MEDICAL PRACTICE

Contemporary Themes

Boom in private rest homes in Southampton: impact on the elderly in residential care

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Abstract

A survey in 1986 of 450 elderly people in 51 private rest homes and 206 residents of seven local authority (part III) homes in the Southampton area showed no significant difference in overall dependency between the two populations. Although age and sex distributions of the residents of part III homes had remained the same between 1982 and 1986, the average level of dependency had fallen significantly. Since the provision of places increased because of expansion in the private sector residential care institutions are generally catering for a more independent population.

Introduction

Changes in government regulations in 1983 allowed elderly people in Britain to claim supplementary benefit payments to help them meet the cost of care in private rest homes. This financial encouragement has led to rapid expansion of the private sector, whereas the provision of places in local authority (part III) homes has been constrained by the financial restraints facing local authorities. Before the introduction of these state subsidies for private care the rigorous admission policies for part III accommodation operated by local authorities were seen as a necessary way of rationing scarce resources under pressure from demographic change. In contrast care in private residential homes is now seen as

an entitlement for those elderly in care or looking for care, provided only that applicants meet criteria of financial need. Thus an attempt to introduce measures of "privatisation" into British social policy may inadvertently have created a dual system of public finance for residential care of the elderly.

The implications of these developments have prompted debate. Citing the lack of preadmission assessment in much of the private sector, critics have implied that this will inevitably lead to "inappropriate care" for those "who may have remediable disease" or for whom "residential care is quite unnecessary." They register concern at "the sight of large amounts of money being siphoned off into . . . low priority . . . low dependency residential care." Meanwhile, among local authorities, it had been regarded as self evident that levels of dependency in part III homes for the elderly had risen over many years and would continue to rise inexorably. A survey of homes in 12 local authorities showed a considerable increase in levels of dependency between 1971 and 1981, the proportion of "minimally dependent" residents falling from 45% to 16%; similar trends occurred in Leicester and Manchester between 1976 and 1979.^{5,6}

We set out to ascertain present levels of disability among residents in private and local authority homes for the elderly and to assess the impact of the rapid growth of the private sector in the Southampton District Health Authority. In 1977 there were two local authority places for every place in a private rest home. In 1986 there were 628 places in 14 part III homes, compared with 1749 places in 129 private rest homes. The private sector provision has risen sixfold since 1977, so that there are now three times as many elderly people in private care as in local authority homes.

Methods

We surveyed 51 private rest homes and seven local authority part III homes for the elderly, selected on the basis of their location within the City of

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Southampton. A uniform admission policy applies in all part III homes in the district, applications being assessed by a panel. One specialist home for the elderly mentally infirm takes those with more severe psychiatric disturbances or dementia, and this home was not included in the study. The survey included 469 residents in the private sector and 206 in local authority homes; 19 residents were omitted (five refused, seven were profoundly deaf, and seven were aphasic). The survey version of the Clifton assessment procedure for the elderly was used to obtain information on both mental and physical disability.⁷ This is a standardised questionnaire comprising a 12 item information/orientation section directed to the subject and a six item physical disability section directed to a care attendant familiar with the subject. Dependency grades from A (no impairment, independent) to E (severe impairment, maximum dependency) can be derived by subtracting the physical disability from the information/orientation score.

A previous study in Southampton used the same questionnaire to survey residents in five part III homes.⁸ One subsequently closed, but the remaining four were included in the sample of seven part III homes in the present study. Thus information for two major comparisons was available: the elderly population of the private sector could be compared with their contemporaries in local authority care at the time of the survey in 1986, and residents of four part III homes could be compared with the elderly living in the same homes four years previously in 1982. In both surveys trained observers from the university geriatric medicine group administered the information/orientation questionnaire directly to each resident and obtained information about physical disability of each resident from responsible care staff. The four part III homes included in both surveys were representative of the range of such accommodation available in Southampton, from an old converted property to the newest purpose built home (opened in 1981).

Results

The mean age of the 450 residents of private rest homes was 83.5 years, similar to the mean age of 82.7 years for the 206 residents of part III homes. The proportion of women was higher in the private sector (84%) than in the local authority homes (73%; $\chi^2=10.74$, $df=1$, $0.01>p>0.001$); the 75 men in the private sector were distributed among only 29 of the 51 rest homes surveyed.

The distribution of residents according to disability grade was remarkably similar in the private and part III homes (table I), with the mean (SEM) Clifton assessment procedure for the elderly scores being almost identical at 3.7 (0.40) and 3.8 (0.27) respectively.

TABLE I—Distribution of dependency according to grade on Clifton assessment procedure for the elderly in part III and private rest homes in 1986. Values are numbers (percentages) of residents

Grade	Part III			Private		
	Women	Men	Total	Women	Men	Total
A	18 (12)	14 (25)	32 (16)	46 (12)	22 (30)	68 (15)
B	44 (29)	19 (34)	63 (31)	118 (31)	28 (38)	146 (32)
C	37 (25)	8 (14)	45 (22)	74 (26)	16 (22)	90 (20)
D	28 (19)	9 (16)	37 (18)	76 (20)	3 (4)	79 (18)
E	23 (15)	6 (11)	29 (14)	63 (17)	4 (6)	67 (15)
Total	150 (100)	56 (100)	206 (100)	377 (100)	73 (100)	450 (100)

The data obtained with the Clifton assessment procedure for the elderly on 143 residents of four part III homes in 1982 were compared with those for 125 residents in the same homes in 1986 (table II). Eleven residents were common to both surveys. After 1982 there was a considerable shift in the population of part III homes towards the independent grades of A and B. Whereas 39% of residents in part III homes were in the most demanding categories of D and E in 1982, by 1986 only 28% were so dependent. The

TABLE II—Distribution of dependency according to Clifton assessment procedure for the elderly. Values are numbers (percentages) of residents

Year	Grade					Total
	A	B	C	D	E	
1982	15 (11)	40 (28)	32 (22)	36 (25)	20 (14)	143 (100)
1986	22 (18)	42 (34)	26 (21)	17 (14)	18 (14)	125 (100)

mean (SEM) score on the Clifton assessment procedure for the elderly rose from 2.7 (0.3) in 1982 to 4.3 (0.4) in 1986 (difference between means=1.6, 95% confidence interval 0.69 to 2.51; $t=3.5$, $df=266$, $p<0.001$). Although the proportion of residents of part III homes scoring seven or less on the information/orientation subtest (consistent with dementia) fell from 49% in 1982 to 42% in 1986, the difference in the mean information/orientation score did not change significantly over the four years (difference between means=0.5, 95% confidence interval -0.45 to 1.45; $t=1.04$, $df=226$, $0.5>p>0.1$). The elderly living in part III homes were significantly less physically disabled in 1986 than in 1982 (difference between means=1.1, 95% confidence interval 0.46 to 1.74; $t=3.34$, $df=266$, $p<0.001$). Among the six aspects of physical disability explored by the survey the greatest change was found in the prevalence of incontinence, which fell from 40% in 1982 (20% frequently—namely, three times a week or more) to 33% in 1986 (less than 10% frequently).

Discussion

Demographic and social factors mean that it is usual to find more elderly women than men in residential care. The proportion of women in private rest homes in Southampton (84%) is identical with that found in Manchester.⁹ The greