery to the aged community in Victoria.

1.1.5 It is pleasing to report that, in addressing the matters raised in this Report, a framework which should provide a sound foundation for the future provision of aged care services is in the process of being established. Initiatives undertaken or currently proposed include:

- the establishment of a Division of Aged Care Services incorporating both health and community services for older Victorians;
- the release of a series of key aged care policies by the Minister for Aged Care in July 1993;
- the development of an overall strategic plan for aged care services by December 1993; and
- the introduction by June 1994 of the Federal Government's nursing home funding mechanism (CAM/modified SAM), which relates the level of funding provided to each individual's care needs.

1.2

SUMMARY OF MAJOR AUDIT FINDINGS

1.2.1 Major findings arising from the audit review of aged care services are set out below. These findings should be considered in the totality of the discussion in this Report. To facilitate consideration of the findings, this summary lists the major findings within broad categories which relate to major themes of this Report.

MAJOR DEVELOPMENTS

- During 1990 and 1991 the Department built 11 new community-based nursing homes.

  Paras 5.62 to 5.68

- While the State Government has not been as proactive as the Federal Government in policy development for aged care in prior years, the Minister for Aged Care released, in July 1993, a series of key policies for the next 4 years. Many of these policies address issues identified during the course of the audit.

  Paras 3.43 to 3.52

DELIVERY OF AGED CARE SERVICES

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- In terms of physical quality of residential care, the audit found that the medical and nutritional care of residents was generally of a high standard.

  Paras 4.15 to 4.18

- In some cases resident care programs did not satisfactorily address residents' individual needs for pain and continence management.

  Paras 4.15 to 4.18

- The quality of life extended to residents in the context of providing freedom to manage their financial affairs, promoting self-esteem and the hygiene of residents met the standards applicable for the private and voluntary sectors.

  Paras 4.21, 4.40 and 4.51

- The emotional and psychological well-being of some residents was not addressed, with some appearing to be culturally and emotionally isolated.

  Para. 4.22

- Although an "open door" approach was adopted for visiting arrangements, the extent of formally established contacts with the community varied between facilities.

  Para. 4.23

DELIVERY OF AGED CARE SERVICES - *continued*

- Limited availability of visiting and recreational areas at some facilities restricted social relationships of residents.

  Para. 4.24

- Some residents spent the day in either their ward, a day room or by their beds because of space constraints.

  Para. 4.25

- The use of multi-storey buildings to house residents and the relative remoteness of some of these facilities restricted outings and access to grounds and gardens.

  Para. 4.26

- The ability of residents to control their daily activities was unnecessarily restrictive due to the inflexible operating routines.

  Paras 4.17 and 4.29

- Open plan wards accommodating 20 to 30 residents inhibited the provision of a homelike environment and did not provide an acceptable level of privacy.

  Paras 4.35 and 4.41

- The privacy and dignity of residents in institutionalised facilities was also adversely affected by:

  - residents not completely screened from the view of others while receiving nursing care;
  - toilets co-located with showers and only separated by shower screens;
  - bathrooms shared by both male and female residents; and
  - medical treatment records for individual residents displayed publicly.

  Para. 4.41

- Residents were not permitted to participate in a variety of activities due to the structure of many facilities and the poor co-ordination of volunteer support.

  Paras 4.44 and 4.45

- Caring for older people, many of whom are bedridden, in unsuitable buildings with limited fire safety procedures presented a potentially hazardous situation.

  Para. 4.49

- The provision of short-term aged care services in the form of acute, post acute, rehabilitation and geriatric assessment services to older people was of a high standard.

  Para. 4.53

- The accommodation of potential nursing home patients in acute hospitals for extended periods signifies problems associated with access to long-term and short-term aged care services and adversely impacts on hospital waiting lists and costs.

  Paras 4.85 to 4.89

DELIVERY OF AGED CARE SERVICES - *continued*

- Access to aged care services was restricted by:
  - the concentration of the Department's resources in a small number of geriatric centres;

    Paras 4.70 to 4.72
  - the lack of information available to the community on public sector aged care services;

    Paras 4.65 to 4.69
  - inadequate services to those with specific aged care needs such as dementia sufferers and those requiring respite care;

    Paras 4.112 to 4.176
  - an inequitable distribution of nursing home and hostel beds; and

    Paras 6.26 to 6.32
  - the under-supply of hostel beds in the State.

    Paras 6.20 to 6.25
- The establishment of a number of multi-purpose centres has assisted in providing appropriate aged care services in rural and remote areas.

  Paras 4.80 to 4.83

FACTORS IMPACTING ON THE DELIVERY OF AGED CARE SERVICES

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- Prior to July 1993 policies and overall planning strategies for State-wide aged care services were deficient.

  Paras 5.6 to 5.19
- Appropriate needs-based planning is required to ensure that resource allocation decisions, associated with the delivery of aged care services, are soundly based.

  Para. 5.23
- An institutional focus of caring for the aged, and the inappropriate institutionalisation of some residents in geriatric centres and public nursing homes in the past, has led to a lower quality of life for some residents.

  Paras 5.30 to 5.49
- Funding for the Home and Community Care Program was increased by $12 million for 1993-94 to expand services in Victoria.

  Para. 5.38

FACTORS IMPACTING ON THE DELIVERY OF AGED CARE SERVICES - *continued*

- The changing nature of residential aged care services has resulted in the placement of more dependent residents in public hostels.

  Paras 5.55 to 5.59

- Two new nursing homes visited by audit had admission waiting times in excess of one year.

  Paras 5.69 and 5.70

- Standards for the provision of care and monitoring procedures, developed by the Federal Government for the private and voluntary sectors, were not introduced by the State Government for the public sector until recently.

  Paras 5.71 to 5.75

- The Department has in the past been largely inflexible and unable to adequately meet the changing aged care needs of the community. However, recent developments in policy formulation for aged care services indicate that the Government is becoming more responsive to community needs.

  Paras 5.111 to 5.113

EFFICIENCY OF AGED CARE SERVICES **Page 103**

- In the past, the Department has not managed the resources involved in the delivery of aged care services in the most efficient manner.

  Para. 6.1

- During 1991-92 the costs involved in providing nursing home services were in excess of $100 million higher than those that would have been incurred by the private and voluntary sectors while delivering the same level of services.

  Paras 6.2, 6.43 to 6.52 and 6.54

- Nursing and personal care costs in public facilities significantly exceeded those incurred by private and voluntary providers.

  Para. 6.55

- There has been limited consideration of contracting out functions in public facilities.

  Paras 6.62, 6.63, 6.84, 6.85 and 6.89

- The sale of surplus property holdings in some aged care facilities would provide funding for government to relocate existing nursing home services to more appropriate smaller nursing homes in the community. Property holdings ranged up to 132 hectares.

  Paras 6.116 to 6.122

- The restructuring of the Mount Eliza Centre provides an excellent example of how property sales revenue can be used to upgrade and relocate aged care facilities.

  Paras 3.49 and 6.122

- The absence of appropriate costing systems has contributed to the inefficiencies in the provision of aged care services.

  Para. 6.136

1.3

OVERALL RESPONSE BY SECRETARY TO THE DEPARTMENT

1.3.1 The Department of Health and Community Services acknowledges the substantial effort to review aged care services and commends the audit review for recognition of key planning and service development issues.

1.3.2 The audit review's acknowledgment of recent developments in the Department's management of aged care is noted and concurs with the Department's view that a number of reform and redevelopment strategies are required to enhance aged care services.

1.3.3 Aged care is an extensive program in which both the Federal and State Governments have responsibility. The State Government is committed to resolving areas of duplication between governments to ensure that State resources are efficiently applied to areas of State responsibility and recent policy initiatives, acknowledged in the audit report, are consistent with that objective. The audit report correctly identifies that a continuing factor impeding the State Government's objectives in reform of aged residential services is current Federal Government policy on access to capital and recurrent funding by public sector agencies delivering residential care. Under this policy, Federally funded residential care services delivered by public sector agencies are denied access to capital funding and recurrent funds to these services are reduced by a return on investment factor. This effectively prevents involvement of the private and voluntary sector providers in the redevelopment of residential care services currently provided by the public sector in contradiction of policy objectives of both levels of government. This is a significant barrier to the relocation of public nursing home beds from large geriatric centres to smaller community-based nursing homes. The Department is negotiating with the Federal Government to have this problem addressed.

PART 2

Conduct of the Audit Review

AUDIT OBJECTIVES

2.1 The objectives of the audit of aged care services in Victoria were to evaluate the extent to which:

- the operations of State geriatric centres, nursing homes and hostels in delivering aged care services were effective;
- these residential establishments for the aged were operating in an economic and efficient manner;
- the procedures established by the Department of Health and Community Services to manage the public resources involved in the provision of care for the aged were adequate; and
- services have been provided in accordance with government policy objectives and legislative requirements.

AUDIT SCOPE

2.2 The scope of the audit was centred around the objectives of the Department, as outlined in the *Health Services for Older People* Discussion Paper 1991 and subsequently adopted by the Department in July 1993. These objectives required that:

- the Department provide a range and mix of services to meet the current needs of the aged community it services;
- aged care services provided by the Department are equitably distributed;
- people in need of aged care services can access these services;
- the quality of care provided to the aged is adequate;
- older people are involved in the planning, development and delivery of services targeted to their needs;
- special needs of various community groups are met;
- aged care services are provided in a flexible structure which is responsive to the changing needs of the community; and
- aged care services are efficiently provided.

2.3 Many of these objectives and the Federal Government's Outcome Standards for the care of older people residing in private and voluntary nursing homes are consistent with the requirements of the former State Government's 1987 Social Justice Strategy.

Information gathering processes

2.4 In conducting the audit, relevant records were examined and discussions held with key officers involved in the provision of aged care services from:

- the Department of Health and Community Services' head office;
- regional offices of the Department;
- a number of geriatric centres, public nursing homes and publicly operated hostels;
- the Federal Government's Department of Health, Housing and Community Services; and
- Aged Care Assessment Teams.

2.5 Discussions and meetings were also held with other relevant parties, including the Aged Care Research Group, representatives from the 2 Private Nursing Home Associations and the National Institute of Gerontology and Geriatric Medicine.

2.6 As part of the evidence gathering process, questionnaires were sent to all geriatric centres, public nursing homes, regional offices of the Department and the assessment teams. The review of geriatric centre and nursing home efficiency relied heavily on the information generated from these questionnaires: a strategy adopted to generate information from the large number of public sector aged care providers. Audit requested cost data on direct care, information on hotel services such as catering, cleaning and laundry, and other indirect services including maintenance and administration. The review of the operational efficiency of aged care providers was primarily based on financial information relating to the 1991-92 financial year.

2.7 An advertisement was also placed in the press inviting comments from the public concerning the provision of aged care services in Victoria.

Review of quality of care

2.8 Audit engaged the services of Brous Consulting Group which provided the services of a geriatrician and a registered nurse to assist in assessing the quality of aged care services. To avoid any potential conflict of interest resulting from the assignment, a geriatrician from another State was engaged. Dr L.J. Mykyta, the Senior Director of Geriatric Medicine at the Queen Elizabeth Hospital in South Australia, who is the National President of the Australian Geriatrics Society with substantial experience in geriatrics and rehabilitation in South Australia, New South Wales and Queensland, undertook the review at the selected geriatric centres. Ms K. Flanagan, a registered nurse with experience on a Federal Government monitoring team, provided the nursing expertise to the project when undertaking the review at the geriatric centres and the rural public nursing home.

2.9 In the absence of any comprehensive quality of care standards developed at a State level for the delivery of nursing home care, **the Federal Government's Outcome Standards for Australian Nursing Homes**, applicable to the private and voluntary sectors, were used as a guide in undertaking this element of the audit. According to the Federal Government, these standards reflect good practices found in many private and voluntary nursing homes and the aspirations of consumers. The Australian Council on Health Care Standards Accreditation Guide was used as a reference in the assessment of short-term aged care.

2.10 Notwithstanding that residents cared for in the nursing home wards of geriatric centres were on average more dependent than residents in private and voluntary nursing homes, all relevant factors were considered when undertaking the quality of care reviews. Due to the way in which the Outcome Standards are structured, there is a tendency for some overlap in the standards which is reflected in the audit findings.

2.11 The audit review of quality of care involved evaluating the physical health care provided to a small number of residents, observing the care delivered in wards, physical inspections of facilities, a review of resident records and discussions with residents, their relatives and medical and nursing staff.

2.12 The audit questionnaires circulated to all geriatric centres and nursing homes in Victoria were utilised to obtain additional information on the systems and procedures in place to assist in determining the adequacy of the quality of care provided to older people throughout the State.

Assistance provided during the conduct of the audit

2.13 Management, employees and various groups involved in the aged care industry provided significant support and assistance throughout the course of the audit. I wish to acknowledge the contribution that such assistance made to the preparation of material for this Report.

PART 3

Background

AGED CARE IN VICTORIA

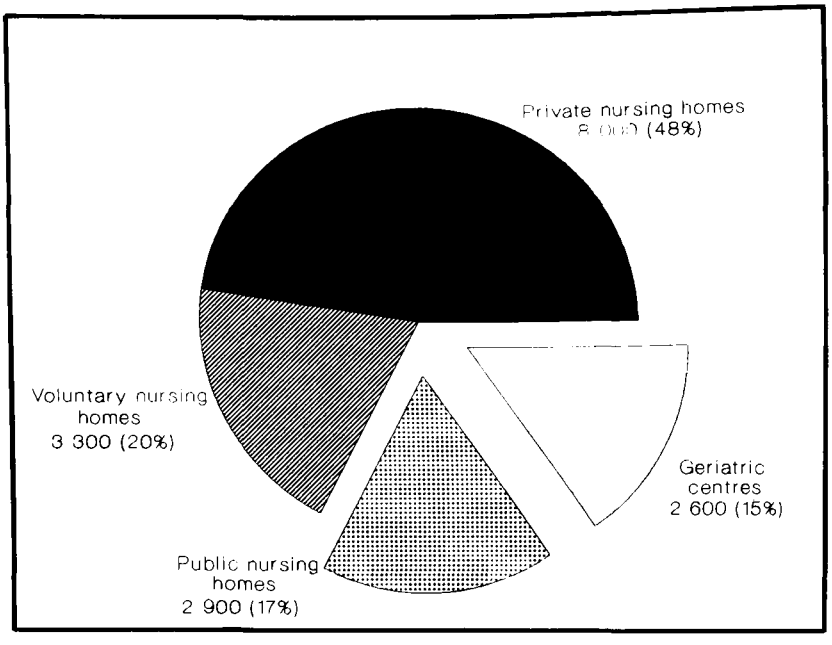
3.1 Victoria's aged population is increasing as a result of demographic trends. According to the Australian Bureau of Statistics, the aged population in Victoria (70 years and over) increased by 9.4 per cent between 1986 and 1991 and is expected to increase by a further 40 per cent between 1991 and 2001. At the same time, the total Victorian population increased by 5.6 per cent and is expected to increase by only 17 per cent between 1991 and 2001. Based on these figures, the aged population is increasing faster than the general population, a trend which is likely to continue into the next century. Using the information generated by the Bureau, the proportion of the Victorian population aged 70 years and older is expected to increase from 7.3 per cent in 1991 to 8.8 per cent in 2001. The numbers of people 75 years and over will increase from 191 000 in 1991 to 278 000 in the year 2001.

3.2 More older people in the community and greater longevity increases the need for aged care services. As people age, their health needs change. Increased levels of physical frailty, greater prevalence of severe handicap and disability, chronic illness, dementia and incontinence occur more frequently.

A Charge Nurse offering care and friendship to one of her patients.

3.3 Only 18 per cent of nursing home beds provided in Australia are operated by the public sector. In Victoria the public sector involvement is almost double the national average with one in 3 nursing home beds publicly provided by geriatric centres and nursing homes. Chart 3A shows the composition of Victoria's 16 800 nursing home beds by service providers.

CHART 3A
NURSING HOME BEDS IN VICTORIA, JUNE 1992



Source: Audit questionnaires and annual reports.

3.4 The Minister for Aged Care in July 1993 announced that:

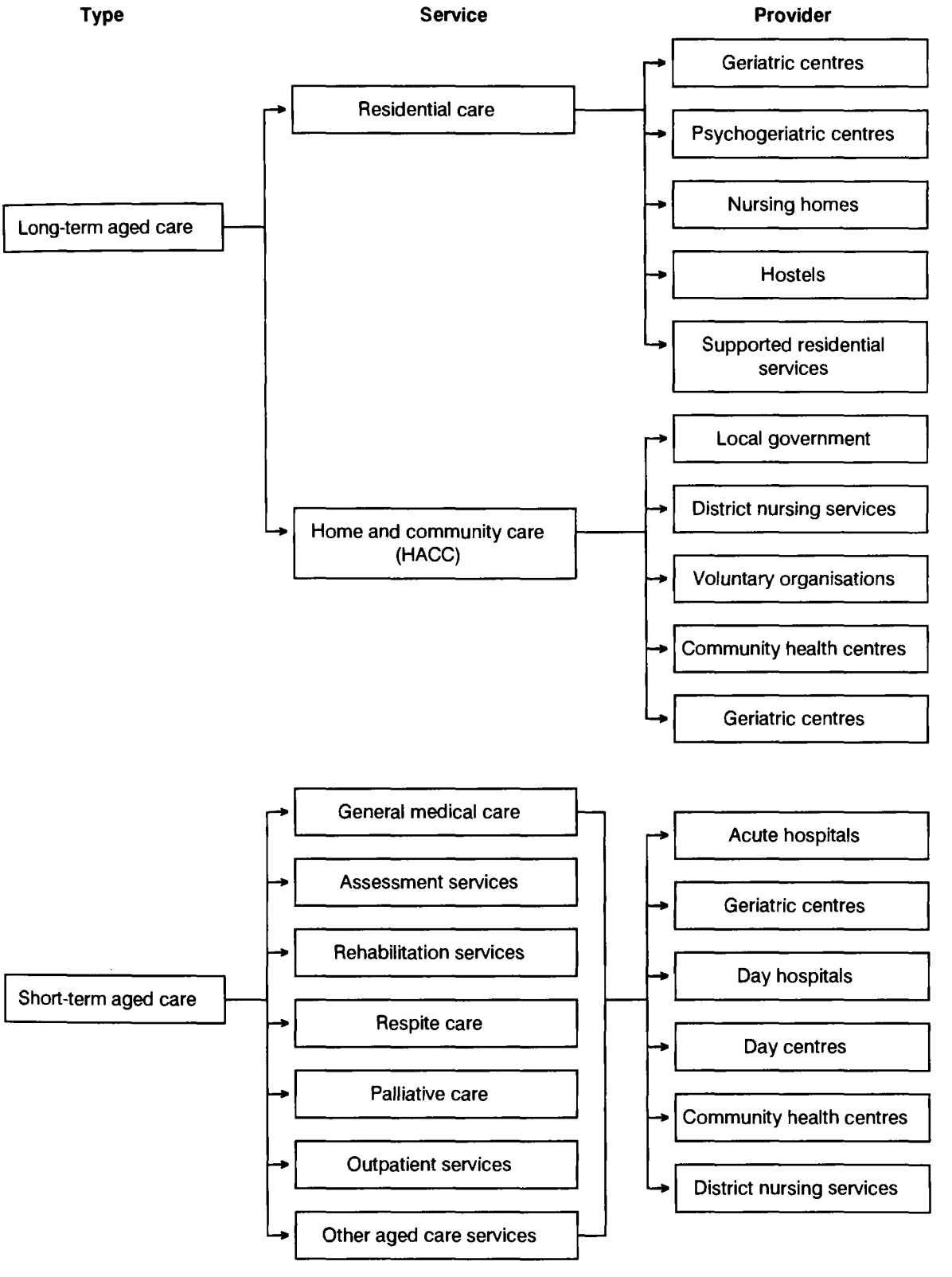
"...over the next 5 years, the Government will aim to transfer public nursing homes to the private and voluntary sectors and to reduce the public sector to 10 per cent of nursing home beds. The remaining stock of public nursing home beds will be redistributed to areas of need and some specialist long-term aged care services will be provided. The Department will negotiate with the Commonwealth Government and the residential care industry to expand the role of the private and voluntary sectors in nursing homes and hostels in Victoria".

3.5 Aged care services in Victoria comprise residential care (including psychogeriatric care), home and community care, general medical care and a variety of other services. These services are delivered by public, private and voluntary service providers. To manage the delivery of publicly operated health services, the Department operates a regional organisational structure which incorporates 3 metropolitan and 5 country regions. Regional offices co-ordinate and monitor the activities of pubic health service providers and provide a communication link between the Department and these service providers. Functions undertaken by regional offices include strategic planning, negotiating health services agreements and monitoring the efficiency and effectiveness of individual service providers.

SERVICES PROVIDED

3.6 Aged care services can be categorised according to long and short-term aged care. Various forms of services and providers are shown in Chart 3B.

CHART 3B
PROVISION OF AGED CARE SERVICES



Long-term aged care

3.7 Long-term aged care is provided to individuals who, due to their increasing frailty, or level of physical or intellectual disability, are no longer able to live independently. These people have relatively stable medical conditions and are unlikely to greatly improve their level of functioning through medical intervention. Long-term aged care can be classified as either residential care or home and community care.

Residential care

3.8 Residential care involves the provision of accommodation, nursing and personal care for residents in 5 care settings comprising geriatric centres, psychogeriatric centres, nursing homes, hostels and supported residential services. While these care settings all provide accommodation, the level of nursing and personal care provided differs. A small proportion of people in need of nursing home care are also temporarily cared for in acute hospitals while awaiting suitable nursing home or hostel placement. The various forms of residential care are discussed hereunder.

Nursing home care (geriatric centres and nursing homes)

3.9 Nursing home care is provided for older people and younger people, many of whom are disabled and in need of constant care and supervision. In addition to the services provided by geriatric centres and public nursing homes, services are provided by private nursing homes (profit orientated), non-profit voluntary organisations and various public hospitals.

3.10 The Department's 5 500 public nursing home beds are provided by 15 large geriatric centres and 82 nursing homes (excluding specialist nursing homes such as homes for the blind). A further 11 300 nursing home beds are provided by private and voluntary nursing homes.

3.11 Nursing home bed provision and distribution is controlled by the Federal Government through the establishment of a national nursing home bed planning ratio (which sets a benchmark of 40 beds per 1 000 population 70 years and over) and by controlling the issue of licences for new nursing homes.

Psychogeriatric care

3.12 Specialised aged care is provided to residents with psychiatric and/or intellectual disabilities by the Department through a network of extended care services within its major residential psychiatric facilities. In recognition of the need to provide these services in a less institutionalised setting, processes have been implemented by the Department over the last 3 years to replace larger psychiatric facilities with smaller scale community-based accommodation (psychogeriatric centres).

Hostel care

3.13 Hostel care is provided for people who are less dependent than nursing home residents and includes accommodation and supportive and personal care in a group setting. Hostel care is also provided by private and voluntary organisations.

3.14 The provision and distribution of hostel beds is administered by the Federal Government through its bed planning ratio of 55 per 1 000 population 70 years and over, and by controlling the issue of hostel licences. **This planning ratio was reduced to 52.5 in the Federal Government's August 1993 budget with 2.5 hostel places being converted to community aged care.**

3.15 In Victoria, hostel services are primarily provided by private and voluntary organisations, with only 41 hostels (15 per cent) administered by geriatric centres and public hospitals.

Supported residential care

3.16 Supported residential services known as "special accommodation houses" are essentially private sector, non-subsidised, hostels. These facilities provide accommodation and personal care for elderly residents who are relatively independent.

Home and community care

3.17 Home and community care relates to nursing, personal and domiciliary care provided at home or a community setting. The provision of this form of care has been recently expanded by the Federal Government as the emphasis has moved away from residential care, in recognition that people prefer to be cared for in their own homes and in their own communities.

3.18 The Federal Government's Home and Community Care Program incorporates a number of pre-existing programs including district nursing, meals on wheels, home help and home maintenance. In addition to these services, the Program provides allied health services such as physiotherapy, podiatry, speech therapy, occupational therapy, assessment and referral services.

3.19 Community care is provided by a wide range of service providers which include local government, district nursing services, voluntary organisations, community health centres, geriatric centres and the community services section of the Department.

Short-term aged care

3.20 The vast majority (90 per cent) of older people live in the community. Their health care needs include a range of services which extend beyond the residential care framework described earlier in this Report. These services are described below.

General medical care

3.21 General health services are essentially the same as those provided to the wider community. However, due to the frail nature of many patients and the multiplicity of problems often associated with older people, the time taken to recover after an acute illness or injury is usually much longer than for younger people.

3.22 General medical care includes acute and post-acute care. Acute care involves the restoration of the health of older people to an optimal level following an acute illness or remediable condition.

3.23 Post-acute care is a relatively lower level of care provided to patients following an accident or serious illness. The care provided is aimed at restoring functions and improving the patient's ability to undertake activities of daily living. Both acute and post-acute services are provided by the private and public sector and are funded by the Federal and State Governments, patient fees and health insurance funds.

3.24 Inpatient acute and post-acute care for the aged is provided in acute hospitals and some geriatric centres. Post-acute care is also provided in the community through the provision of home nursing services.

Assessment services

3.25 Geriatric assessment aims to facilitate access of older people to appropriate residential and community care upon request or referral. This objective is achieved through the operation of regionally based, multi-disciplinary aged care assessment teams located in public hospitals, geriatric centres and community health centres. In Victoria, there are 19 assessment teams, 11 of which are situated in metropolitan health regions and 8 in country regions.

3.26 State and Territory health authorities receive funds from the Federal Government to develop and maintain the assessment teams, which operate within Federal Government guidelines. In Victoria, additional funding is provided by the State Government to support these teams.

Rehabilitation services

3.27 Rehabilitation is provided to minimise the effects of impairment, disability or handicap and to restore individuals to their optimal level of functioning. The services are provided by both the private and public sectors and are funded by Federal and State Governments, patient fees, health insurance funds, and in Victoria by WorkCover and the Transport Accident Commission.

3.28 Inpatient rehabilitation services are provided by private hospitals and the public sector through acute hospitals and geriatric centres. Home and community based rehabilitation services are provided by day hospitals, community health centres and by allied health and home nursing staff in older peoples' own homes.

Respite care

3.29 Respite care is short-term care for individuals who are usually cared for in their own home. It is designed to give relief for the regular care provider.

3.30 In the private and voluntary sectors, respite care is provided in nursing home beds and specially designated hostel beds. Respite care is also provided in geriatric centre hospital beds and in public nursing homes. Alternatively, respite care can be provided in older peoples' own homes through the use of visiting carers.

Palliative care

3.31 This form of health care focuses on controlling pain, alleviating symptoms and supporting the individual and their families in the terminal stage of an illness. Specifically planned palliative care is provided by the voluntary sector, community agencies, dedicated hospices and, to a lesser extent, the public sector in registered nursing home beds and in specially designated palliative care beds.

Outpatient services

3.32 These services are provided through day hospitals, day centres, community health centres and district nursing services. Day hospitals provide non-residential care such as medical care, nursing, physiotherapy, occupational therapy, podiatry, speech therapy and counselling. Day centres provide activities for older people which are intended to promote independence and enhance daily living skills and includes the provision of personal care and meals.

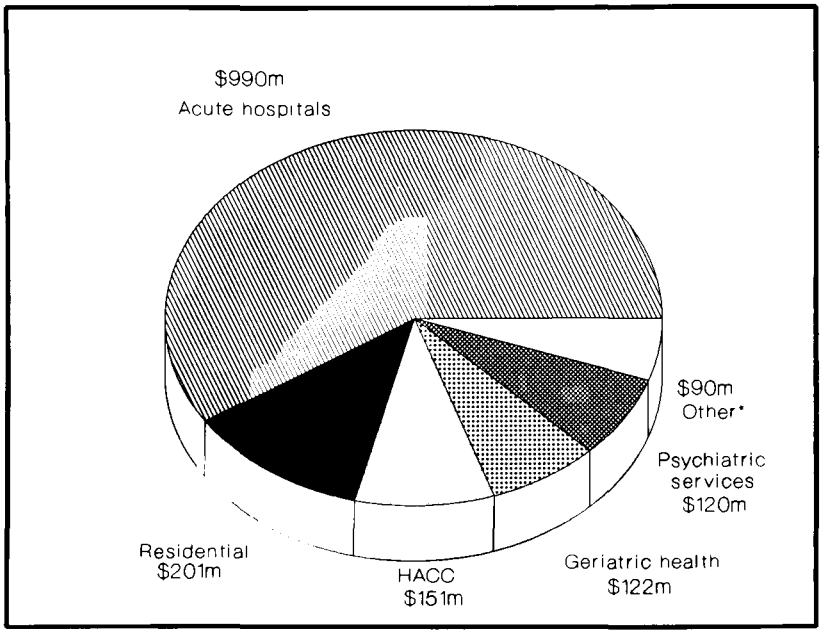
Other aged care services

3.33 Other services available to the aged include clinics providing incontinence management and treatment, and pain management and group therapy programs.

COST OF AGED CARE

3.34 The current Government has recognised the importance of the cost involved in providing services to the aged, acknowledged its responsibility to guide the planning and delivery of key services and appointed a Minister for Aged Care. Chart 3C shows the State Government's budgeted expenditure on aged care for 1992-93 which amounted to $1.7 billion, or 56 per cent of the $3 billion health budget.

CHART 3C
BUDGETED EXPENDITURE ON AGED CARE, 1992-93
($million)



* Other includes: Community health ($35m), Assessment ($29m), Ambulance ($20m) and Dental ($6m).

Source: *Everyone's Future Directions for Aged Care Services in the 1990s* issued by the Department of Health and Community Services.

FUNDING ARRANGEMENTS

Private and voluntary nursing homes

3.35 Private and voluntary nursing homes are funded primarily by the Federal Government's CAM/SAM system introduced in 1987-88. This system provides funding for nursing and personal care through the Care Aggregated Module (CAM) and for accommodation costs through the Standard Aggregated Module (SAM). CAM links the level of funding provided for nursing and personal care to the relative dependency of residents in order to ensure their needs are met. The introduction of this module was achieved through the establishment of uniform national nursing and personal care staffing standards, linked to the relative care needs of each resident. SAM provides a standardised mechanism to fund nursing home infrastructure costs as well as domestic services, administration and other overhead costs.

3.36 Additional funding comprising approximately 23 per cent of total funding is provided through resident contributions, which are currently restricted to 87.5 per cent of the age pension.

Public nursing home beds

3.37 Acute hospitals, geriatric centres and nursing homes in the public sector receive joint funding from the Federal and State Governments for nursing home beds. The Federal Government provided funding of $51.50 per bed day on average, which represented about 68 per cent of the funding provided to the private and voluntary sectors under CAM/SAM. In addition to the Federal funding, the State Government provided funding on average of $95.50 per bed day for nursing home beds in geriatric centres and $54.50 per bed day for nursing homes during 1991-92.

3.38 A number of newer public nursing homes operate on Federal Government CAM/modified SAM funding, with supplementary funding provided by the State Government. CAM/modified SAM does not provide funding to cover a return on investment which is provided to private and voluntary nursing homes. In 1991-92 the CAM/modified SAM funding was on average $63 per bed day.

3.39 Current funding arrangements for nursing home care provided by the public system in Victoria, based on information provided by geriatric centres and nursing homes, is shown in Table 3D.

TABLE 3D
AVERAGE FUNDING OF PUBLIC NURSING HOME BED DAY COSTS, 1991-92

	Older-style geriatric centres and nursing homes		*New-style nursing home (CAM/modified SAM funding)*
Funding provider	*Geriatric centres*	*Nursing homes*	*Nursing homes*
	($)	*($)*	*($)*
Federal Government	51.50	51.50	63.00
State Government	**95.50**	**54.50**	**22.00**
Resident	23.00	23.00	23.00
Total	**170.00**	**129.00**	**108.00**

3.40 The CAM/modified SAM funding approach will be phased in for all geriatric centres and older-style public nursing homes by July 1994.

Hostel funding

3.41 Hostels are funded by the Federal Government through its personal care subsidy and by hostel residents. Most residents make capital contributions on their admission to the hostel and pay ongoing fees based on their financial position. Residents classified as financially disadvantaged do not pay capital contributions and their ongoing fees are generally limited to 85 per cent of their age pension. In these instances, an amount equal to the capital contribution for the financially disadvantaged is provided by the Federal Government.

Home and community care

3.42 Home and community care is jointly funded by the Federal Government, States and Territories through the Home and Community Care Program. The total budget for the Program in Victoria amounted to $171 million for 1993-94.

MAJOR DEVELOPMENTS

Federal level

3.43 The Federal Government has been at the forefront of the current developments in aged care, with its Aged Care Reform Strategy establishing the framework for the provision of effective aged care services for the past 8 years. Principles of this strategy were initially laid down in the Federal Government's *Home and Community Care Act* 1985 and the 1986 review of the former Federal Department of Community Services and Health on Nursing Homes and Hostels.

3.44 The Strategy consists of 8 stages, 5 of which were completed between 1986 and 1991, with the remaining stages expected to be completed over the following 5 years. Major reforms in relation to the provision of aged care services, initiated as part of the Strategy, include the:

- Establishment of national nursing home and hostel bed planning ratios for the public, private and voluntary sectors. These ratios set an objective for bed provision within health regions and sub-regions (a sub-region is a group of municipalities within a region). **The ratios were 40 nursing home beds and 55 hostel beds per 1 000 population 70 years and over;**
- Establishment of the Special Services Program in order to care for the needs of ethnic communities, Aboriginals and Torres Strait Islanders, dementia sufferers and other frail aged with special needs;
- Introduction of the uniform CAM/SAM funding system for private and voluntary nursing homes;
- Introduction of specific outcome standards and quality of care requirements for private and voluntary nursing homes. Thirty-one standards relating to 7 areas comprising health care, social and emotional independence, freedom of choice, homelike environment, privacy and dignity, variety of experience and safety are outlined in the Federal Government's 1987 publication entitled *Living in a Nursing Home*;
- Integration of a user rights philosophy into the aged care program, which includes increased information for residents and relatives on their rights and care choices;
- Establishment of 107 Aged Care Assessment Teams throughout Australia to provide assessment services to the aged. The aim of these services is to match individual needs with appropriate service provision, thereby ensuring that those individuals with high dependency are admitted to residential care while others are directed to appropriate community-based services;
- Development of outcome standards for hostels; and
- Establishment of Federal Government monitoring teams to independently review the operations of private and voluntary nursing homes to ensure the Outcome Standards are met.

3.45 Progress of the Aged Care Strategy was reviewed by a team of consultants engaged by the Federal Government in 1990-91 and the findings were documented in the *Aged Care Reform Strategy Mid-Term Review 1990-91*. The Review:

- charted the progress made with the *Reform Strategy*; and
- established future directions in aged care to ensure effective and efficient services are available to meet the needs of older people and their carers.

State level

3.46 Recent developments in the provision of public aged care services include the release of a discussion paper in November 1991 entitled *Health Services for Older Victorians* as the first step towards the establishment of a State-wide strategy for aged care, and the introduction of a phased implementation of the CAM-modified SAM funding module for residential care services in geriatric centres and public nursing homes by 30 June 1994. In July 1993 an interim bed day rate was established pending development of a case-mix measure for rehabilitation services.

3.47 While the Department has not adopted comprehensive quality of care standards, it set a 5 year goal in August 1991 for:

- uniform standards of care and accommodation to be provided in private, voluntary and public nursing homes and hostels; and
- public nursing homes and hostels to meet the requirements of the Federal Government's Outcome Standards for nursing homes.

3.48 To meet these goals, a series of objectives relating to care standards, accommodation standards, residents' rights, the development of policies and plans to set the future direction of residential care, and financial matters were developed. These objectives were required to be met at specific intervals over the ensuing 5 years. In particular, care standards in public sector nursing homes and hostels were to be reviewed by 1 July 1992 and the standards were to be brought in line with the requirements of the Federal standards and State legislation by 1 July 1994.

3.49 It is pleasing to report that a number of service providers have moved, or are proposing to move, their services to smaller community-based facilities in order to address physical access problems. Several examples to illustrate this point are as follows:

- the Mount Eliza Centre has relocated 30 nursing home beds and 30 rehabilitation beds from its Mount Eliza site to a small community-based nursing home and a small rehabilitation centre in Rosebud;
- the North West Hospital is currently in the process of relocating 90 nursing homes beds from its Mount Royal and Greenvale campuses to small 30 bed nursing homes in Brunswick, Keilor and Melton;
- the Kingston Centre plans to relocate 60 nursing home beds from the Centre to Moorabbin; and
- the Grace McKellar Centre is in the process of relocating 30 nursing home beds from its North Geelong site to South Barwon.

3.50 In addition, the Minister for Aged Care released in July 1993 a series of key policies to be pursued by the Department over the next 4 years which comprise major goals, key objectives and strategies proposed to achieve the objectives.

3.51 The measures outlined in the Government's policy address the challenges that have emerged from the ageing of the population and the increased life expectancy resulting from economic and social progress. *"Lack of coherent planning, discontinuity between inpatient and home-based services, poor co-ordination of community health and community care, and inflexible work practices"* have, according to the Government, diminished the efforts of all concerned. In response to these challenges, the Victorian Government acknowledges that, while all 3 levels of government have a role to play, it has a particular responsibility to guide the planning and delivery of key services to ensure the most cost-effective results for older people. Issues addressed in the policy include:

- the need for older people to provide for themselves and have access to responsive services that are targeted to those most in need;.
- services provided to the aged are to be efficiently and effectively co-ordinated and be sensitive to the needs of ethnic communities;
- home and community care services are to be expanded while the emphasis of geriatric centres is to be shifted from residential care to rehabilitation and assessment services;
- the Department is to improve the quality of public nursing home care and relocate nursing home beds from large geriatric centres to smaller community-based services;
- the number of beds in the public sector and the costs of operating public nursing homes are to be reduced; and
- the number of private and voluntary beds is to be expanded.

3.52 It is pleasing that many of these initiatives address issues raised throughout this Report.

PART 4

Delivery of Aged Care Services

OVERVIEW

4.1 One of the Government's aims is to ensure that high quality aged care services covering the physical health care of older people and their quality of life are provided.

4.2 In relation to nursing home care it is necessary to understand the transformation over time of the profile of residents of geriatric centres and public nursing homes. Prior to the mid-1980s, nursing homes were generally regarded as communal residences for older people of relatively good health who preferred not to live alone or did not have any relatives on whom they could depend.

4.3 Following the expansion of assessment teams in Victoria in the mid-1980s, access to nursing home care has been more stringently controlled. Older people who require considerable nursing and personal care because of their medical condition access nursing home services, while those less dependent are referred to more appropriate hostel or community-based services. However, there are still a number of residents, with relatively low dependence, remaining in geriatric centres and public nursing homes who were admitted in a period of less stringent assessment.

4.4 As almost all public nursing home beds are provided in large geriatric centres or form part of a nursing home attached to a public hospital, the facilities are likely to be managed and staffed in a similar way to public hospitals.

4.5 The physical structure, size and location of facilities, the institutional focus, traditional nursing attitudes and the unresponsiveness of the public sector over past years to changing care standards contributed to aspects of quality of life that were below the standards required for the private and voluntary sectors. As such, audit is of the view that some residents in the public system do not enjoy the quality of care that is laid down for older people who reside in private and voluntary nursing homes. In forming this view, audit recognises that the strict adherence by the public sector to the Federal Government Outcome Standards would be impractical in some circumstances and the dedication of the majority of people involved in the provision of such care is unquestioned.

4.6 In terms of nursing home care, the audit review found that **the overall physical health care of residents was of a high standard** in relation to the provision of appropriate medical and nutritional health care, oral and dental health care, and the provision of equipment to improve resident mobility and dexterity.

4.7 However, in some cases, care programs required improvement to ensure residents' individual needs for pain and continence management services were addressed.

4.8 In assessing the quality of life experienced by residents receiving nursing home care, the audit review revealed that residents were given appropriate freedom to manage their financial affairs, an "open door" approach was applied for visiting arrangements, some homelike features were introduced into institutional settings and residents were assisted by staff in maintaining their self-esteem and cared for in a hygienic environment.

4.9 There was, however, **substantial scope to improve the quality of life of older people within the public aged care system** by giving greater attention to:

- recreational and social facilities for residents;
- resident participation in decision-making;
- the privacy, dignity and independence of residents;
- the emotional and psychological well-being of residents; and
- certain aspects of residents' safety especially in relation to fire protection.

4.10 Many of the quality of life requirements could not be met primarily due to the old and inappropriate infrastructure within the public aged care system and the lack of funds available for capital works in this area. This observation was supported by the Minister for Aged Care in the July 1993 policy statement in which it was acknowledged that:

> *"Victoria still has a large number of old institutional beds in State geriatric centres and outdated buildings around the State. These facilities do not meet modern standards for providing a homelike environment within local communities".*

4.11 The audit disclosed that **the delivery of short-term aged care services was also of a high standard.** Specifically, audit found accurate diagnosis, correct assessment of disabilities, use of appropriate treatments, prevention of further disabilities and the provision of adequate rehabilitation services.

4.12 However, the development of outcome standards, clinical indicators and quality assurance programs to provide a framework against which to measure the quality of acute and post-acute care, rehabilitation and geriatric assessment services by geriatric centres and the larger public nursing homes required attention.

4.13 In relation to the supply of services, audit found that it was difficult for some sections of the aged community to access appropriate health care and that the delivery of appropriate services for the aged with specific needs had not been adequately addressed.

- *RESPONSE provided by Secretary, Department of Health and Community Services*

  In this section of the Report, the findings of the audit are endorsed. Comments pertaining to matters of standards of care in nursing home and hostel services and special needs of particular nursing home and hostel clients are not responded to individually. As the audit report acknowledges, the Department is in the process of implementation of Federal Government funding principles, management structures and outcome standards for public sector nursing home and hostel services.

ASSESSMENT OF QUALITY OF CARE

4.14 The results of the comparison of the standard of physical health care and the quality of life experienced by nursing home residents in geriatric centres and public nursing homes with the Outcome Standards applicable to the private and voluntary sectors are outlined below. The comparison of the quality of short-term aged care services with the standards for best practice, as outlined in the Australian Council on Health Care Standards, is also discussed. As indicated previously, the detailed quality of care reviews were undertaken at a selected number of geriatric centres and a rural nursing home by specialists and the findings were considered to be representative of aged care in the public sector. As part of the assessment process, questionnaires were also issued to all geriatric centres and nursing homes.

Nursing home care in geriatric centres and public nursing homes

Physical health care

4.15 The objective for physical health care as outlined in the Outcome Standards is to ensure that *"Residents' health will be maintained at the optimum level possible".*

4.16 The Outcome Standards require that the provision of health care to older people needs to be supported by many other services to raise their quality of life. Matters emphasised include the following:

- nursing home residents are entitled to the same high quality health care from health practitioners of their choice as exists for other members of the community;
- any medical crisis involving a resident within a nursing home should be treated in the same way as if the person affected resided in the community;
- specific care objectives, which build upon existing abilities and potential, and form the basis of individual care plans, should be developed for each resident;
- the resident and his/her representative, where appropriate, should be included in discussions concerning care objectives aimed at maintaining and, where possible, improving physical independence; and
- residents should be as free from pain as possible.

4.17 Comments on various elements of physical health care, identified during the audit review, are detailed below.

Nutrition

Residents were adequately nourished and hydrated with their dietary needs assessed by a dietician. However, the type of meals provided in some facilities was unnecessarily restrictive with residents either not having any choice of menus or being unaware that alternative meals were available on request.

Oral and dental health

The review indicated that satisfactory attention was given to residents' oral hygiene and denture care.

Pain management

Current nursing home practices, which in some instances did not necessarily link patient discomfort and behaviour to pain, meant that residents suffering from pain were not identified in all cases. Furthermore, appropriate pain management programs developed in consultation with the resident and or his/her representative had not been established.

Continence

The standard of continence management varied, with individual continence management programs not established in all cases. Specialist advice indicated that certain staff were not fully aware of the principles of continence management.

Skin care

Residents were assisted to maintain their skin, hair and nails in a clean, healthy condition consistent with their age and general health. Any breakdown of skin integrity was diagnosed, appropriately treated and regularly checked.

Allied health services

There was a wide divergence in the provision of allied health services available to residents. In some instances, such services were not available to residents at smaller centres.

Mobility and dexterity

Although equipment and facilities such as hand rails, walking and eating aids, and good floor and pavement surfaces were available in most centres to maintain and improve resident mobility and dexterity, some staff tended to perform tasks for and/or assist residents, rather than encouraging them to walk and act independently.

Choice of medical practitioner

The standard of medical care provided by in-house medical staff was found to be generally of a high standard. However, residents were not free to choose their own general practitioner.

Medical records

Improvements were needed in the maintenance of medical notes and records, particularly the completion of pre-admission notes, the availability of records after hours and on weekends, and the identification of medical treatment in resident records.

4.18 In summary, audit found that the overall physical health care of residents was of a high standard. However, greater attention needs to be given to some areas such as pain management and the development of continence management programs.

Quality of life

4.19 The quality of life of nursing home care is addressed by 6 outcome standards which cover issues relating to social and emotional independence, freedom of choice, the provision of a homelike environment, privacy and dignity, giving residents a variety of experiences and safety matters.

Social and emotional independence

4.20 The Outcome Standard prescribes that *"Residents will be enabled to achieve a maximum degree of independence as members of society"*. According to the Standard, residents' independence is one of the major outcome goals of nursing homes and is to be considered as the basis upon which all care is to be provided. At all times nursing home staff have a responsibility to aim to achieve a balance between encouraging independence and providing support. The Standard advocates various methods to preserve independence. These methods involve:

- maintenance of family and friendships, with appropriate access to and help with telephones, encouraging visits, facilities for children (such as a play area) and hospitality (tea making or kiosk);
- self management of financial affairs;
- encouragement of religious and cultural practices; and
- the maintenance of obligations as citizens which involves encouraging interest in community and current affairs and exercising rights such as voting.

4.21 The audit revealed that residents were found to have a reasonable amount of freedom to manage their financial affairs. Specifically, intellectually competent residents were able to manage their own affairs and were responsible for making decisions regarding the safekeeping of money, documents and other valuables. In addition, residents who were able to do so, were encouraged to select and purchase items and services of their choice.

4.22 The emotional and psychological well-being of some residents was not addressed resulting in a consequential lowering of quality of life for those residents. In some cases, residents were culturally and emotionally isolated and family support was low. According to specialist advice this is likely to lead to behavioural problems and boredom.

4.23 An "open door" approach was adopted to visiting arrangements, however, the extent of pre-arranged contacts with, or visits from, the community varied between individual facilities. At some facilities residents were seldom taken outdoors and had limited contact with local communities whereas, at some others, the high level of interaction between these facilities and the community enabled residents to be more socially independent.

4.24 Facilities for residents to provide refreshments such as tea and coffee or meals for visitors, and access to private telephones were generally not provided. Furthermore, private sitting areas were not available to enable residents to entertain their visitors. These factors, combined with a limited availability of central and accessible recreational spaces and opportunities, restricted social relationships of residents to those with nursing staff.

4.25 Audit observed that some residents spent the day in their ward, a day room or by their beds because of space constraints. Ambulant residents were free to go outdoors, however, the physical structure of the buildings and location of some facilities often restricted resident mobility.

4.26 The large number of residents housed in multi-storey buildings and the relative remoteness of the facilities from local communities, presented particular problems for substantially immobile people in terms of participating in outings and accessing the grounds and gardens.

4.27 In general, social and personal profiles of residents were not maintained, and catering and information services (newspapers and literature) were not orientated to ethnic and cultural needs. Further comments in relation to delivering appropriate services for the aged with specific ethnic needs are contained later in this Part of the Report.

Freedom of choice

4.28 The Outcome Standard requires that *"Each resident's right to exercise freedom of choice will be recognised"*. This Standard is concerned with enabling nursing homes to maintain necessary routines while allowing residents to retain some control over activities and follow their preferred habits. The Standard recognises that for people entering a nursing home, the change in their normal lifestyle and in the level of control they have over their environment is probably the most traumatic experience they encounter.

4.29 The physical structure and inflexible operating routines of many large geriatric centres and nursing homes impacted adversely on each resident's freedom of choice, for example limited bathroom facilities restricted the availability of showers at certain times of the day.

4.30 Residents' committees, which are formed to encourage participation in matters of more general interest, had not been established in a large number of facilities.

4.31 Complaint mechanisms tended to be of an informal nature. Where these mechanisms were more formalised, not all staff were familiar with procedures. However, suggestion boxes and questionnaires to investigate the level of resident satisfaction had been established in some nursing homes surveyed by audit.

Homelike environment

4.32 According to the Outcome Standard, *"The design, furnishing and routines of the nursing home will resemble an individual's home as far as reasonably possible"*. This Standard requires management to *"attempt to create and maintain a homelike environment"* which gives residents a feeling of security. The major theme of the Standard is that:

> *"A homely, personalised environment in which residents are able to retain their identity, values and individuality adds greatly to their quality of life. A pleasant, safe environment in which residents feel comfortable can be achieved in many ways."*

4.33 According to senior management of the Department, the high levels of dependence of nursing home residents, the need for physical nursing care and preventative or precautionary measures established for residents suffering from confusion and dementia place restrictions on compliance with this standard. Nevertheless, the following statement contained in the Standard emphasises the need to create an environment in which residents can feel comfortable and at home despite their nursing care needs:

> *"It must be remembered that, although provision of high quality nursing care is essential, a nursing home is not a hospital."*

4.34 The Standard includes the following requirements:

- residents should be encouraged to bring their own personal possessions such as photographs, mementos and small items of furniture;
- paintings, plants and pets, where appropriate, should be allowed;
- an imaginative and flexible use of space should be encouraged; and
- the decor and temperature of the living areas of the hospital should be consistent with a homelike environment.

4.35 Audit observed that the physical structure of most geriatric centres and public nursing homes, which is institutionalised in nature, inhibited the potential for providing an environment similar to that of one's own home. Most of the centres were established in the last century, the most recent being constructed in 1984. In some cases, the typical public nursing home beds were located in 20 to 30 bed wards in large older style multi-storey buildings. Where private rooms were available they tended to be small in size. This form of institutional accommodation has few characteristics normally associated with a family home, provides limited scope for residents to bring in furniture and personal belongings, and restricts access of residents to gardens and facilities.

An older multi-level geriatric centre.

4.36 Notwithstanding these constraints, the audit disclosed that some progress had been made in certain facilities where a number of measures had been introduced such as partitioning large ward areas and encouraging residents to bring in their furniture and personal belongings. Also, the use of plants, flowers and paintings improved the appearance of wards.

4.37 The following audit findings illustrate that other facilities have retained a hospital-like environment in the provision of nursing home care:

- resistance by management to more progressive measures, such as the abolition of the requirement for nursing home staff to wear uniforms and allowing residents to maintain pets;
- in general, furnishings and decor were institutional in appearance;
- the temperature in certain living areas was not kept at a comfortable level; and
- noise levels provided an unnecessary intrusion into the lives of residents.

4.38 Security is another important aspect of a homelike environment. The Standard requires that a nursing home has policies which enable residents *"to feel secure in their accommodation"*. Based on the review by the specialist, the frequency of resident transfers within and between wards contributed to resident insecurity. The problem was further exacerbated in some cases by the lack of a definite plan which outlined proposed movements and provided for resident participation in planning and executing such transfers.

Privacy and dignity

4.39 The Outcome Standard prescribes that *"The dignity and privacy of nursing home residents will be respected"* and includes recommendations relating to staff attitudes, modes of address, rights to privacy with regard to space and belongings, bathing, friendships, privacy from unwanted sound and confidentiality of information.

4.40 The audit review found that nursing staff assisted residents in maintaining their self-esteem and encouraged them to be well-groomed and dressed appropriately for the time of day and weather conditions.

4.41 The open plan ward-like environment in most geriatric centres adversely impacted on the level of privacy enjoyed by some residents. Unsatisfactory practices identified by the review included:

- residents not completely screened from the view of others while receiving nursing care;
- toilets co-located with showers and only separated by shower screens;
- bathrooms shared by both male and female residents;
- an excessive amount of noise at night;
- signs detailing characteristics of individual residents' condition displayed publicly;
- facilities to enable relatives to visit residents in private were generally lacking; and
- storage space for patient clothing and other property and valuables was limited.

4.42 There was a marked difference in staff attitudes between centres. In some, staff were very progressive, with residents treated as individuals rather than patients.

Variety of experience

4.43 One of the objectives of the Outcomes Standards is that *"Residents will be encouraged and enabled to participate in a wide variety of experience appropriate to their interests and needs".* While recognising the difficulties of *"increasing dependency or diminishing intellectual competence"* and the need to recognise *"the freedom to choose not to participate",* the Standard recommends that nursing home staff organise and encourage group events and activities tailored to meet individual needs. Involvement of friends, volunteers and ties with the local community are seen to be important in arranging activities which are enjoyable and assist in maintaining skills.

4.44 A major problem associated with providing nursing home care in large geriatric centres rather than in small community-based nursing homes is the relative isolation of these facilities from local communities. The location, size and imposing nature of these institutions separates them both physically and socially from their local communities.

4.45 The audit disclosed that it was not uncommon for residents to be socially isolated, with very little family support and limited involvement with friends. In these circumstances, volunteer and community support provided the main avenue of access for residents to a wide variety of experiences. However, some improvements such as the maintenance of social profiles of residents identifying residents' backgrounds, cultures and preferences would enable effective delivery of support services.

4.46 The combined effect of the abovementioned factors is that some residents only had access to a limited range of activities, which resulted in these residents experiencing long periods of inactivity and boredom.

Safety

4.47 The Outcome Standard requires that *"The nursing home environment and practices will ensure the safety of residents, visitors and staff"*. Although the objective relates to the maintenance of resident safety, the first concern in the Standard is the *"residents' right to participate in activities which may involve a degree of risk"*. The Standard recommends that *"risk taking is a normal part of everyday life and residents should not be unnecessarily deprived of this right"*. Notwithstanding this recommendation, the Standard addresses issues concerning environmental safety, accident and injury risk, infection, fire hazard, security, aggressive behaviour and use of restraints.

4.48 The adoption of a custodial attitude by some nursing staff to nursing home care meant that residents were not encouraged to undertake activities with an element of risk such as accessing the facilities' gardens unaccompanied by hospital staff, sleeping in beds with rails lowered and making tea.

4.49 As with the achievement of other standards, the extent to which facilities provided protection from fire hazards was affected by their physical structure. Caring for older people, many of whom are bedridden, in unsuitable buildings with limited fire safety procedures presents a potentially hazardous situation. Many of these buildings were not fitted with sprinkler systems, smoke detectors, and fire and smoke barriers.

4.50 Security wards, containing individuals suffering dementia who are prone to wander, presented additional problems in relation to resident safety. In the event of a fire, locked doors used in these wards may unnecessarily hinder the ability of staff to evacuate residents.

4.51 While the audit review identified a number of other specific problems associated with resident safety such as inappropriate floor surfaces and old equipment in need of replacement or urgent maintenance, it was pleasing to find that geriatric centres and nursing homes were generally clean and maintained appropriate standards of hygiene in accordance with public health standards. Furthermore, residents with infections or infestations were managed in such a way as to prevent the spread of disease to others.

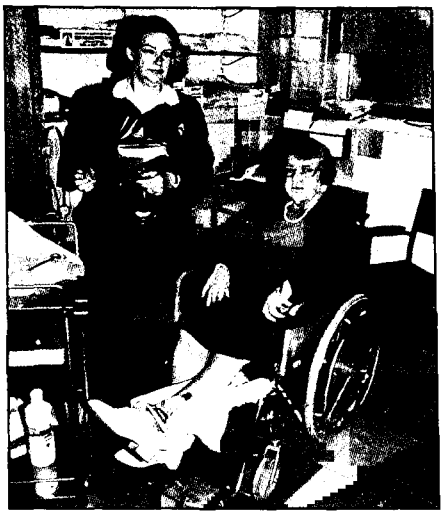
4.52 In conclusion, the audit found that although the quality of life of residents was satisfactory in some areas such as providing an element of freedom to manage their financial affairs, promoting self-esteem and the hygiene of residents, there was substantial room for improvement in many respects. To bring the quality of life of older people in the public system up to the standard required for the private and voluntary sectors, greater attention will need to be given to:

- **increasing recreational and social facilities for residents;**
- **improving resident participation in decision-making;**
- **promoting the privacy, dignity and independence of residents;**
- **placing greater emphasis on the emotional and psychological well-being of residents; and**
- **providing adequate measures for the safety of older people that reside in outdated buildings.**

Short-term aged care

4.53 As indicated earlier in this Report, geriatric centres provide short-term aged care services in the form of acute, post-acute, rehabilitation and geriatric assessment services in addition to the provision of long-term residential care services. High-quality physical health care involving medical care includes the accurate diagnosis, correct assessment of disabilities, use of appropriate treatments, prevention of further disabilities, and rehabilitation to maximise the functional abilities and independence of each resident. According to the specialist advice engaged by audit to undertake the review, **the quality of these short-term aged care services was of a high standard.** In particular, the audit found that in the geriatric centres reviewed:

- the quality of acute care services was generally of a high level;
- rehabilitation services were well developed and of a high calibre;
- multi-disciplinary teams in relation to rehabilitation services were effective, morale was high and there was evidence of appropriate staff development and research activity;
- geriatric centres were generally servicing their catchment areas; and
- assessment teams were well integrated into regional services.



Rehabilitation services provided in a geriatric centre.

4.54 Audit did, however, identify there was a need to develop appropriate performance measures and ensure effective quality assurance programs are in place so that the quality of short-term aged care services can be assessed on an ongoing basis.

Outcome Standards and clinical indicators

4.55 For short-term aged care services, outcome standards, similar to those developed by the Federal Government for nursing home and hostel care, have not been developed by the Department or particular geriatric centres.

4.56 In assessing short-term aged care services, clinical indicators are a valuable tool which can be used to measure the quality of care. These indicators, which identify processes, clinical events, complications, outcomes or other facets of care and provide an insight into the quality of services provided, had also not been developed.

4.57 As such, it is not possible for geriatric centres to measure the quality of short-term services that they provide.

Quality assurance programs

4.58 The Australian Council of Health Care Standards (ACHS) Accreditation Guide defines quality assurance as *"A formal process whereby the quality and appropriateness of patient care and/or department performance is documented and evaluated by the professional group responsible or within a multi-disciplinary team".*

4.59 This process involves a planned and systematic approach to monitoring and assessing the care provided or the services delivered. The monitoring and assessing activities identify opportunities for improvement and appropriate actions to be taken. Regular evaluation of actions taken and feedback on the results of quality assurance activities are then communicated to staff.

4.60 A quality assurance program would normally include a review of the:

- various short-term aged care services against the ACHS Accreditation Standards;
- performance of the geriatric centres' personnel;
- procedures followed and outcome of short-term aged care services (clinical review); and
- provision and utilisation of the facilities' resources.

4.61 The audit review of 10 geriatric centres revealed that only 5 centres had acquired accreditation and only the Anne Caudle geriatric centre fully met the quality assurance component of the Standards.

4.62 Based on the work undertaken by the ACHS and the audit review, there was scope to improve quality assurance programs in geriatric centres. The following specific problems were identified:

- quality assurance committees, designed to co-ordinate and review quality assurance programs, had not been established in all geriatric centres;
- although many facilities successfully implemented systems for collecting performance data such as accident and incident reports, sanity reports and infection control committee reports, not all facilities completed the evaluation cycle by analysing the data collected and implementing changes to effect improvements; and
- documentation, such as results of data collection and summary reports to support quality assurance activities, were not always available.

4.63 The absence of an effective quality assurance program limits the ability of geriatric centres to assess the quality and appropriateness of patient care.

4.64 Appropriate outcome standards and clinical indicators need to be developed by the Department, in consultation with geriatric centres, for short-term aged care services, and quality assurance programs are in need of further review.

ACCESS TO AGED CARE SERVICES

Information on aged care services

4.65 Individuals need to have access to appropriate information about the availability of services, their rights, entitlements and responsibilities. This information is provided through a number of different sources which include local general practitioners, service providers, the Department and assessment teams.

4.66 Based on information generated from formal community consultation processes such as the North West Hospital's 1992 *Ageing People-Growing Needs, Consultation on Aged Related Services* review, there are many weaknesses in the information chain through which government and service providers reach the community. In relation to geriatric centres in particular, the hospital review found that it was common for the general community to know little about the services provided by the centres and to be confused about the centres' clientele. The hospital review also found that some local general practitioners were unwilling or unable to provide information regarding aged care services available through formal government programs.

4.67 Audit identified **a large disparity between geriatric centres in relation to the quantity and quality of written material available outlining aged care services**. Furthermore, residents' handbooks which provided information on meal times, visiting hours, other services available such as hairdressing, podiatry and dental care, and activity programs had not been developed by a number of geriatric centres.

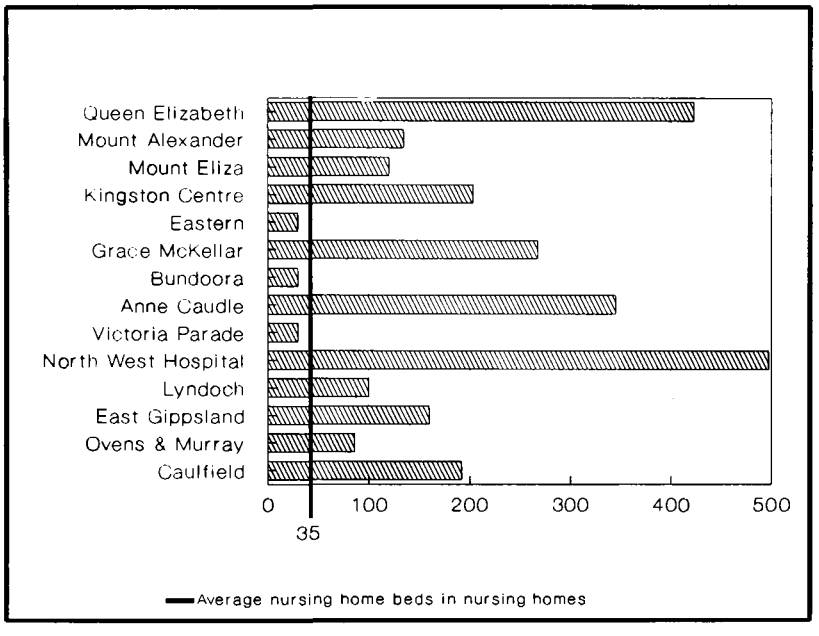
4.68 The audit review also disclosed **little in the way of publicly available information on aged care services provided under specific government programs**. This practice results from the Department's view that both the provision of aged care services and the information regarding these services is the responsibility of individual service providers. While recognising that there is some merit in the Department's view, this attitude seems to overlook the demand by the community for accessible and comprehensive information on all public sector aged care services.

4.69 Where information on aged care services is not readily available to the community, misunderstandings regarding available services can arise, resulting in some older people failing to access appropriate services and support.

Physical access to services provided by geriatric centres

4.70 The average number of nursing home beds in Victoria's geriatric centres is 187, compared with an average of 35 beds in the State's private, voluntary and public nursing homes. Chart 4A shows this comparison and demonstrates the concentration of nursing home beds in geriatric centres.

CHART 4A
REGISTERED NURSING HOME BEDS IN GERIATRIC CENTRES, JUNE 1993



Source: Audit questionnaire and annual reports of geriatric centres.
Note: Hampton Rehabilitation Hospital, which is classified as a geriatric centre, has been excluded because it does not have any nursing home beds. The nursing home beds at the North West Hospital are located on 2 major sites.

4.71 In addition, the majority of rehabilitation and geriatric assessment beds for the aged are also located in these geriatric centres.

4.72 The concentration of the Department's resources into a small number of geriatric centres, restricts access of local communities to aged care services.

4.73 Additional factors impacting on community access to services are the:

- lack of public transport in some instances;
- size and physical layout of certain centres; and
- location of some centres on undulating sites.

Access to services in rural and remote areas

4.74 Information contained in the *Mid-Term Review* indicates that **15 per cent of older Australians aged 70 years and over live in rural and remote areas.** In Victoria, the majority of aged care services provided to people living in these areas is provided by public sector organisations. In relation to nursing home beds provided in rural and remote areas, 3 600 beds or 70 per cent are publicly provided (refer to Part 6 of the Report for further details).

4.75 The challenge facing the Department is how to provide flexible and responsive services which meet the needs of, and can be adequately accessed by, the aged located in rural and remote communities, with limited resources.

4.76 Specific difficulties faced by the Department in the delivery of aged care services in these areas include:

- distance and geographical location;
- lack or absence of adequate public transport;
- high cost of providing infrastructure and support services in country areas;
- reluctance on the part of older people to move from local communities to larger centres; and
- sparse and declining rural populations.

Strategic planning

4.77 Assessing the needs of people living in rural and remote areas is dependent on the availability of appropriate information. The audit review indicated there was little information available on the specific needs of the aged, availability of aged care services and the utilisation of these services.

4.78 In the draft strategies developed by the Department and the regional offices, the special needs of people living in rural and remote regions is recognised. However, there is an absence of specific strategies to deal with the special problems faced by people living in these areas.

4.79 If the Department is to adequately address the care needs of the aged population, mechanisms need to be developed to collect sufficient information to enable the development of specific strategies which address the requirements of older people living in rural and remote areas.

Development of multi-purpose centres

4.80 Older people living in small rural or remote communities usually do not have access to a range of aged care services because the size of their local community cannot support the services required.

4.81 An innovative approach has been taken in some country areas to address the abovementioned matter through the development of multi-purpose centres. These centres, located in areas such as Lakes Entrance, Violet Town and Sea Lake, bring together existing services and develop additional services from a single base. The services provided include acute care, nursing home and hostel accommodation, community health services, counselling, and a range of home and community care services.

4.82 Benefits generated from multi-purpose centres include:

- sharing of overhead costs and scarce professional skills;
- better co-ordination of service delivery;
- ability to attract additional services to an area;
- providing flexible services to address differing local and regional needs; and
- reducing the number of *nursing home-type* patients in rural hospitals.

4.83 Since early 1990, the Federal Government has encouraged the development of multi-purpose centres through the provision of Federal funding. **It is pleasing to note that 9 multi-purpose centres have already been developed throughout Victoria and a further 3 are planned to be in operation by early 1994.**

Access to long-term aged care services

4.84 As discussed in more detail in Part 6 of this Report, there is a substantial over-supply of nursing home beds and an under-supply of hostel beds in Victoria compared with the Federal Government's standard. However, in some sub-regions, there is a shortage of nursing home beds compared with the Federal Government's planning benchmarks.

Interim nursing home care in acute hospitals

4.85 Older people account for a significant proportion of acute hospital usage. According to the *Mid-Term Review,* patients aged 60 or more accounted for 32 per cent of hospital discharges and 53 per cent of bed use in Victorian public hospitals during 1988-89. The *Mid-Term Review* also indicated that 1.5 per cent of discharges and 19.8 per cent of occupied bed days are accounted for by people over 60 years with lengths of stay in excess of 35 days.

4.86 It is important for acute hospitals to determine when older people in need of nursing home care are accommodated in acute hospitals longer than medically necessary.

4.87 The Federal Government, as part of its Medicare agreement with the State Governments and Territories, introduced a classification system in 1980 to identify long-stay patients in acute hospitals. The designation of *nursing home-type* patients is applied to persons who have been hospitalised for longer than 35 days and a medical practitioner has not confirmed that the patient is in need of acute care.

4.88 In June 1992, patients meeting the above criteria in Victoria's metropolitan area comprised 2.3 per cent of the bed use in acute hospitals while in the non-metropolitan area they represented 11 per cent.

4.89 The use of acute hospital beds for interim nursing home care for extended periods signifies problems associated with access to long-term and short-term aged care services. In audit opinion, such a situation is inappropriate due to a number of factors which include the following:

- Long-term care in acute hospitals is, in audit opinion, unlikely to be the most appropriate environment to care for older people. Facilities and procedures in acute hospitals may contribute to patient dependency, which may in turn lead to a deterioration in an elderly patient's functional capacity;
- Caring for *nursing home type* patients in acute hospital beds reduces the number of beds available for acute care services. With the demand for acute care services exceeding supply (especially in relation to elective surgery), any reduction in the availability of acute care beds **will result in an increase in waiting times for acute care;** and
- Use of acute hospital beds to provide interim nursing home care does not represent the most efficient use of resources as **the average cost of providing nursing home services in a public nursing home in Victoria during 1991-92 was approximately $129 per day, compared with $400 or more for an acute hospital bed.**

Access to short-term aged care services

4.90 Short-term aged care services consist of general medical care and the provision of specialist geriatric health services which include rehabilitation, geriatric assessment, and health management and maintenance services.

4.91 General medical care for older people is essentially the same as that provided to the wider community and includes acute and post-acute care. The care provided is aimed at restoring functions and improving the patient's ability to undertake the activities of daily living. Acute hospitals provide the majority of general medical care for older people although some geriatric centres provide inpatient acute and post-acute services.

4.92 Based on information maintained by the Department, the State's geriatric centres provided short-term aged care services in 1 059 hospital beds. Short-term aged care is also provided by public hospitals and, in some cases, nursing homes.

4.93 If aged care services are to be effective, then people in need of short-term aged care should be able to access the services they require. The audit review identified a number of instances where older people could not access these services. The following broad needs for additional short-term aged care services were identified by assessment teams or geriatric centres during the course of the audit:

- acute care beds in the Goulburn region;
- geriatric assessment beds in the Barwon, Goulburn and South Eastern Metropolitan regions;
- post-acute beds in the Western Metropolitan region; and
- rehabilitation beds in the Loddon Campaspe, Barwon, Goulburn, Western Metropolitan and South Eastern Metropolitan regions.

4.94 Where appropriate services are not available, older people may be denied the care they require or have to travel long distances to access services. The absence of post-acute and rehabilitation services is likely to increase the dependency of older people living in the community and result in their premature admittance to institutional care.

4.95 The audit revealed that the Department proposes to transfer residential care facilities away from geriatric centres to more appropriate community-based nursing homes, with some centres proposing to expand their acute, post-acute and rehabilitation services, while others are proposing to introduce these services.

Residential care facilities used for younger people

4.96 The *1991-92 Annual Report* of the Federal Department of Health, Housing and Community Services indicated that at 30 June 1992 there were 409 nursing home residents aged less than 60 years in Victoria, representing 3 per cent at the State's total nursing home population.

4.97 **The accommodation of younger people (less than 60 years of age), the majority of whom are disabled, in nursing homes which are predominantly designed for the aged, limits the availability of nursing home beds to accommodate older people.** In audit opinion, this situation is inappropriate as some disabled people require highly intensive support services because of the degree of their disability. Currently, nursing home standards do not provide for this level of care and are therefore not relevant to the needs of those young disabled requiring specialised care. In addition, the lifestyle and environment in nursing homes is unduly restrictive on the young disabled. Care of this type is inconsistent with the philosophy behind the Federal Government's policy which advocates the disabled should be cared for in the least restrictive form of care, preferably in their own homes.

4.98 It is audit's view that if alternative accommodation cannot be found for these younger people, it would be more appropriate to care for them in separate areas within aged care facilities. The funding of the services provided in these areas would ideally be separated from nursing home funding and be sufficient to adequately meet their care needs. Discussions with departmental staff indicated that the approach outlined above has been adopted recently by the Department to care for younger people in some geriatric centres.

Outpatient services provided by day hospitals

4.99 Outpatient services are provided by day hospitals and day centres. Day hospitals, which do not provide residential care, offer medical, nursing, physiotherapy, occupational therapy, podiatry, speech therapy and counselling services. Day centres provide a less intensive level of care, which includes activities for older people such as the provision of personal care and the preparation of meals that are intended to promote independence and enhance daily living skills.

Uneven distribution of day hospital services

4.100 Day hospital facilities have not evolved in a systematic manner with their placement dependent upon the availability of capital funding, local community support, involvement of existing service providers and political imperatives. The absence of a planned approach to the provision of day hospital facilities has also resulted in an uneven distribution of day hospital services within the State.

4.101 Audit was advised by a number of assessment teams that there was a need for more day hospital services in their catchment areas. The extent of this uneven distribution is demonstrated in Table 4B which outlines the number of people 70 years and over compared with the number of day hospitals in each region.

TABLE 4B
NUMBER OF PEOPLE 70 YEARS AND OVER PER DAY HOSPITAL BY REGION

Region	*Population 70 years and over*	*Number of day hospitals*	*Aged population per day hospital*
Country -			
Goulburn	15 060	22	690
Loddon Campaspe	17 760	20	890
Barwon South West	14 920	15	990
Central Highlands	20 610	18	1 150
Gippsland	26 510	9	2 950
Metropolitan -			
North Eastern	45 720	8	5 720
South Eastern	84 160	8	10 520
Western	85 950	4	21 490

Source: *Day Hospitals* - Department of Health and Community Services (June 1993), and *Population statistics* - Australian Bureau of Statistics (1991 Preliminary Census).

4.102 As outpatient departments in acute hospitals provide day hospital services and the capacity of metropolitan day hospitals usually exceeds that of hospitals located in rural areas, the distribution of day hospital services between the metropolitan and rural areas is less uneven than depicted in the above table.

4.103 The significant variances illustrated in Table 4B, which may be indicative of inequitable distributions of services, highlights the requirement for needs-based planning.

Co-ordination of day hospital services with inpatient care

4.104 The audit reviewed the activities provided to older people by a day hospital and how it co-ordinated its activities with an adjoining geriatric centre. The audit found that the day hospital services had not been adequately co-ordinated with those services provided by the centre. In addition, the day hospital was operating in isolation, with discrete goals and objectives and policies governing the access to treatment that only partially complemented the activities of other units within the geriatric centre.

4.105 Where day hospital services and services provided by geriatric centres or hospitals are not adequately co-ordinated, the length of stay of patients is likely to be unnecessarily extended in acute hospitals or geriaric centres to the detriment of patients requiring admission to these facilities.

Day hospital activities

4.106 The audit review indicated that the social and recreational activities provided in the day hospital were unnecessary and unlikely to represent the best use of professional staff resources. In addition, these social and recreational activities are the province of day centres or community-based local organisations rather than major health units.

4.107 Rehabilitation services are normally the dominant activity of a day hospital, complementing and continuing the major rehabilitation activity of acute hospitals and geriatric centres. However, the audit review indicated that the provision of rehabilitation services was not a high priority. Where day hospitals do not provide sufficient rehabilitation services, this situation may result in a shortage of day patient rehabilitation services, leading to longer lengths of stay for older people in acute hospitals or geriatric centres.

Quality of care

4.108 As with all health services, the standard of care is an essential determinant of the effectiveness of day hospital services. At present, independent reviews to assess the quality of day hospital services are not undertaken. The absence of quality assurance policies in a large number of day hospitals raises doubts over the effectiveness of the internal quality control mechanisms of such hospitals.

Overall conclusion

4.109 Audit concluded that to improve community access to aged care services, the Department needs to encourage geriatric centres to continue to progressively reduce the size of their main facilities by transferring services to small community-based facilities. In the interim, geriatric centres need to make appropriate improvements, where cost-effective, in areas such as transport access and the marketing of services.

4.110 Consideration also needs to be given to locating nursing homes in areas that are experiencing nursing home bed shortages and providing additional short-term services to older people where required. In considering these measures, attention will need to be given to the incidence of older people with long lengths of stay in acute hospitals.

4.111 The practice of locating younger people in nursing home beds and issues relating to access to outpatient services and the operation of day hospitals are in need of review.

APPROPRIATE SERVICES FOR THE AGED WITH SPECIFIC NEEDS

4.112 As indicated in the *Health Services for Older Victorians* 1991 Discussion Paper, the Department is of the view that special attention needs to be given to certain groups with special needs such as the carers of older people, the ethnic aged, dementia sufferers and people in rural and remote areas in order to ensure that all eligible people have access to aged care services. The Department aims to achieve improved access to aged care services by ensuring the design and delivery of services address the special needs of the community and by redressing inequalities experienced by the disadvantaged within the community.

Respite care

4.113 Respite care is primarily aimed at providing relief for the carers of older people living in private homes. Carers may be spouses, other relatives or friends of the elderly person. According to information collected by the Australian Bureau of Statistics, this group of people are the largest providers of services to the aged, **accounting for some 90 per cent of all services provided.**

4.114 The traditional type of respite care is temporary accommodation for older people in nursing homes and hostels (from one to 6 weeks). Other forms of respite services include:

- day respite in a nursing home, hostel or community health centre, allowing the carer to carry out other activities; and
- respite support for the carer by the provision of a replacement carer.

4.115 Respite is preferably a planned part of the elderly persons care program, but may be unplanned or in response to an emergency such as an illness of the carer.

4.116 Residential respite care provided by geriatric centres, public nursing homes and hostels has 2 primary aims, namely to provide:

- Relief for carers; and
- Medical servicing to older people. This involves an assessment of their physical condition, providing services to restore their general state of health and, where necessary, correcting medication. Recipients of these services include those that are in need of professional care at regular intervals to assess and restore their physical condition which, for a number of reasons, may be deteriorating while they are at home. Without the provision of the abovementioned services, many of the people receiving respite care would be unable to remain at home.

Planning the provision of respite care

4.117 The Federal Government, in an attempt to ensure the provision of adequate respite care, adopted a planned approach by developing population-based benchmarks for the provision of these services. The Federal Government's current planning target for respite care in nursing homes and hostels is 2 and 1.6 places per 1 000 people aged 70 years and over, respectively. In the overall planning of residential care, which aims to provide 95 places per 1 000 people aged 70 years and over (40 nursing home and 55 hostel), 3.6 of the 95 residential care beds are to be used for respite care within the public, private and voluntary sectors.

4.118 From a State perspective, the provision of appropriate respite care should be dependent upon identifying the need for these services within the community. The audit disclosed that the **provision of respite care in Victoria was historically based rather than appropriately planned to meet community needs.**

4.119 In the absence of a needs-based planning approach to the provision of respite care, the Department cannot be assured that its resources are effectively targeted to meet the community need.

4.120 The Department, in conjunction with its regional offices, should attempt to identify the specific need for respite care within each health region and provide respite services within the population benchmarks set by the Federal Government for the provision of respite care.

Adequacy of current respite care services

4.121 Discussions held with nursing home and hostel staff indicated wide variances in the utilisation of respite care. Some facilities provided a co-ordinated and well patronised respite service, while others indicated that services were under-utilised.

4.122 In order to assess the adequacy of respite services, audit used the Federal Government's planning target as a guide. **In June 1993, Victoria had 482 respite places in geriatric centres and nursing homes and 135 hostel respite places less than required by the Federal Government standard.** Relevant details obtained from the Department are disclosed in Table 4C.

TABLE 4C
RESPITE CARE PROVISION IN VICTORIA AT JUNE 1993

Facilities	*Beds provided*	*Federal Government standard*	*Shortage of beds*	*Percentage under-provided*
Geriatric centres and nursing homes	140	622	482	77
Hostels	357	492	135	27

4.123 The *Aged Care Reform Strategy Mid-Term Review 1990-91*, indicated the principal reason for the under-provision of respite care in the past has been the low level of funding provided by the Federal Government to the private sector. Respite services are more expensive for a nursing home or hostel to provide than regular services because of the logistics of managing short-term clients. Problems such as cancelled bookings, emergency changes, unplanned overstays, preparatory work needed in pre-planning and acclimatising clients to different environments, add significantly to the costs of providing these services.

4.124 The allocation of respite beds is further complicated by the incidence of unplanned and emergency requirements (both admissions and over-extended stays), which affect the availability of pre-allocated beds.

4.125 In order to address the financial disincentives associated with the provision of respite care, the Federal Government in July 1991 increased the supplementary funding provided to nursing homes and hostels for these residents. Based on discussions with senior officers from within the aged care industry, service providers have been slow to respond to these incentives.

4.126 Although respite care, in addition to that provided in designated respite beds, is provided in permanent nursing home beds in some public nursing homes, there is a significant shortage of respite services. Where sufficient respite care is not available, carers of dependent older people are not provided with adequate support and there is an increased likelihood that these older people will be prematurely admitted to residential care. **In audit opinion, appropriate action has not been taken to address the significant shortage of respite services within the State.**

Co-ordination of respite care services

4.127 As with most social services which are provided by a number of different organisations, respite care is more effective where the activities of individual service providers are appropriately co-ordinated.

4.128 Based on inquires addressed at service providers, a review of feedback from community consultation processes undertaken by a large geriatric centre and information contained in regional strategy documents, audit is of the opinion that **individual providers of respite care were operating in isolation, with no effective co-ordination of their services.** The absence of a co-ordinated approach to the provision of respite care results in user frustration, especially when a perceived lack of respite services is accompanied by some service providers complaining of under-utilised respite beds.

4.129 The audit found that there was a need to co-ordinate the residential respite services provided by geriatric centres, nursing homes and hostels through greater liaison between these facilities. As an alternative to overcome this lack of co-ordination, **a market opportunity exists for the provision of central booking services for respite care with users contributing to the cost of the services.** The Department should consider encouraging the private sector to avail themselves of this opportunity.

Information on respite services

4.130 Access to respite care is to a large extent dependent on community awareness of service availability. Where people are unaware of the existence of services or how to access them, they may be denied the care they require.

4.131 The audit found that there was scope for the Department to improve the level of community awareness regarding the availability of respite care services through, for example, **publicity campaigns and the provision of information for distribution by local general practitioners.**

4.132 It is interesting to note that services for carers have been identified as one of the priority areas for growth funds in the Government's July 1993 aged care policy which indicates that the provision of accurate and up-to-date information about available services is a way of assisting carers.

Flexibility of service delivery

4.133 Respite care requirements for older people vary according to individual circumstances. The need for these services can be on a planned, regular or emergency basis and can arise form a number of circumstances, including:

- holiday respite;
- short-term inability of individuals to care for themselves;
- illness of the carer; and
- recuperative placement following hospitalisation.

4.134 The audit found that respite services were relatively inflexible with many facilities preferring or requesting respite residents to stay for a defined period. There was a reluctance to take residents for short periods of time.

4.135 A range of options to address the inflexibility of respite services needs to be considered. These options could include:

- using day hospitals and day centres to provide overnight and short-term respite; and
- developing respite units in geriatric centres using geriatric assessment beds to provide these services.

Use of respite services for restorative care

4.136 Services involved with restoring the physical condition of respite recipients, although beneficial to these individuals, are not normally associated with respite care. The audit revealed that short-term restorative services were provided by many geriatric centres as part of respite care.

4.137 This situation indicates that the existing level of community support services for the provision of restorative care to older people is inadequate. The use of respite beds to provide short-term restorative services restricts the number of beds available to provide relief to carers which is the main objective of respite care. When respite beds are funded under the proposed CAM/modified SAM arrangement, the level of funding will not be sufficient to meet the costs associated with the restorative care currently provided.

4.138 The availability of community-based care needs to be expanded to reduce the level of restorative care in geriatric centres, thereby increasing the availability of respite beds for those in need.

Community respite care

4.139 As a result of the need to familiarise respite recipients with a new environment and the associated trauma which can often accompany this process, it is recognised within the health industry that the most appropriate care setting for respite care is often in the older person's own home. However, **most geriatric centres and public nursing homes have concentrated their resources on the provision of inpatient respite care.**

4.140 This has led to a shortage of community-based respite care. A number of assessment teams informed audit of a need for additional home-based respite services.

4.141 According to expert advice obtained by audit, the lack of home-based respite services is likely to adversely affect the quality of life of many respite care recipients, as older people prefer to remain in their homes and respite care provided in such surroundings is less disruptive to the individuals concerned.

4.142 As with inpatient respite care, community-based respite care needs to be expanded to meet the needs of the aged community. However, as the overall provision of respite care increases, there needs to be a change in the balance of care so that a greater proportion of respite care services are provided in the community. Such an approach is consistent with the general theme of the Government's aged care policy of giving priority to home and community care services. The Minister for Aged Care stated in July 1993 that *"...the system of home and community care services must be expanded and improved if it is to meet the challenge of an ageing population and the shift in the 'balance of care' away from residential services".*

- *RESPONSE provided by Secretary, Department of Health and Community Services*

  Respite care services are funded by the Federal Government through access to nursing home beds and the Respite Care program. Respite care is also provided through day care and home-based services funded by Federal and State Governments through the Home and Community Care program.

  The Department considers there are significant issues of equity and access in current Federal Government respite care arrangements. The Division of Aged Care Services completed a review of public sector respite care services in February 1993 as a basis for planned access to Federal Government funding of bed-based and community-based respite care services.

Ethnic aged

4.143 The Australian Bureau of Statistics data indicates that the proportion of people from non-English speaking backgrounds within the aged population is increasing. In 1986, people from non-English speaking backgrounds represented 18 per cent of the population 65 years and over. By 1991, this percentage had increased to 22 per cent of which approximately half were unable to speak English.

4.144 Language difficulties and cultural barriers can preclude non-English speaking older people from gaining access to a range of health services and supportive care. According to the Department the residential care needs of the ethnic aged can be addressed in 2 ways, namely:

- the development of ethnic specific services, for example, involving the opening of a nursing home which caters exclusively for residents born in a particular country; and
- developing measures to enhance access to mainstream aged care services.

4.145 The Department has recently developed guidelines to assist agencies improve services provided to the ethnic aged. These guidelines entitled *Working with people from Non-English Speaking Backgrounds-Guidelines for Health Agencies December 1992,* were designed to improve the quality of health services provided to people from non-English speaking backgrounds (NESB) and to improve their access to mainstream aged care services.

4.146 The audit review of services provided to people from NESB, using the State Government's guidelines as an appropriate standard, disclosed that a number of principles outlined in the guidelines have yet to be implemented. These matters are discussed below.

Organisational structure

4.147 The Department's guidelines state that in order to provide effective aged care services to the ethnic aged, geriatric centres need to establish an appropriate structure to organise and co-ordinate their activities. In accordance with the guidelines, this structure should include the appointment of an Ethnic Health Co-ordinator with overall responsibility for ethnic aged care and the establishment of an Ethnic Advisory Committee designed to develop links with community organisations.

4.148 However, the review revealed that some geriatric centres had yet to appoint an Ethnic Health Co-ordinator or establish Ethnic Advisory Committees.

4.149 Where responsibility for ethnic aged services has not been designated to a senior member of a geriatric centre staff, ethnic health services may not be totally adequate. Furthermore, in the absence of an Ethnic Advisory Committee, links to the ethnic community and to community organisations may be impaired.

Planning

4.150 As with other aged care services, ethnic aged care is more effective where the resources available for these services are appropriately targeted to meet community needs. A needs-based planning approach to the provision of ethnic aged care services is a method of ensuring resources are appropriately targeted.

4.151 The review disclosed that few, if any, formal reviews of aged care services (ethnic health audits) were undertaken by geriatric centres to assess how well these services were responding to the needs of NESB clients . In effect, there is very little detailed information on the nature, characteristics and health status of the NESB aged population or on the services currently provided to them. Without this information, the limited resources available to provide ethnic aged care will not be used in the most effective manner to satisfy the community's needs for these services.

4.152 Ethnic health plans, which address ethnic community aged care needs, have not been developed by most geriatric centres. Where ethnic health strategies have not been established, geriatric centres are unable to ensure that their ethnic health objectives are met.

Communication

4.153 Access to aged care services is dependent not only on the availability of services, but also on the elimination of barriers such as language and culture which can preclude specific groups from gaining access to the services they need. The availability of appropriate interpreter services, the provision of information regarding hospital services in languages other than English and the use of multi-lingual signs and symbols indicating the availability of interpreter services, can be used to reduce the effects of language barriers.

4.154 The audit review revealed the following problems within a number of facilities visited:

- With the exception of the offices occupied by the assessment teams, audit did not sight any multi-lingual signs or symbols throughout the centres;
- Resident needs for interpreter services were not recorded on client files. In the absence of such information, geriatric centres cannot be assured that individuals in need of interpreter services received such services;
- Although staff fluent in more than one language were employed by geriatric centres, there was little correlation between the languages spoken by the staff and the language spoken by the residents from NESB. Therefore, the centres' ability to adequately respond to the diverse needs of NESB residents is restricted; and
- Information provided on aged care services was usually only available in English.

4.155 Public aged care facilities need to implement the guidelines developed by the State Government to care for people from NESB backgrounds. Attention needs to be given to the provision of appropriate organisational structures to control and co-ordinate services, the development of needs-based planning to focus resources and to the effective communication of information to the ethnic aged.

Dementia

4.156 Dementia is considered by the Federal Government, in its Aged Care Reform Strategy, to require special attention due to the growing incidence of the disease in the aged population and the special nature of care required to manage some of the problems arising from the deterioration in mental capacity of older people.

4.157 The *World Health Organisation Draft International Classification of Diseases, 1990* describes dementia as:

> *"A syndrome due to disease to the brain, usually of a chronic or progressive nature, in which there is impairment of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. Consciousness is not clouded. The cognitive impairments are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation. This syndrome occurs in Alzheimer's disease, in cerebrovascular disease, and in other conditions primarily or secondarily affecting the brain."*

4.158 According to the Department's *Health Services for Older Victorians Discussion Paper 1991,* dementia can be classified as mild, moderate and severe. Information disclosed in the discussion paper indicates that the mild classification of dementia is difficult to diagnose and rarely requires institutional care. Symptoms of moderate and severe dementia include incontinence, wandering, aggression and confusion.

4.159 The *Mid-Term Review* estimated that there were 106 700 people 70 years or over suffering from moderate or severe dementia in 1991 which represented 10 per cent of older people within Australia. In general, these people were evenly distributed between community and residential care, with long-term psychiatric facilities accounting for less than 5 per cent of dementia sufferers. The majority of those in residential care (37 per cent) were accommodated in nursing homes, however, anecdotal evidence suggests that there has been a marked increase in the number of hostel residents with dementia.

4.160 The *Mid-Term Review* also indicated that overall, the number of dementia sufferers increased by 19 per cent between 1986 and 1991 and is expected to increase in the future, but at a slower rate.

4.161 Although it is recognised that the overall responsibility for dementia care rests with the Federal Government, audit is of the opinion that the public sector in Victoria, as a major provider of dementia care, has an indirect responsibility to ensure that services are adequate and appropriate.

4.162 The audit review revealed that some new nursing homes had developed innovative approaches to caring for the particular needs of dementia sufferers. For example, one nursing home provided space for residents to wander while at the same time preventing them from leaving the nursing home. However, a number of inadequacies in the provision of care were identified during the audit which are outlined below.

Assessment of services

4.163 Formal reviews, designed to assess the responsiveness of services provided to meet the needs of dementia sufferers, had not been undertaken. Geriatric centres had not collected information on the services provided by their centre or by other service providers in the region. At a central agency level, the Department had not:

- gathered information on the incidence of dementia within each region and had not identified the specific needs of sufferers;
- detailed the problems associated with dementia such as the behavioural peaks and troughs experienced by sufferers or the problems with patients who wander at night; and
- assessed the extent to which the aged care needs of sufferers were adequately addressed.

4.164 Without formal reviews, geriatric centres are unable to evaluate the adequacy of their current dementia services and identify any areas where these services can be improved.

Strategic plans

4.165 As with other aged care services, strategic plans are useful in converting the aims and objectives of geriatric centres and public nursing homes into action programs. However, only limited attention had been given to the development of strategies to address the special aged care needs of dementia sufferers. As a consequence, these organisations cannot give any assurance that their objectives in relation to the care of sufferers have been achieved.

Provision of special dementia care services

4.166 According to information received from assessment teams, services specifically designed for the care of dementia sufferers along with respite care represented the services with the greatest scope for improvement.

4.167 The majority of assessment teams identified deficiencies with the availability of appropriate care for sufferers. Specific problems raised included the shortage of:

- psychogeriatric centres;
- purpose-built dementia nursing homes and hostels;
- respite care for dementia sufferers; and
- appropriate units within nursing homes and hostels to care for dementia sufferers.

4.168 Where specific services are not available, dementia sufferers are inappropriately accommodated in geriatric centres and psychiatric institutions or remain in the community without the care they require. The absence of respite care in some areas also places strain on those individuals caring for dementia sufferers in the community.

4.169 The shortage of specific dementia aged care services further highlights the problems associated with not allocating resources on a needs-based planning basis.

- *RESPONSE provided by Secretary, Department of Health and Community Services*

  Agreed. Dementia is a key policy area for the Federal Government and is the focus of the National Action Plan for Dementia which provides funding and guidelines for the delivery of a wide range of dementia specific services in residential and community care services.

Dementia sufferers located in public facilities in contrast to the private and voluntary sectors

4.170 Audit discussions with staff providing residential aged care reflected a common theme in relation to the care of residents suffering dementia. It was argued that the public sector, in contrast to the private and voluntary sectors, was caring for a substantially higher proportion of the difficult and violent aged and a greater percentage of those suffering dementia. This situation was caused by the private and voluntary sectors' ability to be selective regarding admissions, whereas the public sector is required to accept any member of the aged community in need of care.

4.171 Audit was advised by service providers that the factors contributing to the lesser number of dementia sufferers located in the private and voluntary sectors are as follows:

- the disruptive effect on other residents and staff;
- the higher costs associated with providing aged care to these residents; and
- the standard level of funding provided is not sufficient to cover the higher costs associated with caring for dementia sufferers.

4.172 As no statistics were available to substantiate or refute the views of the service providers, audit was unable to confirm such views. However, in the event that such a situation does in fact exist, **the concentration of residents suffering from dementia in public residential care facilities for the aged results in the State system incurring higher costs compared with the private and voluntary sectors.**

Residential care facilities

4.173 Specialist advice provided to audit by professionals involved in the care of dementia sufferers indicated that such residents should be provided with sufficient space within the care facility to wander. The physical layout and facilities available in most public nursing homes, geriatric centres and hostels are not designed to accommodate the behavioural problems of these residents and therefore represent an inappropriate environment for their care. Many of the shortcomings associated with the care of dementia sufferers are exacerbated by the inappropriate and restrictive nature of many public residential care facilities.

Community care

4.174 Public nursing homes have traditionally catered for the care of people suffering dementia through the provision of inpatient services (in a nursing home ward or hostel). Alternatives such as day activities in supported accommodation or community-based dementia care have not been fully evaluated and appropriate services developed. Without such services, individuals requiring a lower standard of care in their home or local community would be inappropriately placed in an institutional care setting.

Access to information on dementia

4.175 Access to specialist information on dementia is an important aid to assist nursing staff to adequately care for the special needs of this group of people. The audit review revealed that staff in nursing homes and hostels have limited access to services and information that can assist with the management of dementia sufferers.

4.176 In order to ensure that the special needs of older people suffering from dementia are adequately addressed, the Department, geriatric centres and public nursing homes need to examine a range of matters including the need to develop strategic plans to:

- **avoid the concentration of difficult residents and dementia sufferers in public nursing home beds;**
- **expand the provision of community-based services to dementia sufferers; and**
- **change the physical structure of residential care facilities to better reflect their special needs.**

PART 5

Factors Impacting on the Delivery of Aged Care Services

OVERVIEW

5.1 In examining the factors that impacted on service delivery to older people, it is important to acknowledge the diverse range of factors influencing service delivery. In audit opinion, a number of factors contributed to aspects of poor performance.

5.2 Management of aged care services in Victoria in the past has been less than satisfactory, especially in comparison with the major initiatives introduced by the Federal Government since the 1980s. The audit review also revealed that planning for the delivery of aged care services has been inadequate, the infrastructure to provide quality services to older people has been unsuitable and, until recently, the State Government has been largely unresponsive in addressing the needs of older people.

5.3 From a managerial accountability viewpoint, a number of key mechanisms should have been in place in the past in order to provide efficient and effective services to older people in Victoria. A comprehensive planning framework designed to address the rapidly changing nature of the aged care service system and the provision of suitable infrastructure to meet the needs of older people are strategies which, in audit opinion, should have been implemented to achieve this aim. Overall, it is essential that the State Government responds to the needs of older people.

5.4 However, it is pleasing that several of these inadequacies referred to above are under review by the current Government.

5.5 The factors that emerged from the audit review which impacted on service delivery to older people in the past are discussed in detail below.

- *RESPONSE provided by Secretary, Department of Health and Community Services*

  The comments and findings in this section of the Report are accepted.

INADEQUATE PLANNING

5.6 During the early 1980s, the Department moved from a centralised management structure to a regional structure consisting of 5 country and 3 metropolitan regions. Each region had an office employing between 16 and 22 staff. In 1993 the structure of the Department was expanded to incorporate an additional metropolitan region.

5.7 The regional offices provide the mechanism by which the Department's aims and objectives are conveyed to individual public health service providers. The close proximity of regional offices to local communities facilitates responsiveness to local community needs.

5.8 As mentioned earlier in this Report, functions undertaken by regional offices include strategic planning, negotiating health service agreements, and monitoring the efficiency and effectiveness of individual public health service providers such as acute hospitals, geriatric centres, nursing homes and hostels.

Strategic planning

5.9 Strategic planning involves the translation of an organisation's goals and objectives into plans of action.

Long-term residential aged care

5.10 In the Auditor-General's *Report on Ministerial Portfolios, April 1991,* the following comment was made in relation to the planning of aged care services in Victoria:

> *"Apart from regional plans and strategies which have generally evolved on an ad hoc basis in response to local needs, the Health Department of Victoria has not developed overall planning strategies and policies for the future direction of State-wide residential care services for the aged. There has been no formal review of policies in this area of the Department's operations for at least 5 years".*

5.11 A subsequent review of residential aged care services, undertaken by the former Economic and Budget Review Committee in late 1991, also identified deficiencies in the planning of these services. The Committee's *Report on matters arising from the Auditor-General's 1989-90 Report on Ministerial Portfolios-November 1991* included the following comment:

> *"The Committee finds that the failure of the Health Department of Victoria to develop overall planning strategies and policies for residential care in Victoria has led to a mis-allocation of resources in the aged care area".*

5.12 As referred to earlier in this Report, the Department in November 1991 released a discussion paper entitled, *Health Services for Older Victorians.* This paper presented the current and emerging health issues affecting older people, identified a number of key strategic planning issues and proposed options for the future development of aged care services.

5.13 When this audit of aged care commenced, policies and overall planning strategies for the long-term direction of State-wide residential care services for the aged had yet to be developed by the Department. **However, as indicated earlier, audit is pleased to report that the Minister for Aged Care has now released a series of aged care policies.**

5.14 In contrast, the Federal Government, which has overall responsibility for the provision of residential aged care, has been actively involved in the planning process through:

- the establishment of planning ratios which link the provision of nursing home and hostels beds to the size of the aged population; and
- the use of Aged Care Advisory Committees in each State to control and direct additional residential aged care services to areas of greatest need.

Short-term aged care

5.15 In the absence of formalised State-wide planning policies and strategies, short-term aged care services have evolved in an unsystematic manner. As such, the Department cannot ensure that aged care services provided are consistent with State Government policy. Without the broad guidance and direction provided by a strategic plan, an unco-ordinated approach to service delivery, resulting in duplication of services or deficiencies in service provision, is inevitable.

5.16 Discussion with departmental staff revealed that a State-wide strategic plan for long-term and short-term aged care is planned to be released in December 1993.

Day hospital services

5.17 The effectiveness of day hospital services is dependent on the extent to which these services are properly planned. The audit review revealed a number of deficiencies in planning, including:

- a formal policy statement, outlining the aims and objectives of day hospitals and the services they provide, had not been completed by the Department;
- detailed strategies for day hospital services attached to geriatric centres and acute hospitals, which translate the Department's aims and objectives into an appropriate action program, had not been developed in all instances; and
- the location of day hospital facilities throughout the State has occurred in an unstructured manner, rather than from a systematic evaluation of the needs and requirements of the aged community.

5.18 The deficiencies, in audit opinion, have contributed to an inequitable distribution of day hospital services, a lack of co-ordination between day hospitals and associated inpatient facilities and the provision of some inappropriate day hospitals activities which were discussed in more detail in Part 4 of this Report.

5.19 It is important that the provision of day hospital services be adequately planned. This should involve the Department developing an appropriate policy statement, regional offices adopting needs-based planning techniques to target resources, and geriatric centres and hospitals developing detailed strategies for their day hospital services.

- *RESPONSE provided by Secretary, Department of Health and Community Services*

  Agreed. The Department considers the review and expansion of day hospital services to be a priority for attention.

Regional planning

5.20 Regional offices are responsible for planning and strategic direction at a regional level. An important component of this role is the development of appropriate regional plans for the provision of aged care services to older people.

5.21 The audit disclosed that, although regional strategic planning documents for aged care services had not been finalised by the 8 health regional offices, some progress had been made in that 3 draft plans had been prepared and another 3 were in the developmental stage.

5.22 A review of the 3 draft strategy plans disclosed the following deficiencies:

- A needs-based planning approach for the allocation of resources to meet the demand for aged care services had not been adopted. For example, in one region the community's specific aged care needs had not been determined and a planning framework based on age profiles, living arrangements and socio-economic factors, had not been developed;
- Outdated information obtained between 1986 and 1988 was used to plan aged care service delivery in 2 regions; and
- In most cases, appropriate time frames and responsibilities for task completion were not established. As an illustration, in early 1989 a strategy was developed by a region to transfer nursing home beds from a geriatric centre to small community-based nursing homes. However, a time frame for the transfers was not established. At the date of preparation of this Report the planned relocation of nursing home beds has not been completed.

5.23 To ensure that planning decisions are soundly based and aged care resources are equitably distributed, there is a need for regional offices to adopt appropriate needs-based planning techniques, maintain up-to-date information on aged care needs and service utilisation, and establish time frames and responsibilities for the completion of planning strategies.

- *RESPONSE provided by Secretary, Department of Health and Community Services*

  Agreed. The release in December 1993 of a State-wide plan for long-term care and short-term care of older people will provide the framework for regional planning and development of health services for older people.

Service provider planning

5.24 Business plans developed by service providers are useful in ensuring that the broad departmental and regional aims and objectives are reflected in the services provided and in providing a detailed outline for aged care service delivery.

5.25 The audit review indicated that, despite a 1991 departmental objective to prepare business plans, a significant number of geriatric centres and public nursing homes had not developed such plans by October 1992. In the sample of 110 geriatric centres and nursing homes included in Table 5A, 48 per cent indicated that they had not developed business plans and a further 30 per cent did not respond to the questionnaire.

TABLE 5A
DEVELOPMENT OF BUSINESS PLANS, OCTOBER 1992

	Business plan completed	*Business plan not developed*	*No response*	*Total sample*
Geriatric centres	6	4	5	15
Nursing homes	18	49	28	95
Total	**24**	**53**	**33**	**110**
Percentage	22	48	30	100

Source: Audit questionnaire.

5.26 If service providers are to ensure that resources are effectively targeted to meet the aged care needs of their local communities, urgent attention will need to be given to the development of appropriate business plans.

- *RESPONSE provided by Secretary, Department of Health and Community Services*

  The Department agrees that agencies should develop appropriate business plans to manage redevelopment of services and achieve benchmark costs and service outcomes.

Discharge planning

5.27 Planned discharge of patients from acute hospitals, geriatric centres and day hospitals is designed to ensure that adequate support services are arranged to meet individual patient needs prior to their discharge. Effective planning begins with a determination by staff, the patient and family of the tasks the patient can do alone, the aid and support that is needed, and the community services that are available. This process should be facilitated by a skilled discharge co-ordinator with a sound knowledge of the community services available and the criteria for eligibility to these services.

5.28 The audit found that **discharge planning arranged for older people was generally satisfactory.** Nevertheless, the process could be improved by the:

- use of skilled discharge co-ordinators;
- planning of discharges occurring at the earliest possible time rather than when the patient is ready to leave;
- development of suitable discharge planning policies, procedures and referral mechanisms; and
- provision of information on the range and type of support services available.

5.29 Resolution to the above problems would improve bed usage and ensure the continuity and appropriateness of care for individual patients.

CHANGING NATURE OF NURSING HOME CARE

Institutional focus compared with community care

Quality of life issues in an institutional environment

5.30 As indicated earlier in this Report, aged care can be provided through the provision of nursing home care, hostel care, and home and community care. The present balance of care in Victoria is historically based, reflecting policy responses to changes in the need for aged care generated by population increases.

5.31 Traditionally, health care services provided to older people have tended to be institutionally focused. This focus is reflected in the organisational ethos, operational practices and attitudes of staff in some geriatric centres and public nursing homes which have evolved in a background of institutional style buildings. In these facilities, staff have generally regarded their role as one of providing clinical services to residents in an institutional setting, instead of a service aimed at making residents feel that they are in their own homes. Audit fully appreciates the practical limitations placed on the ability of these older-style public facilities to provide residential services in a style similar to that available in a community care setting or one's own home.

5.32 Notwithstanding these constraints, it is pleasing to report that in some nursing homes, positive steps were being taken to address the desirability of moving away from an institutional focus.

Shifting the balance of care from residential to community care

5.33 Audit discussions with experts within the health industry indicated that the most appropriate setting for aged care is in the home and not in an institution. This view is supported by the *Nursing Homes and Hostels Review 1986* which states that:

- *"Aged and disabled people should as far as possible be supported in their own home, in their own communities";* and
- *"Aged and disabled people should be supported by residential services only where other support systems are not appropriate to meet their needs".*

5.34 The Department, in its document *Achieving Better Health and Health Services, Strategic Directions 1992-94*, accepted that not all health needs can or should be met by health institutions and that the needs of older people can often best be met in their own home or in the local community. In the same document the Department also recognised the historic concentration on residential care and established an objective to change the current balance of residential and community care to better reflect local needs and priorities.

5.35 Similarly, the July 1993 government policy outlines a series of directions aimed at giving priority for older people to live independently in their own homes. It acknowledges that *"... during the last few years, there has been a conscious attempt to limit the growth of expenditure on nursing homes, and to expand the services funded under the HACC Program. The State Government is indirectly responsible for managing nearly a third of all nursing home beds. This portion will fall as the State builds up its specialist aged health services and home care programs".*

5.36 The ability of older people to remain in their homes is dependent on the level, range and quality of services available within the local community to meet their care needs. Expanding services in the local community to cater for complex care needs of the aged, as well as providing basic services, enables more dependent people to be maintained in the community at a lower overall cost to the State.

5.37 Although the level and quality of community-based services has been improved in recent years, it is evident from a review by audit of geriatric centre expenditure that while resources are still predominantly applied for residential care, a need exists for additional home and community services. During the course of the review, audit was advised by certain assessment teams of a number of service gaps in the provision of community services. In particular:

- the North East and South Western assessment teams indicated a general lack of appropriate community care in their catchment areas;
- the St George and Victoria Parade teams indicated that they often have to provide domiciliary therapy due to the absence of this service in their catchment areas;
- a lack of flexibility in the delivery of domiciliary services was identified by the Gippsland teams;

- a shortage of home-based respite care was identified by the Mount Royal, Mooroopna, Mildura Base and Gippsland teams; and
- the Mooroopna and Mount Eliza teams indicated that the lack of appropriately designed day care facilities for younger disabled people results in these people inappropriately using day centres that were designed for older people.

5.38 **Audit commends the current State Government whose objective is to continue with the commitment to establish an appropriate balance of residential and community care in order to obtain the most equitable and effective use of its resources and achieve the preferred outcome for older people and their carers.** In this regard the State Government in its 1993-94 budget redirected funding from residential care to provide an additional $12 million for home and community care services. Additional funding could be used to:

- increase the availability and level of domiciliary care;
- provide alternative hostel care options, such as the delivery of services to people in their existing accommodation from neighbouring hostels;
- provide additional day hospitals and day centres which could meet the health care needs of older people living in the community, thereby reducing the need for nursing home admissions; and
- expand rehabilitation and post-acute care services in the home by medical, nursing and allied health staff.

Inappropriate institutionalisation

5.39 In the early 1980s, a number of reviews of aged care were undertaken. These reviews expressed concern in relation to the inappropriate admission of older people into institutional services, indicating that inadequate assessment procedures and lack of suitable alternative services had resulted in a mismatch between the care requirements of individual residents and the type of care provided.

5.40 The reviews found that the inappropriate institutionalisation of some members of the aged community prior to the mid 1980s had contributed to:

- **The provision of care in an inappropriate environment.** As most people now prefer to be cared for in their own homes, taking people out of their homes and placing them in institutions unnecessarily inhibits their freedom and restricts their independence, which in turn adversely affects each resident's overall quality of life;
- **A deterioration in the level of functioning of some residents.** Where the level of care provided is in excess of the residents' individual needs, their well-being is often adversely affected as they tend to become more dependent in this environment;

- **Increased aged care costs.** Due to the direct relationship between the level of care provided and the cost of providing the care, the cost of nursing home care per person is more expensive than hostel or community care. In Victoria, publicly provided nursing home care costs on average $135 per day, while hostel care is in the order of $61 per day, with community care at around $33 per day; and
- **An increase in the average length of stay** for residents in nursing homes results in a reduction in the turnover of residents. This in turn restricts community access to nursing home beds and results in **people in need of nursing home care inappropriately located in acute hospitals.** The care provided in acute hospitals is not designed for long-term aged care patients and extended stays in these hospitals can actually increase patient dependencies. Also, caring for people in need of long-term aged care in acute hospitals is inefficient due to the substantially higher cost of the care provided.

5.41 With increasing demands for aged care and the scarcity of resources available to satisfy these demands, providing services in excess of those required by the aged community is inefficient. Committing large amounts of money to inpatient nursing home care results in less funding available for other forms of aged care services such as home and community care.

5.42 Inappropriate institutionalisation of the aged was recognised as a major problem by the *Nursing Homes and Hostels Review 1986*. The Federal Government's Aged Care Reform Strategy attempted to address the problem by:

- Establishing an effective geriatric assessment service to prevent the inappropriate placement of the aged in nursing homes. As indicated earlier in this Report, the use of Aged Care Assessment Teams was expanded in Victoria to assess the needs of the aged and ensure that only those requiring a high level of ongoing nursing home care be admitted to a geriatric centre or nursing home;
- Introducing a funding system for nursing and personal care costs which linked the subsidy provided to each resident's level of dependency and provided financial incentives for private and voluntary nursing homes to take higher dependency residents; and
- The establishment of a planning ratio which effectively provided a ceiling on the number of nursing home beds in each region.

5.43 Based on information contained in the *Mid-Term Review* in 1990-91, the abovementioned Federal Government initiatives have ensured that services provided in private and voluntary nursing homes have been effectively matched to the individual needs of residents. **In relation to public nursing homes, the matching of services provided with individual resident needs has only been partially addressed.** As the assessment teams only allow people in need of nursing home care to access public nursing homes, it is unlikely that newly admitted residents will be inappropriately placed. However, State operated nursing homes do not receive funding for residents based on their level of dependency as do private and voluntary nursing homes. As a consequence, there has been little incentive in the past for publicly operated nursing homes to identify and relocate residents, admitted prior to initiatives introduced by the Federal Government, who have levels of dependency below that now required for nursing home care.

5.44 As public nursing homes introduce CAM/modified SAM over the next year, their funding will be based on dependency of residents. Those residents who do not qualify for nursing home classification therefore would not attract CAM/modified SAM funding. This should provide the necessary incentive for these organisations to relocate such residents to more appropriate care environments. **The relocation of such residents, where possible, would overcome the adverse consequences that occur from the inappropriate institutionalisation of older people.**

5.45 Information obtained during the course of the audit in relation to residents' length of stay in 9 geriatric centres and 67 public nursing homes at June 1992 are included in Table 5B.

TABLE 5B
RESIDENT LENGTH OF STAY IN GERIATRIC CENTRES AND PUBLIC NURSING HOMES, JUNE 1992
(number of residents)

	Length of stay			
Facility	< 4 years	4-10 years	> 10 years	**Total**
	(no.) (%)	*(no.) (%)*	*(no.) (%)*	*(no.)*
Geriatric centres	1 095 (74)	316 (21)	64 (5)	1 475
Public nursing homes	1 312 (73)	441 (25)	30 (2)	1 783

Source: Audit questionnaire.

5.46 With a national average length of stay in nursing homes of 21 months (as indicated in the *Mid-Term Review*), it is reasonable to assume that if residents were appropriately placed in geriatric centres and nursing homes, there should be very few, if any, residents with lengths of stay in excess of 4 years. **The existence of one in 4 residents with lengths of stay in excess of 4 years indicates that, based on the current admission criteria used by assessment teams, a significant number of current residents were inappropriately placed in geriatric centres and public nursing homes. These residents would have been more appropriately placed in less intensive care environments, such as hostels or retained in their own homes with adequate community support.**

5.47 Geriatric centres surveyed by audit identified 19 residents who did not require the level of care provided in a nursing home. It is likely that the actual number of residents that could be relocated is substantially higher than this figure as 60 per cent of centres surveyed did not provide any information. The transfer of such residents to hostels or relocation into the community with support care services, would provide a more appropriate environment and reduce aged care costs to the Department.

5.48 In order to ensure that resident care is adequately matched to resident needs, geriatric centres and public nursing homes should review long-term residents, identifying and relocating residents with low dependency needs to more appropriate care settings where possible.

5.49 As mentioned earlier, in recognition of the preference of older people to be cared for in the community, the Minister for the Aged announced in July 1993 that increased funding would be provided for home and community care services.

Increased dependency of residents in the public system

5.50 A very dependent resident (RCI-1) requiring extensive care may be someone who is bedridden, incontinent, has badly impaired sensory skills, or is incapable of undertaking basic activities such as washing, dressing and eating without total assistance. Alternatively, a less dependent resident (RCI-5) may require some supervision and assistance with mobility, limited continence care, supervision or assistance with activities of daily living and have minor behavioural problems.

5.51 As a result of Federal Government action to reduce nursing home numbers, the dependency levels of residents in nursing homes is increasing. In the public sector these increased dependency levels are more pronounced, as the private sector has the ability to be more selective on admissions, whereas the public sector accepts any member of the aged community in need of care.

5.52 According to the findings of the *Mid-Term Review*, at a national level the relatively higher levels of dependency in public nursing homes is evidenced by the average length of stay of 62 weeks, which is 45 per cent less than in private nursing homes and 25 per cent less than in voluntary nursing homes.

5.53 The Department advised audit that for many highly dependent residents, some aspects of the Outcome Standards such as the provision of a homelike environment are less relevant to their needs.

5.54 Based on specialist advice, audit adopted the view that the Outcome Standards were an appropriate guide during the audit of the quality of nursing home care in late 1992. However, as the Outcome Standards were established 6 years ago, there may be a need to re-assess the Standards to reflect any changes in the profile of public sector nursing home residents.

Hostel care

5.55 Discussions with hostel management indicated that the profile of hostel residents was changing as the hostels connected to public hospitals were accepting an increasing number of more dependent residents.

5.56 The Federal Government's policy of reducing nursing home bed numbers combined with the Department's policy of using designated nursing home beds for other aged care services, has resulted in the placement of individuals in hostels who would qualify for nursing home care.

5.57 The increase in dependency of hostel residents was also acknowledged by research undertaken by the *Mid-Term Review* whose findings indicated that the dependency of many hostel residents is equivalent to the less dependent nursing home residents.

5.58 Audit identified a number of problems associated with placing more dependent residents in hostels, namely:

- the range and level of care provided to some hostel residents may not be sufficient to meet their needs;
- the location of residents who have behavioural problems in hostels can have a disruptive effect on the hostel environment and an adverse effect on the other less dependent hostel residents;
- additional strain is placed on the limited number of hostel beds; and
- the funding provided by the Federal Government may not be sufficient to adequately care for such residents.

5.59 Public hospitals providing hostel services need to review the dependency profiles of their residents, ensuring that adequate facilities and appropriate services are provided to meet the higher dependencies associated with some of the residents.

INFRASTRUCTURE

Physical structure of aged care facilities

5.60 The audit found that the physical environment of public nursing homes impacted on the achievement of at least half of the Federal Government Outcome Standards. Nursing home care is often provided in multi-storey buildings with large hospital-style wards which are not currently recognised as the appropriate setting for such care. These buildings make it difficult to create a homelike and safe environment for residents. In addition, the open plan ward-like environment affects the level of privacy available to residents.

A large multi-storey geriatric centre.

5.61 Concentrating large numbers of the aged in institutional settings can affect the level of acceptance of geriatric centres and nursing homes by the local communities. Without community acceptance, appropriate ties cannot be established between nursing homes and their local communities. Such interaction is necessary to provide residents with a wide variety of experiences.

Delays in commissioning new nursing homes

5.62 A major initiative of the former State Government's 1988-89 Budget was to increase the number of public nursing home beds within Victoria by 550 over 4 years. The program aimed to convert 220 acute hospital beds to nursing home status, mainly in rural areas, and to construct 11 new 30 bed community based nursing homes to provide an extra 330 beds at a capital cost of $26.5 million.

5.63 In the Auditor-General's April 1991 *Report on Ministerial Portfolios*, it was reported that several of these nursing homes remained unoccupied for long periods of time, although facilities were ready for occupation. The audit found that delays of between 15 and 29 months occurred in the opening of 4 nursing homes.

5.64 With these nursing homes remaining vacant for extended periods of time, for example the nursing home in Bundoora only admitted residents in March 1993, almost 2.5 years after it was built, scarce government resources were invested prematurely in unproductive infrastructure while other valuable aged care services remain unfunded.

5.65 Although constructed to provide nursing home care, the nursing home in Bundoora is currently used to provide rehabilitation and assessment services to older people living in the North Eastern Metropolitan Region. Discussions with management of the adjoining rehabilitation centre, which has responsibility for the nursing home, revealed that the facility was not used to provide nursing home care as it was not possible to operate the home purely on CAM/modified SAM funding.

5.66 Although recognising that delays in commissioning these new nursing homes arose due to prolonged negotiations between the Federal and State Governments over recurrent funding arrangements, audit considers that, in future, appropriate funding arrangements should be finalised prior to the works commencing.

New nursing homes - design and demand

5.67 The former Government, in building 11 new nursing homes, attempted to incorporate many of the homelike qualities espoused in the Federal Government Outcome Standards into the design of these homes.

5.68 The nursing homes provide modern facilities comprising individual rooms, new furnishings and equipment, separate dining rooms en-suites and showers, and in some cases private gardens.

A new nursing home constructed in 1991.

Modern homelike furnishings of a new nursing home.

5.69 As people are attracted to more modern facilities, long waiting lists for the new nursing homes have arisen, while some older nursing homes have empty beds. Two new nursing homes identified by audit had average waiting times in excess of a year. Details of the number of people on the waiting list and the average time taken to gain admittance for these 2 nursing homes are outlined in Table 5C.

TABLE 5C
WAITING TIME FOR ADMISSION TO NEW NURSING HOMES

Nursing home	*Number of people on waiting list*	*Average time taken to gain admittance*
Westernport	107	> 3 years
Donwood (Croydon)	46	>1 year

Source: Information supplied by the Westernport and Donwood nursing homes.

5.70 While recognising that families would prefer for their relatives to be accommodated in these new homes and that they choose to accept delays in admission, such actions increase the number of patients situated in interim nursing home beds in geriatric centres and acute hospitals. These actions also adversely impact on waiting lists for geriatric centres and acute hospitals, and result in the inappropriate use of State resources.

CONTROL OVER THE QUALITY OF RESIDENTIAL NURSING HOME CARE

5.71 Procedural controls in the form of appropriate standards of care and monitoring practices over publicly provided residential nursing home care were not in place until July 1993 when the current Government commenced the introduction of the Federal Government's Outcome Standards and use of monitoring teams. The absence of these mechanisms in the past has impaired the quality of care provided to older people by the public system. Further comments concerning these matters are outlined below.

Outcome Standards

5.72 For over half a century Victoria has had in place specific legislation dealing with the protection and well-being of residents in private nursing homes. However, this legislation primarily focused on the physical aspects of care relating to buildings, linen and food preparation, and not on quality of life issues relevant to nursing home residents. The Outcome Standards introduced by the Federal Government in 1987 for private and voluntary nursing homes were not until recently adopted by the Department for use in State operated nursing homes and geriatric centres.

5.73 In 1991 the Department developed its own outcome standards which were incorporated into legislation for the health industry. This legislation, which widened the scope of the former legislation to include voluntary as well as private nursing homes, was intended to complement and support the Federal Government's Outcome Standards and provide a mechanism for the swift introduction of a range of intermediary sanctions in cases where standards were compromised in the private and voluntary sectors.

5.74 As indicated in Part 4 of this Report, there was substantial scope to improve the quality of life of older people residing in geriatric centres and public nursing homes. In audit opinion, the lack of quality of care standards for the delivery of aged care services in the public aged care system contributed to this situation.

5.75 Current departmental negotiations with the Federal Government, designed to raise existing Federal funding of public nursing home beds from an average of $51.50 to $63 based on resident dependency levels (CAM/modified SAM funding), will result in the phased introduction of Federal Government Outcome Standards into these homes by July 1994.

User rights philosophy

5.76 Although a user rights philosophy was introduced into private and voluntary nursing homes in August 1989, this philosophy has not been adopted by the Department for use in State operated health agencies. Such a philosophy, embracing a statement of resident rights, formalises the basic rights of nursing home residents and ensures that both carers and residents are aware of these rights.

5.77 As with outcome standards, the introduction of CAM/modified SAM funding into public nursing homes will involve these homes adopting the Federal Government's user rights philosophy.

Monitoring the quality of care

5.78 The Department employs 10 qualified nurses to undertake quality of care reviews, however, these nurses have only reviewed the quality of care in the private and voluntary sectors.

5.79 It was not until July 1993 that an agreement was reached with the Federal Government to introduce monitoring teams to conduct independent reviews of the operations of health agencies providing public nursing home care. Although the quality of care provided in these agencies was not dependent on the existence of external reviews, such reviews will provide an objective assessment of the quality of nursing home services.

5.80 Discussions with senior management of the Department indicated that by July 1994 all public nursing home beds will be subject to Federal Government monitoring teams.

FUNDING MECHANISMS

Traditional funding mechanisms

5.81 Health agencies have traditionally been provided with funding which reflects their historical operating costs, appropriately adjusted each year for cost of living increases. The system of linking funding to inputs was to change in 1986-87 with the introduction of health service agreements between the Department and health care agencies. These agreements were designed to link funding to the level of agency output, measured in terms of services provided.

5.82 However, the audit disclosed that **despite the establishment of health service agreements, health care agencies involved in the delivery of aged care continued to be funded according to historical inputs,** such as staff employed and other operating costs. This finding is consistent with the comment in my May 1992 *Report on Ministerial Portfolios*, on the operation of health service agreements in public hospitals, that in reality the provision of government funding was predominantly based on resource inputs.

5.83 Linking funding to inputs does not provide incentives to agencies or the Department to:

- re-allocate resources to areas of higher priority service needs including new policy initiatives and services;
- improve service efficiency and use savings to fund additional services; and
- fund alternative forms of health delivery, e.g. community care in preference to inpatient care.

Case-mix funding

5.84 The Department is currently moving to a resource allocation system which links health agency funding to the specific output of each agency. This funding mechanism, known as "case-mix funding", is to be introduced in 5 stages. The first stage is being introduced for 1993-94 and involves the provision of 30 per cent of each agency's inpatient budget by way of case-mix funding.

5.85 In order to identify and measure the output of health agencies, specific case-mix categories need to be developed. The Department proposes to use Diagnostic Related Groups (DRGs), which link patients with similar clinical characteristics, as a case-mix measure. Under this system, health agencies will receive funding for patients treated, based on the individual DRG classification of each patient. The quantum of funding to be provided for each DRG classification will reflect the average operating cost of providing the particular services involved.

5.86 **The introduction of case-mix funding should also result in the Department purchasing the most cost-effective services for older people.** However, there is a risk that case-mix funding, if not properly controlled, may have an adverse impact on older people. These individuals, who are often frail and experience multiple health problems, usually take longer to recover following an acute illness or accident than a younger person. As specific allowance is not made for older patients within specific DRG classifications, potential exists for acute hospitals to discriminate against these individuals which would limit their access to appropriate health services and adversely affect their quality of life.

5.87 In relation to long-term aged care, the phased introduction of CAM/modified SAM funding for public nursing homes to June 1994 will result in the reduction of nursing home costs. Nevertheless, **resources are unlikely to be effectively targeted until the Department introduces appropriate population based resource allocation mechanisms for long-term aged care services.**

5.88 As case-mix funding has not been introduced for most of the specialist short-term geriatric services, many of the problems with the funding of aged care services have still not been addressed. **For short-term aged care services, a resource allocation mechanism, which links funding to services provided, needs to be developed.** However, such a system should take account of the specific nature of specialist aged care services.

- *RESPONSE provided by Secretary, Department of Health and Community Services*

  Agreed. The Federal Government has responsibility for resource allocation of nursing home and hostel (long-term) services. The Department is seeking to redistribute public sector resources to achieve greater distributional equity. The Department is moving towards unit costing for other aged care services.

ORGANISATIONAL FRAMEWORK

Background

5.89 As indicated earlier in this section of the Report, the Department in the early 1980s moved to a regionalised structure. The principal aim of regionalisation was to improve the Department's responsiveness to community needs by placing regional offices in close proximity to local communities.

5.90 One of the factors contributing to some of the problems highlighted in the delivery of aged care services, e.g. in relation to planning health services, was the Department's inability to fully implement an effective organisational structure for regional health services. This view was supported by the findings of the 1992 *Victorian Health System Review* which was commissioned by the former Victorian Minister for Health in February 1991.

5.91 It was not until June 1993 that the 3 metropolitan regional offices were relocated from the Department's offices in the Melbourne central business district to their respective regions. An additional metropolitan region was also created at this time.

5.92 Prior to June 1993 the role and responsibilities of the Department, its regional offices and aged care service providers were not clearly defined. Furthermore, where responsibilities had been assigned, they were not always supported by appropriate delegations of authority.

5.93 The deficiencies resulted in health agencies often by-passing regional directors and dealing directly with the Department's executive management or the Minister. This situation commonly occurred in regard to industrial relations issues arising prior to 1993.

5.94 The role of regional offices, in the provision of aged care services, was partially clarified when aged care service managers were appointed within each regional office in June 1993.

Co-ordination of aged care activities

Provision of services

5.95 There are a significant number of participants involved in the planning and provision of aged care services including the Federal Government, the Department, local governments and public, private and voluntary operated services.

5.96 The audit revealed that there were inadequate linkages between acute care, residential care and community care services used by older people. This situation has arisen largely as a result of the Department's system of funding the historical inputs of individual facilities rather than the services required within regions and sub-regions. The system in place during the audit encouraged service providers to retain patients rather than facilitating their movement through the aged care system.

5.97 Consideration needs to be given to the development of agreements between public and private acute hospitals and geriatric centres to improve co-ordination of services where significant patient transfers occur.

Quality of services

5.98 In all States other than Victoria, the provision of medical services to older people (geriatric medicine) is an integral part of the general public hospital system. However, in Victoria, these services have largely been developed in geriatric centres including rehabilitation hospitals as well as acute hospitals. The North Eastern Metropolitan Region's *Discussion Strategy Paper 1989* identified the following problems associated with the system:

- As people age they experience a range of physical, mental and social changes which strongly influence the type of treatment they require in hospital. Acute hospitals do not have an adequate level of resources and have not developed an appropriate level of expertise in geriatric medicine and aged care. In the absence of this expertise, patient care for the aged cannot be optimised in acute hospitals;
- Resident doctors in geriatric medicine are not rotated outside geriatric centres. The lack of medical staff rotations between geriatric centres and acute hospitals limits the number of staff exposed and trained in geriatric medicine;
- The State's teaching hospitals undertake very little research in the area of geriatric medicine; and
- With the lack of expertise in geriatric medicine in acute hospitals, aged people receiving care for extended periods in acute hospitals should be transferred to geriatric centres. Patient access to these facilities is dependent upon the level of liaison between acute hospitals and geriatric centres. At present, the degree of liaison is variable.

5.99 Geriatric centre management indicated that the abovementioned problems were still evident throughout Victoria. As a result of **geriatric services and acute hospital services not being adequately integrated**, the standard of aged care provided to individuals has not been optimised.

5.100 Discussions with representatives from the aged care industry identified a number of strategies which would improve the integration of specialist geriatric services and acute hospital services. These strategies include the establishment of:

- **Geriatric medical units in all teaching and major acute hospitals.** At present a number of these units have been established at acute hospitals including The Royal Melbourne, Austin and Dandenong District Hospitals; and
- **Joint geriatric medicine and psychiatric services in a number of State teaching hospitals.** These services would provide teaching hospitals with expertise in both geriatric and psychogeriatric care which would in turn improve the quality of care available to older people admitted to these hospitals.

Hospital accreditation

5.101 The Australian Council of Health Care Standards (ACHS) was first established in 1974 by the Australian Medical Association and the Australian Hospital Association, as a completely independent non-profit organisation whose goal is to improve quality of patient care in Australian hospitals. This goal has since been extended to encompass the provision of optimal patient care in other types of health care facilities such as nursing homes and geriatric centres.

5.102 To assist in achieving its goal, ACHS has a primary objective to establish and develop standards by which quality of care may be assessed by both the community and the Department, and to survey health care facilities on a voluntary basis using these standards. These surveys act as a basis to accredit the quality of services provided by health care facilities.

5.103 ACHS accreditation provides a valuable mechanism by which the quality of care in geriatric centres can be independently and objectively assessed. These assessments can then be used by the individual agency and the Department to identify and address weaknesses in the quality of aged care services.

5.104 However, audit found that only 5 out of the 10 geriatric centres reviewed had been accredited. In order for the Department to ensure an appropriate standard of aged care services is maintained in State geriatric centres, the Department should implement a program to ensure all geriatric centres have attained ACHS accreditation.

LACK OF RESPONSIVENESS TO CHANGING NEEDS

5.105 The aged community has a great diversity of care needs which are in a state of constant change. For aged care services to be delivered in an effective manner, the level and mix of services provided needs to be adaptable in meeting change.

5.106 To ensure that the care provided continues to be relevant and appropriate, it needs to take account of the changing age composition of the community. Table 5D highlights the changing composition of the aged in Victoria.

TABLE 5D
INCREASE IN VICTORIA'S POPULATION

Year	*Increase in total Victorian population*	*Percentage increase in total Victorian population*	*Increase in the population 70 years and over*	*Percentage increase in population 70 years and over*
1986-1991 *(a)*	224 240	5.6	26 800	9.4
1991-1996 *(b)*	454 480	10.7	79 490	25.6
1996-2001 *(b)*	257 900	5.5	44 400	11.3

(a) Based on 1986 census and preliminary 1991 census.
(b) Based on 1986 population projections.
Source: Australian Bureau of Statistics - population statistics.

5.107 According to the Australian Bureau of Statistics there were 311 000 people aged 70 years and over in Victoria in 1991. The Bureau's projections indicate that this figure will increase significantly between 1991 and 2001 by 40 per cent or 123 890 people.

5.108 The *Health Services for Older Victorians* discussion paper of November 1991 indicated that people between 65 and 74 years of age are usually physically healthy, functionally independent and mentally alert. Their care needs tend to reasonably reflect those of the general public and as such their main care needs include preventative health services, primary health care and occasional access to acute hospitals.

5.109 As people increase in age past 75 years they are likely to have greater levels of physical frailty, and severe handicap and disability, chronic illness, mental impairment, dementia and incontinence become more prevalent. They are also likely to be more socially and economically dependent. Their main care needs will generally include personal help and supervision in their daily activities, nursing care, rehabilitation following falls or illness, incontinence programs, pain management and specialised care for the demented and confused.

5.110 The need for aged care is also influenced by the following factors:

- the level of handicap within the population;
- living arrangements, i.e. whether people live at home on their own, at home with others or in residential care;
- availability of suitable housing;
- availability of carers; and
- the incidence of dementia.

5.111 The audit revealed that the Department had in the past been largely inflexible and unable to adequately meet the changing aged care needs of the community. In particular, the audit found that:

- Although the groundwork for a State-wide strategic plan for aged care was established with the development of the discussion paper in 1991 entitled *Health Services for Older Victorians*, it was not until July 1993 that a government policy addressing the need for services to be responsive to change was released by the recently appointed Minister for Aged Care;
- The ability of geriatric centres and public nursing homes to respond to the needs of the community was limited, as resource allocation decisions were made in the absence of formal processes to identify community needs. In addition, the Department and its regional offices have not developed population based benchmarks for the provision of long or short-term aged care services;
- Although the inequitable distribution of nursing home beds and the concentration of public resources in large institutions has been evident since 1986, only limited action was taken by the Department to improve access to aged care services and correct the uneven distribution of services. Furthermore, the shortage of capital funding and the inequitable basis on which such funding has been allocated, have combined to limit the ability of the public sector to provide appropriate aged care services in response to population changes;
- Care standards and the establishment of monitoring procedures for the State's public nursing homes and geriatric centres have not been developed by the Department. In contrast, as outlined in Part 3 of this Report, the standards for aged care in the private and voluntary sectors have changed significantly following a number of reviews undertaken during the early and mid-1980s;
- Nursing home care continues to be largely provided in older style institutions in hospital-like settings rather than in small homelike nursing homes in community settings or in peoples' own homes. Many of the problems associated with the quality of care in geriatric centres and public nursing homes identified earlier in this Report, such as restricted social independence, inadequate respect for privacy and dignity, and limited freedom, are directly attributable to the Department's inability to respond to the changing requirements for effective aged care;
- With the introduction of CAM/SAM funding in the latter part of the 1980s, it became apparent that public nursing home care was less efficient than that provided by private and voluntary nursing homes. However, until recently, departmental initiatives have made only a limited impact on eliminating these inefficiencies; and
- Systems and procedures have not been developed to measure and evaluate the relative efficiencies of short-term aged care services provided by geriatric centres or to establish an appropriate basis by which these services can be funded.

5.112 The lack of responsiveness has adversely affected the aged community as some of the services received have not been appropriately matched to their care requirements.

5.113 However, recent developments, including the issue of the discussion paper on "Health Services for Older Victorians" and the July 1993 policy for aged care services, which states that available public resources will be managed to ensure access to appropriate and responsive services, indicates that the Government is becoming more responsive to community needs.

INSUFFICIENT RESEARCH

5.114 According to information contained in a House of Representatives Standing Committee for Long-term Strategies report entitled *Expectations of Life: Increasing the Options for the 21st Century*, the increase in the average life expectancy of the population is mainly due to reduced deaths from cardiovascular disease resulting from changes in lifestyle (75 per cent) and medical advances (25 per cent).

5.115 The 1991-92 Annual Report of the National Research Institute of Gerontology and Geriatric Medicine contained the following observations regarding the ageing of the population:

> *"Longer life had been accompanied by less fatal but disabling dependency-induced disorders, such as dementia and chronic arthritis with the largest increase in severe disability occurring in the 85 and over group.*
>
> *"As far as currently known, these conditions are not affected by lifestyle. It will, no doubt, be possible to develop appropriate preventative measures for them in due course when medical research has discovered more about their mechanism or initiatives."*

5.116 Both of these reports recommended that health authorities consider channelling funds into research which is directed towards understanding the cause and development of the diseases that predominate in old age. Improved knowledge should contribute to the prevention of some of these diseases in older people.

5.117 Of the $17.3 million funding provided in Victoria under a program for health education, research and service quality, only $300 000 (1.7 per cent) was used to fund aged care research undertaken by the National Research Institute of Gerontology and Geriatric Medicine. Additional public funding for these purposes was made available from the North West Hospital ($117 000) and the Victorian Health Promotion Fund ($114 000).

5.118 In addition, funding was also directed towards research activities in a number of geriatric centres. However, the amount spent on research represents only a small proportion of the overall funding provided for aged care of $1.7 billion annually.

5.119 As one would expect some correlation between the prevention of health problems and the level of aged care research, the limited financial support for this research is likely to adversely impact on the quality of life and lead to higher institutional care costs in the future.

5.120 In the light of the Reports referred to above, consideration should be given by the Department to reallocating some funds from aged care treatment to research. Over time, this reallocation of funding is likely to improve the quality of life of older people and reduce inpatient aged care costs.

- *RESPONSE provided by Secretary, Department of Health and Community Services*

  Clinical research is substantially funded by the National Health and Medical Research Council, and other sources such as trusts and foundations contribute significantly to clinical research. The Federal Government's Aged Care program funds research into residential care service development and evaluation. Aged Care Services Division will develop research priorities in light of the State's strategic directions in aged care service development and delivery.

PART 6

Efficiency of Aged Care Services

OVERVIEW

6.1 The audit disclosed that the Department has not in the past managed the resources involved in the delivery of aged care services in the most efficient manner. There was scope to reduce the overall costs of aged care services provided by geriatric centres and public nursing homes which include functional areas such as nursing, catering, laundry, cleaning and gardening.

6.2 In comparing the operating costs of public aged care facilities with the costs that would have been incurred if the services had been provided by the private and voluntary sectors, or in comparing the costs between publicly operated facilities, it was evident that, notwithstanding some differences in the composition of residents (such as the presence of higher dependent and demented residents in the public system), substantial efficiency gains could be achieved within the State system. As an illustration, the audit revealed that in 1991-92:

- the average cost of nursing home services in State geriatric centres of $171 per bed day was 87 per cent higher than private and voluntary nursing homes, which represents $66 million additional funding for the year;
- public nursing home costs of approximately $129 per bed day were 42 per cent higher than that of private and voluntary sectors, representing additional annual funding of $37 million;
- costs of rehabilitation and assessment services in geriatric centres ranged from $236 and $477 per bed day; and
- subsidies paid annually to public hostels by the State Government were in excess of $4 million.

6.3 Efficiency measures introduced by the Department during 1992-93 in the provision of nursing home care reduced the potential savings identified above by around $15 million.

6.4 The audit highlighted that substantial savings could be achieved if the Victorian Government achieved its stated aim of transferring public nursing homes to the private and voluntary sectors and reducing the public sector to 10 per cent of all nursing home beds (annual savings of $79 million). If publicly provided bed numbers were reduced to the national average or the Federal limit, annual savings of $51 million or $65 million could be achieved respectively. These estimated savings would be offset by any additional costs involved in the expansion of community and home based services.

6.5 Audit suggests that substantial annual cost savings could be achieved in various functional areas of geriatric centres which were acknowledged by the Minister for Aged Care in his policy statement of July 1993 as very expensive to operate. Table 6A illustrates the potential savings that are available on the basis that the geriatric centres with higher than average costs could reduce costs to that of the average (minimum savings) or centres could operate at the level of the most efficient centre (maximum savings). As the savings identified are based on information provided by approximately half of the geriatric centres, potentially higher savings could be achieved across the entire 15 centres.

TABLE 6A
POTENTIAL ANNUAL COST SAVINGS, 1991-92
($ million)

Functional area	*Minimum*	*Maximum*
Catering	2.2	7.5
Laundry	0.2	0.3
Cleaning	1.2	4.0
Gardening	0.2	0.6
Total	**3.8**	**12.4**

6.6 It was also found that the sale of surplus property holdings in some aged care facilities would provide a substantial return to the Government.

- *RESPONSE by Secretary, Department of Health and Community Services*

  Comments and findings in this section are endorsed.

NURSING HOME AND HOSTEL BEDS

6.7 Analysis by the Federal Government in 1986 disclosed that residential aged care was not effectively targeted and equitably distributed. In particular, there were wide variations in nursing home bed numbers between States, between regions established within States and within regions which resulted in areas remaining under-provided. The analysis also revealed that care for the aged was concentrated on institutional care rather than through the development of home and community care.

6.8 Since that time, the Federal Government has introduced nursing home and hostel planning ratios in order to improve targeting of residential care places. The ratios were designed to link the level of care to forward projections of the aged population, the dependency and level of disability in the community and the availability of alternative services such as home and community care.

6.9 Using the Federal Government's planning ratios as a guide to the appropriate number of beds to be provided at a State level, the audit disclosed that, **while Victoria is more closely aligned to the Federal Government ratios, it still had an over-supply of nursing home beds, a shortage of hostel beds and an inequitable distribution of nursing home and hostel beds between sub-regions** with some bed shortages at a municipal level.

6.10 Further information relating to the overall bed provision and distribution in Victoria is contained in the following paragraphs.

Provision of beds

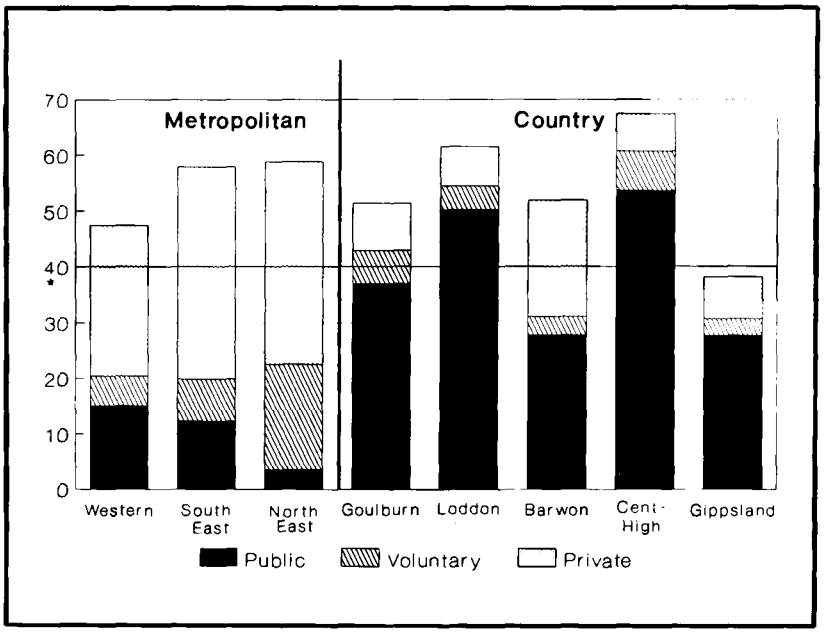
Nursing home beds

6.11 Overall responsibility and control of nursing home care in Australia lies with the Federal Government through its provision of nursing home funding. Most State Governments have a relatively minor role in the provision of these services, which is limited to ensuring compliance with regulations relating to such areas as buildings, linen and food. Nursing homes are owned primarily by the private sector, unlike other forms of institutional care.

6.12 In **Victoria**, the situation is vastly different in that the State Government plays a more significant role in the provision of nursing home care. **Of the 16 800 nursing home beds in the State, 32 per cent are under public sector management, compared with only 9 per cent in New South Wales and an average of 18 per cent for Australia.**

6.13 Chart 6B shows the number of nursing home beds per 1 000 population 70 years and over for each of the 8 departmental regions categorised according to public, voluntary and private nursing home beds. As illustrated in the chart, most of the public nursing home beds (70 per cent) are located in the 5 country-based health regions.

CHART 6B
REGISTERED NURSING HOME BEDS PER 1000 POPULATION 70 YEARS AND OVER BY REGIONS AS AT 1991



* Federal Government benchmark of 40 nursing home beds per 1 000 head of population 70 years or over.
Source: Beds - Aged Care Research Group, Tenth Progress Report, July 1992.
Population Statistics - Australian Bureau of Statistics, Preliminary 1991 census.

6.14 The State provides 2 900 nursing home beds in 113 public nursing homes (including 31 specialist nursing homes such as homes for the blind) and an additional 2 600 beds in 15 State geriatric centres. In rural areas most of the public nursing homes are attached to acute hospitals, while in the metropolitan area most nursing home beds are provided in geriatric centres or small nursing homes under the auspices of geriatric centres. Geriatric centres provide residential aged care services as well as a range of other specialised aged care services such as acute, post-acute, rehabilitation and geriatric assessment.

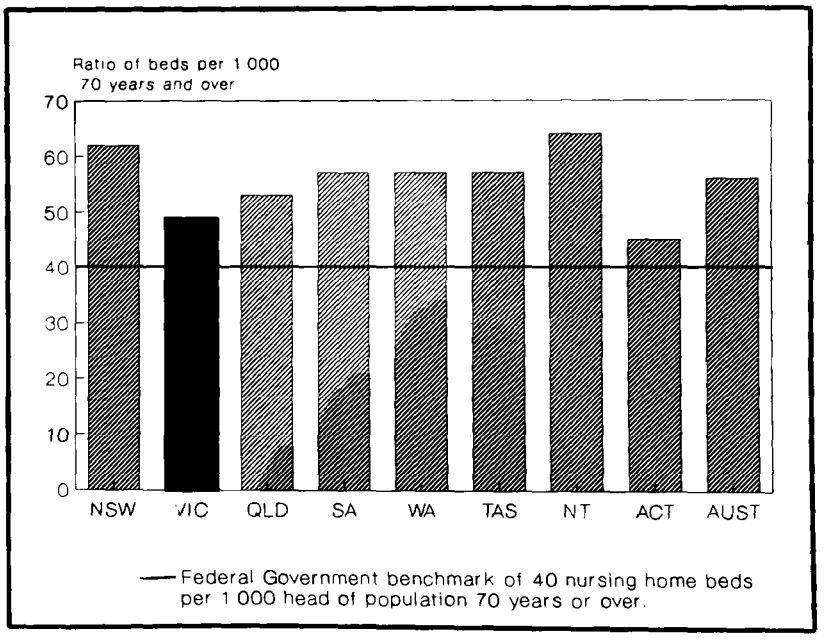
6.15 Victoria, with a ratio of 49 nursing home beds per 1 000 population 70 years and over, has, relative to its aged population, fewer beds than the other States and Territories except the ACT (see Table 6C and Chart 6D). However, all States and Territories have more nursing home beds than the Federal Government planning ratio of 40 beds per 1 000 aged population.

TABLE 6C
NURSING HOME BEDS, INCLUDING APPROVALS IN PRINCIPLE, BY STATE

	1986			1992				
State	Population 70 years and over	Beds	Ratio	Population 70 years and over	Beds	Ratio	Reduction in ratio 1986-92	Excess beds
NSW	390 150	30 128	77	469 500	29 199	62	(15)	10 419
Vic.	**284 210**	**16 061**	**57**	**341 370**	**16 821**	**49**	**(8)**	**3 166**
Qld	181 070	12 407	69	228 500	12 009	53	(16)	2 869
SA	103 630	7 597	73	125 820	7 130	57	(16)	2 097
WA	88 170	6 591	75	107 410	6 156	57	(18)	1 860
Tas.	30 870	2 374	77	37 460	2 144	57	(20)	646
NT	3 030	131	43	2 700	173	64	21	65
ACT	7 800	420	54	11 600	525	45	(9)	61
Australia	1 088 930	75 709	70	1 324 360	74 157	56	(14)	21 183

Source: Beds - Department of Health, Housing and Community Services 1991-92 Annual Report and the former Department of Community Services, 1985 - 86 Annual Report.
Population statistics - Australian Bureau of Statistics.(1986 actual, 1992 projections).

CHART 6D
RATIO OF NURSING HOME BEDS PER 1 000 POPULATION 70 YEARS AND OVER - STATE COMPARISON, JUNE 1992



Source: Beds - Department of Health, Housing and Community Services 1991-92 Annual Report and the former Department of Community Services, 1985 - 86 Annual Report.
Population statistics - Australian Bureau of Statistics.(1986 actual, 1992 projections).

6.16 Using the Federal Government nursing home planning ratio as a guide, **Victoria had 3 166 (23 per cent) more nursing beds in 1992 than the standard.** As demonstrated in Table 6C, the ratio of Victoria's nursing home beds compared with its aged population is declining (all other States and Territories except for the Northern Territory experienced this trend).

6.17 Discussions with departmental staff indicated that the 40 beds per thousand planning benchmark may be too low due to changes in the level of dependency and disability in the community and the availability of alternative services. The relatively lower level of nursing home beds in Victoria compared with the other States and Territories, is compensated by higher expenditure on home and community care. In 1990-91, the Victorian per capita expenditure on home and community care for the population 70 years and over was 15 per cent above the national average.

6.18 With most nursing homes operated by private or voluntary organisations as independent businesses, it is difficult for the Federal Government to reduce nursing home bed numbers. As a consequence, the over-supply of nursing home beds has been mainly addressed by limiting new nursing home licences and relying on the natural increase in the aged population to reduce the availability of beds to the aged.

6.19 With one in 3 nursing home beds in Victoria provided by the public sector compared with an average of one in 6 in the other States, greater scope exists for the relevant authorities to reduce overall nursing home bed numbers through the public system. However, until recently only minor reductions in the number of public nursing home beds have been achieved.

Hostel beds and supported accommodation

6.20 As with nursing home care, the Federal Government has primary responsibility for hostel care, which is predominantly provided by the private sector. Of the 276 hostels in Victoria, only 41 (15 per cent) are operated by public hospitals.

6.21 Supported residential services are essentially provided by private organisations, whereby the costs of accommodation are met by individual tenants. The only State responsibility in regard to the provision of these services is a registration and monitoring role undertaken by the Department. This monitoring role encompasses a review of issues relating to public health, safety and quality of care.

6.22 Using the Federal Government's planning ratio of 55 hostel beds per 1 000 population 70 years and over as a guide, Victoria had an under-provision of 5 553 hostel beds in 1991. This bed shortage is partially offset by the existence of supported accommodation beds in the State. Based on research undertaken by the Department, approximately 44 per cent of supported accommodation beds can be considered as effective substitutes for hostel beds. If the supported accommodation beds are taken into account, **the shortage of hostel beds in the State is reduced to 1 469.**

6.23 The Federal Government is attempting to address the shortage of hostel beds in the public, private and voluntary sectors through the provision of additional hostel services. Approvals for an additional 5 000 beds have been recently granted by the Federal Government, but the current shortage of beds is likely to continue for some time.

6.24 The shortage of hostel beds has either resulted in individuals in need of hostel care staying in the community or being inappropriately placed in acute hospitals. Where, due to a lack of appropriate beds, individuals in need of hostel care reside in the community, unnecessary pressure and hardship is placed on spouses and families responsible for the care of these older people. In circumstances where older people cannot remain in the community, for example, due to the absence of appropriate carers, individuals are likely to be placed in a hospital bed until a hostel vacancy becomes available. As previously indicated, the provision of nursing home care for older people in acute hospitals is inefficient due to the higher cost associated with this level of care.

6.25 The shortage of hostel beds, although partially offset by the existence of special accommodation beds, is still a significant problem facing the State.

Distribution of beds

6.26 To supplement the Federal Government's commitment to address the inequitable distribution of nursing and hostel beds, the Department, in its *Health Service for Older Victorians* discussion paper released in 1991, stated that the traditional role of public sector aged care services included *"...complementing long-term services in the private and voluntary sectors by meeting geographical or other gaps in service provision".*

Nursing home beds

6.27 Even though there is an over-supply of nursing home beds in Victoria compared with the standard set by the Federal Government, the audit review identified that there is an inequitable distribution in sub-regions (sub-regions comprise groupings of local municipalities) throughout the State. To illustrate this issue audit found that within the Western Metropolitan Region the Bulla sub-region had 175 excess beds whereas the Keilor sub-region had a shortage of 80 beds. The Federal Government planning ratio of 40 beds per 1 000 population 70 years and over was used to determine the excess or shortage of beds in each sub-region in the State. In using the planning ratio, audit recognises that it is only a guide rather than a rigid requirement.

6.28 The *Aged Care Reform Strategy* indicates that nursing home services should be easily accessible by older people in their local community. The audit revealed that in addition to the inequitable distribution of beds between sub-regions, significant bed shortages occurred in some municipalities within various sub-regions. For example, in the Western Fringe sub-region the municipalities of Melton and Bacchus Marsh have bed shortages of 30 and 5, respectively, whereas Werribee has 60 beds more than required by the standard.

6.29 Discussion with departmental staff indicated that although the Department was willing to address the uneven distribution of nursing home beds, a number of constraints have prevented it from doing so. These constraints include:

- a lack of capital funding to relocate nursing home facilities; and
- an inability to direct geriatric centres and public nursing homes to reduce nursing home beds as the licences and funding of these services were provided by the Federal Government.

6.30 While audit acknowledges these constraints, the relocation of beds from the Mount Eliza Centre and the planned relocation of beds from other geriatric centres such as North West Hospital demonstrates the Department's ability to initiate change. Furthermore, the Department, through its provision of nursing home supplementary funding and short-term aged care funding, can indirectly control the provision of nursing home beds in geriatric centres and public hospitals if considered necessary.

Hostel beds and special accommodation

6.31 The overall shortage of hostel and supported residential beds is compounded by the inequitable distribution of the relatively small number of beds which are available.

6.32 Using the Federal Government standard of 55 beds per 1 000 population aged 70 years and over as a guide, hostel bed provision within the State ranges from 590 excess beds in the Central Core sub-region (55 per cent more than required) to the Southern Fringe sub-region which is in need of an additional 448 beds. However, almost all municipalities had an under-supply of hostel beds.

6.33 As with nursing home care, the Department is of the opinion that it has limited control over public hostels as these services are provided under an agreement with the Federal Government and the service provider.

6.34 As previously indicated, there is a need to reduce the provision of publicly provided nursing home beds. In bringing this level in line with other States, audit is of the view that publicly provided inpatient nursing home care should be replaced by:

- community-based care; and
- private and voluntary nursing home beds where appropriate.

6.35 The July 1993 policy released by the Minister for Aged Care states that the Victorian Government's recurrent subsidy to public nursing homes and hostels was $113 million in 1991-92. Over the next 5 years the Government will aim to transfer public nursing homes to the private and voluntary sectors and to reduce the publicly provided beds to 10 per cent of all nursing home beds. These public nursing home beds are to be redistributed to areas of need and some specialist long-term care services are to be provided. **The potential annual cost savings to the State Government from reducing public nursing home beds in line with this strategy is approximately $79 million.**

6.36 A reduction in the provision of publicly provided nursing home beds to the national average of one in 6 or in line with the Federal Government limits would result in annual savings of around $51 million and $65 million, respectively. The savings achievable from the reduction in publicly provided nursing home beds would be offset by any additional costs incurred in the expansion of community based care.

6.37 To assist in the effective targeting and equitable distribution of long-term aged care services, the Department should adopt a needs based planning approach to the provision of residential care including hostel services.

Classification of nursing home beds

6.38 As indicated earlier in this Report, public nursing homes are funded by the Federal Government, the State Government and through resident contributions. In Victoria the Federal Government provides an average subsidy of $51.50 per occupied bed day for most public nursing home residents based on the number of registered beds.

6.39 In a selection of geriatric centres audit compared the number of registered beds which attracted funding from the Federal Government with the actual number of beds in use for providing nursing home residential care. This comparison revealed that **the Federal Government was funding 327 nursing home beds which were not provided for the intended purpose.**

6.40 This incorrect classification of nursing home beds has the following implications:

- The Federal Government is paying at least $5.8 million annually for nursing home services which are not provided; and
- Designated (registered) bed numbers are used by the Federal Government to measure each region's service provision in relation to its planning ratio of 40 beds per 1 000 population 70 years and over. This comparison enables the Federal Government to determine future regional nursing home bed needs. The planning process is impaired where service providers use designated nursing home beds for other purposes.

6.41 Geriatric assessment and rehabilitation services, provided in registered nursing home beds, are not adequately supported with funding provided from Federal Government nursing home benefits. The average cost per bed day of a geriatric assessment or rehabilitation bed in a geriatric centre during 1991-92 was $323. However, as the Department's proposed new funding system (based on a modified version of the Federal Government's CAM/SAM funding model) will provide only $91 per bed day, it is clear that nursing home funding will not provide adequate resources to support the provision of geriatric assessment and rehabilitation services. If geriatric centres continue to provide these services in registered nursing home beds following the introduction of CAM/modified SAM, then significant funding will need to be obtained from other sources to support the services.

6.42 Audit was advised by the Department that the Federal Government was aware of this situation and the conversion of a number of nursing home beds to assessment and rehabilitation beds has commenced.

NURSING HOME CARE IN NURSING HOMES

6.43 The audit revealed that the average cost of nursing home care during 1991-92 was approximately $129 per bed day (based on information provided to audit by 67 public nursing homes) which was $38 per bed day(42 per cent) above the level of funding provided under CAM/modified SAM of $91 per bed day.

6.44 The audit found that the majority of nursing homes were not operating at the average cost of $91 per bed day provided under CAM/modified SAM funding, with a considerable variation in the costs between nursing homes. The level of the variation is demonstrated in Table 6E where 15 per cent of nursing homes have bed day costs in excess of $160 while 9 per cent have bed day costs less than $100. In effect, the difference between the cost of care per bed day in the least efficient nursing homes is $60 (60 per cent) higher than the costs in the most efficient homes.

TABLE 6E
COST OF NURSING HOME CARE, 1991-92

Cost per bed day	*Number of nursing homes*	*Percentage of total*
Above $160	8	15
$141 - $160	-	-
$121 - $140	22	40
$100 - $120	20	36
Less than $100	5	9
Total	**55**	**100**

Source: Audit questionnaire.

Newly constructed nursing homes

6.45 As indicated previously in this Report, the Department built a number of new nursing homes during 1990 and 1991. The cost per bed day of 7 of these new nursing homes, that had operated for at least a year, is included in Table 6F which highlights the relatively higher efficiency of these new homes compared with other public nursing homes.

TABLE 6F
NEW NURSING HOMES COST PER BED DAY, 1991-92

Nursing homes	*Cost per bed day*	*Favourable percentage variance in comparison with average cost ($129) of all nursing homes*
	($)	*(%)*
Westernport Memorial Hospital	125	3.1
Daylesford District Hospital	124	3.9
Mount Eliza Centre - Jean Turner	116	10.0
Burwood - Peter James	100	22.4
Wonthaggi and District Hospital	100	22.4
Croydon - Donwood	96	25.6
Eildon and District Hospital	95	26.4
Average	**108**	**16.2**

Source: Audit questionnaire.

6.46 With an average bed day cost of $108, these new nursing homes are $21 (16 per cent) more efficient than the average public nursing home. However, the cost of running these new nursing homes is still on average $17 (19 per cent) higher than the average funding of $91 per bed day available under CAM/modified SAM.

6.47 The relative inefficiency of the older nursing homes can be largely attributed to the physical constraints such as the size, age and inappropriateness of buildings and equipment. Particular problems associated with older nursing homes include:

- additional costs involving administration, security, porterage, car parking, and cleaning and lighting of corridors and office areas, which are associated with larger nursing homes or nursing homes physically attached to public hospitals;
- higher general maintenance costs for items such as lift maintenance associated with multi-level older style buildings; and
- additional costs associated with the operation of large management information systems.

6.48 In addition to these physical constraints, the audit review indicated that the degree of flexibility available in the provision of nursing services and the level of services also impact on the efficiency of nursing homes. **New nursing homes have developed more flexible nursing services by using a mix of casual, part-time and full-time staff (through the use of ward assistants) to provide nursing services instead of only using registered or State enrolled nurses and by providing more flexible rosters for nursing staff.** The opening of new nursing homes has also facilitated the transition to more flexible work practices due to the changed work environment.

6.49 Another problem associated with existing nursing homes is the provision of services which are additional to those recommended by the Federal Government's Outcome Standards. These include:

- internally provided medical services;
- allied health services;

- pharmacy services;
- patient transport; and
- other services such as hairdressing and dentistry.

6.50 Although most residents benefit from the receipt of these services, their provision results in additional departmental expenditure, leaving less resources available to meet more urgent aged care needs.

Potential savings

6.51 Based on information provided to audit, **the maximum potential cost savings that could be generated if public nursing homes were to operate at the level of funding provided to the private and voluntary sectors is in the order of $37 million a year.** As indicated earlier, it is pleasing to note that the Department has commenced a phased introduction of CAM/modified SAM funding into public nursing homes which is to be completed by 1994.

6.52 In the longer-term, the full benefits of introducing CAM/modified SAM funding will only be realised by replacing existing facilities with new smaller nursing homes or by significant capital investment to modernise existing facilities. Due to the high capital costs of upgrading existing facilities and developing new facilities, it will be difficult for public nursing homes to be able to operate on CAM/modified SAM funding.

COST OF NURSING HOME CARE IN GERIATRIC CENTRES

6.53 As with the review of costs in public nursing homes, audit used questionnaires to gather information on nursing home care in geriatric centres. Of the information supplied by 10 geriatric centres that responded to the questionnaire, some information requested by audit was not provided. Information contained throughout this section is based on the information received.

6.54 The survey revealed that the average nursing home bed day cost in geriatric centres during 1991-92 was $171. This bed day cost is $80 (87 per cent) above the level of funding provided under CAM/modified SAM. Audit calculated that **around $66 million per annum could be saved if all geriatric centres reduced their costs to that of the private and voluntary sectors.** A comparison of the average nursing home costs per patient bed day in 7 geriatric centres with CAM/modified SAM funding provided for a resident with a RCI-3 classification is outlined in Table 6G.

TABLE 6G
NURSING HOME BEDS IN GERIATRIC CENTRES
ACTUAL COSTS COMPARED WITH CAM/MODIFIED SAM FUNDING, 1991-92

	Average $bed day		*Variance*	
	Average geriatric centre costs	*CAM/modified SAM*	*Above CAM/modified SAM*	*Above CAM/ modified SAM*
	($)	($)	($)	(%)
CAM costs -				
Nursing and personal care costs	98	58	40	69
SAM costs -				
Catering	18	12.5	5.5	43
Laundry	5	2.7	2.3	85
Environmental services	19	8.1	10.9	135
Administration	10	3.8	6.2	163
Total SAM	52	27.1	24.9	92
Other cost reimbursed expenditure	12	6	6	100
Non-CAM/SAM -				
Medical	2	-	2	
Pharmacy	2	-	2	
Other	5	-	5	
Total costs	**171**	**91.1**	**79.9**	**87**

Source: Audit questionnaire.

Nursing and personal care costs

6.55 As indicated in Table 6G, the average nursing and personal care costs per bed day were $98. These costs were $40 per bed day (69 per cent) in excess of that provided under CAM funding. The audit revealed the following reasons for actual costs exceeding the CAM allowance:

- In 6 geriatric centres, nursing staff numbers exceeded those provided for under CAM funding by between 10 and 125 per cent. In one geriatric centre the actual equivalent full-time nursing staff exceeded the CAM standard by 121. **The engagement of these additional staff is the major cause of nursing and personal care costs in geriatric centres exceeding CAM funding;**
- Generally, nursing staff in geriatric centres are more highly qualified and consequently receive greater remuneration than their counterparts in private and voluntary nursing homes.

  The audit review indicated that in one geriatric centre visited, 80 per cent of the registered nurses in the centre's nursing home wards were either assistant charge nurses or charge nurses. This situation has arisen as a result of the award system which allows for advancement based on years of service. Weekly salaries for registered nurses range from $470 for a first year nurse to $700 for an assistant charge nurse and $776 for a charge nurse;

- The number of nursing staff employed by geriatric centres is also dependent on the bed numbers in each ward. Departmental regulations require each nurse to care for up to 10 residents during the day and 15 residents during the night. This requirement means the optimum number of residents per nurse during the day and during the night are in multiples of 10 and 15, respectively. Combining these 2 requirements provides optimal nursing home or ward sizes in multiples of 30 beds.

  The audit review disclosed that the number of beds in geriatric centre wards ranges from 20 to 30 beds. For each ward with less than 30 beds, there are insufficient residents to fully utilise nursing staff assigned to the wards which increases the costs associated with providing nursing home care; and

- Nursing staff numbers are also affected by the level of flexibility in staffing arrangements. With almost all nursing staff employed on a full-time basis and restrictive work practices built into workplace agreements, geriatric centres have limited scope to effectively allocate adequate staff for peak times (such as meals and showers) and reduce staff at other times. These restrictive work practices arise from an agreement which provides for 2 registered nurses on each shift per ward (CAM funding provides for one registered nurse), fixed rather than flexible rostering of nursing staff and the overlap of nursing shifts (there is a 30 minute overlap on the night and evening shifts and a 2 hour overlap on the day shift).

6.56 Another factor which affects the efficiency of long-term residential care services in geriatric centres is bed utilisation. CAM/SAM funding is based on bed utilisation.

6.57 A review by audit of occupancy rates for nursing home care in geriatric centres during 1991-92 revealed that occupancy levels ranged from 85 to 100 per cent. Using the average occupancy rate of 94.6 per cent for the geriatric centres surveyed by audit compared with the average occupancy rate of 98 per cent in the private and voluntary sectors, the Department has forgone $2.4 million in Federal Government funding and residential contributions as a result of unoccupied nursing home beds.

6.58 Due to the departmental regulated staff to resident ratios and the fixed nature of many of the infrastructure costs, overall costs are not greatly reduced when nursing home beds remain unoccupied. Therefore, with unoccupied beds reducing revenue without a proportional reduction in costs, the overall efficiency of geriatric centres is adversely affected.

6.59 In order to improve the efficiency of the nursing and personal care services in nursing home wards, geriatric centres should:

- **where possible, increase the number of nursing home beds to groupings of 30 to fully utilise available resources;**
- **eliminate any work practices which adversely affect the efficiency of the nursing services; and**
- **minimise any excessive periods where beds remain unoccupied.**

SAM costs

6.60 As indicated in Table 6G, modified SAM funding is provided at a fixed rate of $27 per bed day to cover hotel services, administration and other overhead costs. The Federal Government does not, however, provide details of how the funding should be allocated to services. In the absence of specific guidance from the Federal Government, audit has apportioned SAM funding between catering, laundry, environmental and administrative services on the basis of a notional SAM staffing profile (provided in the Department's *CAM/SAM Trial Protocol* guidelines issued in October 1991). This allocation process has been undertaken to enable a comparison of specific costs incurred by the geriatric centres with SAM funding for 1991-92 with a view to assessing the efficiency of service delivery in the following areas:

- catering;
- laundry;
- cleaning;
- gardening services;
- maintenance; and
- administration.

Catering services

Catering costs

6.61 Catering services represent more than one-third of hotel service costs in most geriatric centres. From the information contained in Table 6G it can be seen that catering costs for geriatric centres were 43 per cent higher than the notional SAM allocation. The audit found that there was a large disparity between the catering costs of individual geriatric centres with cost per meals ranging from $3.06 to $7.62 for 1991-92. If geriatric centres reduced their costs to the average cost, $2.2 million of savings a year could be achieved in the geriatric centres surveyed. Alternatively, if all these geriatric centres operated at the level of the most efficient centre, annual cost savings of almost $7.5 million could be realised. Since June 1992, a number of geriatric centres have significantly reduced their catering costs. For example, one geriatric centre reduced its cost per meal from $6.42 in 1991-92 to $4.30 at February 1993.

Catering services internally provided

6.62 Audit found that catering services were provided internally at the 10 geriatric centres surveyed. Although a number of geriatric centres have recently undertaken reviews of their catering services, these reviews have concentrated on improving the efficiency of internally provided catering facilities. Alternatives to in-house catering facilities, such as the contracting out of all or part of the catering services, had not been canvassed by the geriatric centres.

6.63 In order to ensure that catering services are provided at the lowest cost, geriatric centres should formally evaluate the various options available to provide catering services, including external contracting.

Utilisation of catering facilities for external purposes

6.64 Six geriatric centres provided catering services to outside organisations while one centre shared facilities with other organisations.

6.65 A detailed review by audit of 2 geriatric centres identified excess capacity of their kitchens. With many of the centres reducing their number of inpatient services, it is likely that some or all of the State's other geriatric centres have under-utilised catering facilities.

6.66 In the current economic climate, with geriatric centres under increasing pressure to reduce their net costs, new revenue raising initiatives should be examined. **Better utilisation of catering facilities would provide geriatric centres with an opportunity to increase their externally generated revenue and reduce their net costs per bed day.**

Pooled purchasing

6.67 The audit disclosed that limited use is made of purchasing catering supplies in bulk, in conjunction with other organisations, with only 3 of the geriatric centres surveyed by audit using pooled purchasing as a method to reduce food costs.

6.68 If geriatric centres are to improve the efficiency of their catering facilities, they should investigate the potential for reducing food costs by taking advantage of the combined purchasing power generated through negotiating with suppliers as a unified group.

Kitchen facilities

6.69 The fresh cook and serve kitchens involve cooking and preparing meals using fresh ingredients. These meals are usually centrally bulk prepared, plated for each meal and then delivered to ward areas. Alternatively, the cook and chill meal preparation system involves a central kitchen which prepares meals which are snap frozen. These meals are then transferred from the central kitchen to a secondary kitchen close to where the food will be consumed. The secondary kitchens reconstitute the frozen meals, using special ovens prior to serving. Cook and chill food preparation methods facilitates bulk preparation and plating over one core period of the day, thereby reducing labour costs and enabling additional revenue to be raised by selling some of the bulk meals to other entities such as associated health facilities.

6.70 The audit survey indicated that 7 of the 10 geriatric centres had central kitchens, with the other 3 operating 2 kitchens each. Furthermore, 8 geriatric centres operated fresh cook and serve kitchens, while one geriatric centre operated a cook and chill system and the other operated both fresh cook and serve for its internal meals and cook and chill to provide meals to external organisations.

6.71 Where cook and chill kitchens have been installed, the full benefits generated from using these kitchens has not been realised where they are used to complement the existing facilities, rather than replace them. The full cost savings, resulting from limiting food preparation time and plating over one core period of the day, have not been achieved .

6.72 For the 3 geriatric centres operating more than one kitchen, it is also likely that cost savings can be made by these centres establishing one central kitchen.

6.73 In order to ensure that catering services are provided in the most efficient manner, each geriatric centre should undertake a formal review of such services. These reviews should include an evaluation of alternatives such as central kitchens and cook and chill food preparation methods.

Laundry services

6.74 The laundry and linen services involve the washing and pressing of bed linen and the washing of resident clothing. In most geriatric centres in the audit sample, the laundering of bed linen was undertaken by external linen services while resident clothing was cleaned internally.

6.75 The $5 per bed day paid for laundry services was significantly higher than the notional SAM allowance of $2.70 as outlined in Table 6G.

6.76 Such variance indicates that there is scope to generate cost savings through the introduction of more efficient and effective services. Audit calculated that annual savings of between $170 000 and $220 000 in total could be achieved in the centres surveyed by audit.

Environmental services

6.77 Environmental services include cleaning, gardening, and maintenance services. As indicated in Table 6G, the environmental service costs of $19 per bed day are $10.90 (135 per cent) higher than the notional SAM allowance. The costs associated with the various components of environmental services are discussed in more detail in the following paragraphs.

Cleaning services

Cleaning costs

6.78 The average cleaning costs per square metre in 7 of the geriatric centres ranged from $38 to $98.

6.79 Audit recognises that this comparison does not take into account the varying surfaces cleaned and the differences in the required standards of cleanliness for such surfaces. However, the magnitude of the variance in cleaning costs between the geriatric centres indicates there is potential to significantly reduce the costs of cleaning services.

6.80 Potential savings in cleaning costs ranged from $1.2 million in the geriatric centres included in the audit sample, using the average cleaning cost per square metre as the appropriate base for comparison, to $4 million a year in those centres based on the costs incurred by the most efficient centre.

Planning and management of cleaning services

6.81 The audit disclosed that cleaning tasks and frequency of cleaning were largely historically based, rather than determined by the need for the service. This has led to higher cleaning costs as:

- cleaning requirements were not based on floor areas; and
- cleaning did not reflect the different standards of cleanliness required in nursing home wards, hospital bed wards, administrative areas, rehabilitation facilities and areas set aside for social activities.

6.82 The North West Hospital is to be commended for the purchase of a computerised workload system to assist in the planning and management of its cleaning services. This system enables:

- analysis of cleaning tasks and frequency needs;
- allocation of individual times for each cleaning task;
- staffing to be based on workload needs; and
- costing of all elements of the cleaning program.

6.83 If cleaning costs are to be efficiently managed, geriatric centres will need to:

- **identify the areas within each centre requiring different levels of cleanliness;**
- **measure the floor area of each separate area identified;**
- **develop appropriate information systems to determine and compare cleaning costs over a period of time; and**
- **calculate and periodically record the cleaning costs per metre in each area.**

Potential for outsourcing of cleaning services

6.84 All geriatric centres that responsed to the audit questionnaire had internally provided cleaning services. A number of geriatric centres are undertaking formal reviews of their cleaning functions, however, these reviews are concentrating on improving the efficiency of internally provided cleaning services. Alternatives to in-house cleaning facilities, such as the contracting out of all or part of the cleaning services, had not been canvassed by the geriatric centres surveyed by audit.

6.85 Geriatric centres should formally evaluate the various options available to provide cleaning services, including external contracting, in order to ensure that quality cleaning services are provided at the lowest cost.

Gardening services

6.86 Audit calculated that geriatric centres incurred on average $115 000 annually in relation to meeting the cost of gardening services during 1991-92. Gardening costs in 8 geriatric centres surveyed by audit ranged from $0.15 to $2.69 per square metre.

6.87 If the geriatric centres surveyed by audit could reduce their costs to that of the average, potential annual savings in the order of $200 000 could be achieved. If centres could operate at the level of the most efficient centre surveyed, annual cost savings of around $600 000 could be achieved.

Maintenance

6.88 The average maintenance cost during 1991-92 was in excess of $1 million for the 9 geriatric centres reviewed by audit. The audit disclosed that maintenance costs for 1991-92 ranged from approximately $1 050 per bed in one geriatric centre to $4 300 at another centre.

6.89 Of the $9.3 million spent on maintenance by the geriatric centres surveyed, only $340 000 (4 per cent) was used by geriatric centres to engage external contractors. **With most maintenance activities provided internally, scope may exist to generate cost savings by increasing the use of external contractors to provide maintenance services.**

Administration

6.90 The average administration costs incurred by geriatric centres during 1991-92 was approximately $1.8 million. As indicated in Table 6G the audit disclosed that the average administration cost was $10 per bed day compared with a notional modified SAM allowance of $3.80 per bed day.

Central purchasing and storage of hotel service supplies

6.91 More than half of the geriatric centres indicated they did not have a centralised purchasing function responsible for catering, cleaning, laundry, gardening, maintenance, administration and personal care supplies. In relation to the geriatric centres with centralised purchasing departments, most still maintained separate departments for the purchase and storage of foodstuffs.

6.92 The duplication involved in maintaining separate purchasing and storage functions for each hotel service has resulted in unnecessary costs. Although it may be necessary for practical reasons for the catering departments to retain the storage function over perishable goods, it is more cost-effective in terms of resources and space for the purchasing of all goods and the storage of non-perishable and paper goods to be absorbed by a specialist supply department.

6.93 In order for geriatric centres to ensure their purchasing and storage activities are undertaken in the most cost-effective manner, the costs and benefits of establishing a central purchasing and storage facility for all hotel services should be investigated.

Factors affecting the efficiency of hotel services

6.94 The following factors affecting the efficiency of hotel services were identified by a number of geriatric centres:

- **Inappropriate physical design and poor condition of some buildings**. One geriatric centre indicated that:

  "The physical design of buildings on the Centre's main campus adversely effects the quality and efficiency of hotel services delivery by virtue of the predominance of high-rise, multi-storey ward accommodation and wide-spread layout of the campus. Queuing for lifts in multi-storey buildings impedes efficiencies in delivery of hotel services and is also a cost in terms of maintenance";

- **Age and condition of equipment**. The failure of geriatric centres to adequately upgrade and replace old and inefficient equipment, can largely be attributed to the inadequacies of funding programs in the past;

- **Inefficient work practices.** A number of geriatric centres identified inefficient work practices as contributing to higher costs in the delivery of hotel services. Specific problems include entrenched work practices, restrictions on multi-skilling, adherence to outdated or unregistered industrial agreements, over-staffing and basing work to be performed on historical practice rather than actual patient need; and

- **Industrial relations problems.** Changes to work practices, introduction of new procedures (such as cook and chill food preparation), outsourcing of hotel services and changes to allowances and penalties received by hotel staff, were restricted by the poor industrial relations climate in recent years.

6.95 Responses from geriatric centres indicated that action has been taken to address many of the problems identified above. However, in order for hotel services to be conducted in an efficient manner, the management of geriatric centres will need to prioritise resource allocation and explore avenues for:

- **upgrading old and outdated buildings and equipment;**
- **developing appropriate systems, in conjunction with the Department, to adequately fund future asset upgrades and replacements;**
- **eliminating work practices which adversely affect the efficiency of hotel services;**
- **working with unions to improve the relationships with management; and**
- **outsourcing hotel services where efficiency gains can be achieved.**

Medical services

6.96 Medical services received by residents in private and voluntary nursing homes are provided by external general medical practitioners, with the cost of these services met by Medicare. In contrast, medical services provided to nursing home patients in geriatric centres are provided by the centres' medical staff with the costs met by the State Government. However, the Federal Government's CAM/SAM funding structure does not provide for medical care, presumably on the basis that this care should be adequately provided by local general practitioners with the costs being met by Medicare.

6.97 The detailed audit examination at a large geriatric centre revealed that $300 000, equivalent to $845 per resident per year, was spent on the provision of medical services during 1991-92. Discussion with staff at the geriatric centre indicated that the high use of medical staff in nursing home wards was partly due to the availability of these staff rather than resident need for medical care. In private and voluntary nursing homes where on-site medical staff are not in attendance, nursing staff deal with many of the less serious problems facing residents. However, in geriatric centres, many problems which could be addressed by nursing staff are referred to medical staff due to their accessibility.

6.98 In audit opinion scope exists for significant cost savings through the reduction of internal medical services currently provided to nursing home residents, by using general practitioners to provide medical services as is the practice in private and voluntary nursing homes.

Pharmacy costs

6.99 Pharmaceutical needs for nursing home residents in private and voluntary nursing homes are met by external private pharmacies. The cost of pharmaceutical supplies are met by residents, who claim the majority of their medication costs from the Federal Government under the Pharmaceutical Benefits Scheme. In comparison, nursing home residents in geriatric centres have traditionally been provided with pharmaceutical supplies by internal pharmacies free of charge.

6.100 The audit review of 9 geriatric centres revealed that in 8 centres, pharmaceutical supplies were provided by an internal pharmacy and an external pharmacy was used by one centre where the cost was met by the residents rather than the geriatric centre. The cost of pharmacy services provided to nursing home residents in 1991-92 was $1.5 million or $188 000 per geriatric centre surveyed by audit.

6.101 The high incidence of pharmaceutical drug use by older people is shown in the National Health Strategy's paper *Issues in Pharmaceutical Drug Use in Australia*, which found that over a 6 month period, residents who were on medication averaged around 26 scripts each, with a nursing home resident and a hostel resident receiving a maximum of 197 and 236 scripts, respectively.

6.102 With limited financial resources available to geriatric centres to meet an ever increasing demand for aged care services, the provision of free pharmacy services to nursing home residents may not represent the best use of their resources.

6.103 In order to bring the provision of pharmacy services into line with the private and voluntary sectors and to provide additional resources to cater for urgently needed aged care services, geriatric centres should consider discontinuing their subsidy of pharmacy services to public nursing home residents.

- *RESPONSE provided by Secretary, Department of Health and Community Services*

  Pharmacy services provided in identfied geriatric centres have been funded in 1993-94 through the Victorian Medicare Agreement - Health Program Grant (HPG) of $2 million. The Department's strategic objective is to provide residents in public sector nursing homes with pharmaceuticals supplied under the Pharmaceutical Benefits Scheme rather than the HPG.

Rehabilitation and assessment services

6.104 In relation to short-term aged care services (which include acute and post-acute care, geriatric assessment and rehabilitation), standards or benchmark costs have not been developed by the Department.

6.105 Audit reviewed a number of specific short-term aged care services which were provided by several geriatric centres. The audit revealed that the cost per bed day of providing rehabilitation and assessment services ranged from $236 at one geriatric centre to $477 at the most expensive centre. The average bed day costs for the 7 geriatric centres surveyed by audit was $311.

6.106 With the introduction of case-mix funding the Department has established a specific classification for rehabilitation services. An interim bed day rate of $250 was established for these services.

6.107 With the cost of rehabilitation services in most geriatric centres exceeding the notional funding of $250 a bed day, scope exists to generate savings through reducing costs.

- *RESPONSE provided by Secretary, Department of Health and Community Services*

  Agreed. Case-mix measures for rehabilitation and non-acute clinical geriatric services for implementation in public sector services in 1994-95 are currently being developed by the Department in consultation with agency representatives and clinicians.

Recent developments

6.108 In undertaking the audit during 1992-93, initiatives had been introduced by geriatric centres to reduce the costs involved in nursing home care. According to estimates provided by the Department, the average nursing home costs per bed day have reduced by 10 per cent from $154 in 1991-92 to $141 in 1992-93.

HOSTEL CARE

6.109 As indicated earlier in this Report, the provision of hostel services has traditionally been administered and funded by the Federal Government, with services predominantly provided by the private and voluntary sectors. State Government involvement in the these services is limited with only 15 per cent of Victoria's hostel beds provided by the public sector. Where public hostel beds are provided, they are generally located where there is a limited supply of voluntary and private hostels, such as in country and remote areas.

6.110 Hostel funding is provided by the Federal Government through its personal care subsidy, which has been supposedly set at a level sufficient to enable hostels to operate as private businesses without the need for further subsidy.

6.111 Information provided by the Department indicates that public hostels, although funded under the arrangement described above, have been unable to operate without a significant subsidy from the State. During 1991-92, the State subsidised the operations of public hostels by in excess of $4 million.

6.112 The Department needs to undertake a review of public hostels with a view to eliminating the current hostel subsidies provided by the State Government.

- *RESPONSE provided by Secretary, Department of Health and Community Services*

  Agreed. Currently $4 million remains as State subsidy to a range of public sector hostels and this will be withdrawn in the 1994-95 financial year.

CAPITAL FUNDING

6.113 As private and voluntary nursing homes are intended to be operated as viable businesses, SAM funding includes a return on investment or profit component. This return on investment component is approximately $7.90 per bed day (22 per cent of SAM).

6.114 In the agreement between the Federal and State Governments (to change funding for public nursing home beds from its current level of $51.50 per bed day to CAM/modified SAM funding as outlined in Table 3D), the Federal Government has decided to provide SAM funding of $27.10 per bed day, a level of funding which does not include a return on investment.

6.115 The Department is of the opinion that a significant cause of its inability to address a number of efficiency issues in relation to aged care is the absence of adequate capital funding. The Federal Government's decision to provide CAM/modified SAM for public nursing home beds further limits the availability of capital funding for aged care. Specifically, **the Department is of the view that:**

- Full SAM funding is insufficient to adequately fund non-nursing and personal care costs in nursing homes, a view also supported by many private sector operators. When SAM is modified by excluding a return on investment component, operating public nursing home beds is no longer viable;
- A significant investment in nursing home funding was made by the Department in its construction of 11 new nursing homes in 1990-91. This capital investment, along with previous State Government capital investment, should entitle the Department to the same return on investment that is provided to the private and voluntary sectors;
- The inappropriate nature and poor condition of many existing aged care facilities impacts on the efficiency of the public sector's provision of aged care. The substantial improvements needed to generate operational efficiencies cannot be made without the additional funds generated from the $7.90 per bed day return to investment funding; and
- Closing public nursing home beds and transferring licences to the private and voluntary sectors (as a means of reducing the Department's aged care costs) is not possible as under current arrangements the licences for public nursing home beds can only be transferred on CAM/modified SAM funding. It is therefore extremely unlikely that the private and voluntary organisations would accept these licences unless full CAM/SAM funding was available.

ASSET MANAGEMENT

Property holdings

6.116 Following a consultant's report prepared in 1985 on the property functions of the Victorian Government, it became clear that State Government property holdings held by government agencies were in many cases surplus to operational needs and not efficiently managed. In order to address this situation, the former Government established an Asset Sales Task Force to identify government properties that could be sold to generate additional revenue for government. The Task Force concentrated mainly on the budget sector and did not include the land holdings of geriatric centres and public nursing homes. In this context, a previous audit review by my Office in 1990 of the procedures adopted by the Alfred Hospital for the management of its property holdings revealed the retention of properties that were surplus to its needs.

6.117 The only departmental direction provided to hospitals in relation to land holdings was a central policy statement issued in December 1983. The main thrust of the statement was that public hospitals should comply with government policy, which required publicly-funded institutions to make the most effective and economic use of properties owned, operated and controlled by them.

6.118 The audit review disclosed that geriatric centres, which provide a variety of aged care facilities in addition to short and long-term inpatient services, were often located on large sites. These facilities include:

- separate psychogeriatric centres;
- day hospitals;
- day centres;
- hostels;
- residences for nurses and resident medical offers; and
- research facilities.

6.119 In addition, some geriatric centres own large areas of vacant land as well as a number of residential houses. Land holdings in the 10 geriatric centres surveyed ranged from 0.8 of a hectare to 132 hectares at the Greenvale campus of the North West Hospital.

Unoccupied land at the Greenvale campus of the North-West Hospital.

Retention of properties in excess of geriatric centre requirements

6.120 Property holdings in excess of geriatric centre operational requirements were identified in most sites visited by audit with, in some cases, aged care facilities only occupying a small portion of each site.

6.121 With potential surplus land having a significant value for residential development, scope exists to generate additional revenue for a number of geriatric centres through the sale of this land. **Revenue generated from land sales could be used to provide additional aged care services to satisfy community needs, renovate or redevelop existing facilities or relocate services from existing sites into small nursing homes located in the community. These actions would alleviate some of the budgetary constraints inhibiting the effective provision of aged care services.**

6.122 The recent restructuring of the Mount Eliza Centre, which involved the sale of existing land, provides a good example of how aged care service provision can be improved through the use of property sales to finance the upgrading and relocation of aged care facilities.

AGED CARE ASSESSMENT TEAMS

6.123 In order to ensure that services meet the aged care needs of the community, assessment teams have a crucial role in identifying gaps in current service provision. However the assessment teams, although having the capacity to identify service provision deficiencies, do not have the mandate to address the various aged care needs.

6.124 In most regions, discussions with the assessment teams indicate that the Department's regional offices have been slow to address the deficiencies identified in the provision of aged care services.

6.125 To address these issues, the Federal Government has canvassed the possibility of providing the assessment teams with the resources to buy services that are needed within regions. This would eliminate the current situation where service provision, especially domiciliary care, is at the discretion of local councils and voluntary and private groups, many of which do not provide the aged care services needed by the community. If the assessment teams had the ability to purchase the required aged care services, alternative service providers could be encouraged to enter the market to provide these services.

6.126 Discussion with departmental staff indicated that the Federal Government is trialling a pilot scheme whereby assessment teams purchase aged care services for older people requiring discharge support services.

6.127 A primary advantage of using assessment teams, as the purchaser of aged care services, is that their knowledge places them in a better position to identify the services required. If the assessment teams are to be effective in this function, consideration should be given to establishing a common referral source for all home and community care services as well as residential care services.

INFORMATION SYSTEMS

6.128 The efficiency and effectiveness of any organisation can largely be attributed to the quality of its information systems. Development of appropriate information systems by health agencies, regional offices and the Department, in order to generate accurate and timely information, is essential for the effective management of aged care services. As recognised in the *1993-94 Budget Paper No. 2*, central to the goal of achieving "best practice" management performance by the State public sector is the implementation of an Integrated Management Cycle to co-ordinate the management of a wide range of centrally-directed budget sector activities. One of the characteristics of the cycle is for it to be supported by an adequate and realistic information base which takes into account the nature, detail and use of such information.

6.129 Audit review of information systems within the aged care industry disclosed a number of weaknesses which are outlined below.

Information on community needs and service utilisation

6.130 At present, the lack of clearly defined responsibilities within the public health system has led to some uncertainty regarding responsibility for gathering and maintaining information on aged care needs and service utilisation. This uncertainty has, as stated earlier in this Report, resulted in an absence of information which adequately identifies the aged care needs of local communities and the utilisation of services.

6.131 To ensure that aged care resources are effectively planned and targeted to address community needs, the responsibility for the collection of such information should be clearly allocated and appropriate systems developed.

Integrated patient care management system

6.132 At present, information on individual patient care is primarily recorded on manual patient care plans. The audit found that where patient information has been computerised, the information was contained in fragmented elements within centres. Recording and maintaining information in this manner poses difficulties in accessing patient information on a timely basis.

6.133 In order to overcome the above problems, geriatric centres, in audit opinion, need to develop integrated patient databases which include:

- details of the service provided such as nursing home care, rehabilitation, acute care and geriatric assessment;
- case-mix classification for non-nursing home care;
- patient dependencies for nursing home patients;
- patient history of treatment and care provided;
- nursing requirements; and
- special aged care needs such as interpreter service.

6.134 The implementation of an integrated patient database would improve the quality and efficiency of aged care services by:

- providing useful information for planning individual patient care;
- recording details of care provided;
- improving the effectiveness of discharge planning;
- linking patient dependency (long-term aged care) and case-mix (short-term aged care) to nursing requirements; and
- improving staff allocations and rostering.

Clinical costing systems

6.135 Costing systems within the health sector have measured the costs of inputs such as nursing, medical and hotel services, rather than costing the individual products or services provided. While costing of inputs provides useful information to determine how economically an organisation is operating (i.e. whether inputs are purchased at the lowest price), it does not provide sufficient information to determine efficiency. It is only through the identification and costing of outputs that organisational efficiency can be adequately determined.

6.136 The absence of appropriate costing systems has significantly contributed to the inefficiencies in the provision of aged care services identified in this Report.

6.137 To ensure that individual aged care services are effectively provided, the individual subsidiary services which are incorporated within broadly classified services such as nursing home care, rehabilitation and acute care, should also be identified and costed. For example, the major types of rehabilitation care which include rehabilitation programs for stroke, amputee and orthopaedic patients should be costed.

6.138 For nursing home care, the Department's proposal to introduce CAM/modified SAM funding across all facilities by July 1994 will facilitate the introduction of an appropriate system by which the different levels of nursing home care can be costed and funded. In relation to other specific long-term aged care services such as respite care, interim nursing home care and care of dementia sufferers, separate costing and funding systems still need to be developed.

6.139 Other specialised aged care services such as geriatric assessment and rehabilitation services also need to be divided into specific groupings. A suitable system for grouping like services may be the Resource Utilisation Groups classification system which was developed in the United States. This system involves the apportioning of costs to specific groupings for aged services thereby providing a cost for each individual classification.

6.140 Community service costs also need to be allocated to specific community services, with the number of individuals receiving each service recorded. This would enable the average cost for each community service to be identified.

6.141 Development of appropriate clinical costing systems in geriatric centres and public nursing homes would enable agencies and the Department to:

- **effectively target resources to meet community needs;**
- **plan for the impact of change;**
- **review operational performance;**
- **provide input into policy decisions at both the State and Federal Government level;**
- **monitor and control the ongoing provision of aged care services; and**
- **respond quickly to changes in government policy and changing consumer needs.**

Appendix A

Glossary of terms

GLOSSARY OF TERMS

Acute hospitals	Institutions equipped with surgical, obstetrical and diagnostic facilities for the inpatient treatment of the sick and the disabled, which provide nursing and other professional services.
Acute care	Includes the restoration of the health of older people to an optimal level following an acute illness or remediable condition.
Aged care	Health services provided to people aged 65 years and over.
Aged care assessment teams	Commonwealth approved multi-disciplinary teams of health professionals responsible for pre-admission assessments of potential residents for either nursing homes or hostels.
Allied health professionals	Multidisciplinary team of professionals, including physiotherapists, speech therapists, occupational therapists and podiatrists.
CAM/SAM	Funding mechanism introduced by the Federal Government in 1986 for nursing homes in the non-Government sector as part of a broad strategy of reform of aged care services. Funding for homes is determined by a formula which comprises 3 elements: CAM, SAM and OCRE.
Care Aggregated Module	A component of the CAM/SAM funding mechanism which links the costs associated with providing nursing and personal services to the specific needs of nursing home residents.
CAM/modified SAM	New Federal Government funding system for public nursing homes which provides full CAM and partial SAM funding. SAM funding does not include a $7.90 return on investment component paid to the private and voluntary nursing homes.
Carers	Relatives and friends who care for older people in the community.
Case-mix funding	Mechanism which links funding for health agencies to the level of services they provide.
Community-based care	Aged care services provided to older people in their own homes or on an outpatient basis in the community.
Cook/chill	Food preparation process whereby food is cooked, frozen and then re-heated before eating.
Day hospitals	Facilities attached to acute hospitals and geriatric centres which provide non-residential care such as medical, nursing, physiotherapy, occupational therapy, podiatry, speech therapy and counselling.

Day centres	Facilities operated by local councils, voluntary organisations, geriatric centres and acute hospitals providing activities for older people. These activities are intended to promote independence and enhance daily living skills, and includes the provision of personal care and preparation of meals.
Dementia	Involves a multi-faceted loss of intellectual abilities such as memory, judgement, abstract thought, and changes in personality and behaviour.
Diagnosis Related Groups	Represent classes of hospital patients with similar clinical characteristics. DRGs form a clinical grouping system which describe hospital discharges according to medical condition.
Discharge planning	Process by which an admitted inpatient's needs on discharge are anticipated, planned for and arranged.
Extended care services	Provision of long-term residential health care to individuals in the form of rehabilitative, preventive, social, spiritual and emotional support, as well as nursing and medical services (usually in a geriatric centre).
Federal Government frozen benefit	The benefit paid to public nursing homes, on behalf of residents, towards their care and accommodation in a nursing home. The current payment is $51.50 per bed day.
Federal Government Outcome Standards	The quality of care and quality of life objectives which the nursing home/hostel industry should strive to achieve for all residents.
Federal Government planning ratios	Service provision targets established by the Federal Government to limit residential care services.
General medical care	These services are essentially the same general health services provided to the wider community and include acute and post-acute care.
Geriatric assessment	Process by which multi-disciplinary teams determine the aged care needs of specific individuals and facilitate their access to appropriate aged care services.
Geriatric centre	Publicly operated hospitals specialising in aged care services which include acute care, geriatric assessment, rehabilitation, medical and nursing services, therapy services through allied health staff and residential care through nursing home and hostel components.
Government nursing home	A nursing home operated by or on behalf of a State/ Territory Government.
Hostels	Establishments which provide accommodation care for older or disabled persons who cannot live independently but do not need nursing care. Residents are also provided with domestic assistance (meals, laundry, personal care).
Incontinence	Unable to control excretions voluntarily.

Interim nursing home care	Patients in geriatric centres and acute hospitals who are in need of limited medical care or are awaiting nursing home placement.
Long-term aged care	Provided to individuals who, due to their increasing frailty or level of physical or intellectual disability, are no longer able to live independently. These people have relatively stable medical conditions and are unlikely to greatly improve their level of functioning through medical intervention.
Needs based planning	Planning process which involves the allocation of resources on the basis of community need.
Nursing home type	Patients hospitalised for longer than 35 days who have had an appropriate form completed by a medical practitioner which confirms that they are still in need of acute care.
Multi-purpose centre	Centres which bring together existing health services and develop additional services from a single base. These centres are located in rural and remote areas.
Nursing and personal care staff	Includes the Director of nursing, State registered nurses, State enrolled nurses, nursing assistants and therapists.
Nursing home	Institutions which provide long-term care involving regular basic nursing care to chronically ill, frail or disabled persons.
Other Costs Reimbursed Expenditure	A component of the CAM/SAM funding mechanism which provides a reimbursement for WorkCare insurance, long service leave and superannuation costs incurred by nursing homes in relation to nursing and personal care staff. (Long service leave and superannuation allocations for SAM staff are included in the SAM component.)
Older people	In this Report, older people are those aged 65 years and over, unless otherwise specified.
Palliative care	Health care focused on controlling and alleviating pain and symptoms and supporting the individual and their families through the terminal stage of an illness.
Post-acute care	Involves a relatively lower level of care than acute care which is provided to patients following an accident or serious illness. The care is aimed at restoring functions and improving the patient's ability to undertake activities of daily living.
Private hospital	A privately operated hospital which does not receive operating cost subsidies from the State Government, and patients are required to pay fees.
Psychogeriatric nursing	Institutions which provide a domestic setting for confused, older people who require 24 hour nursing care, but whose behaviour makes them unsuitable for accommodation in a general purpose nursing home, special accommodation house or hostel, and who do not require specialist inpatient treatment in a psychiatric hospital.

Quality assurance	Describes all evaluation activities undertaken by a facility. The process involves a planned systematic approach to monitoring and assessing the care or services provided, which identifies opportunities for improvement and provides a mechanism through which action is taken to make and maintain these improvements.
Resident Classification Instrument	A 5 category classification system used to determine resident dependency levels and care needs of nursing home residents.
Rehabilitation	Services designed to minimise the effects of impairment, disability or handicap and to restore individuals to their optimal level of functioning.
Resident contribution	Contribution paid by residents towards the cost of nursing home care.
Respite care	Short-term care for someone who is usually cared for by a relative, which is designed to give the regular caregiver relief from this role.
Residential care	Long-term care provided in hospitals, nursing homes, hospices and other places where inpatient care takes place, as opposed to home-based care.
Restorative care	Services provided to older people on a short-term basis to restore their physical condition to a level which would allow them to return home with appropriate support.
Standard Aggregated Module	A component of the CAM/SAM funding mechanism which provides a standard grant for non-nursing and non-personal care costs. These costs comprise the infrastructure costs of operating a nursing home which include items such as food, heating, personal toiletries for residents, laundry, maintenance and gardening, the replacement of equipment, upgrading of facilities and the costs of non-personal care staff such as cleaners and catering staff. (The SAM component is a fixed payment currently set at $35 per bed day.)
Short-term aged care	As opposed to long-term residential care, short-term aged care involves care designed to improve physical well-being and restore the health of older people to an optimum level following a serious illness.
Supported residential services	Privately operated residences providing accommodation with personal care or assistance for older people and people with physical, psychiatric and/or intellectual disabilities.
Younger disabled	Disabled person less than 60 years of age.


HONI·SOIT·QUI·MAL·Y·PENSE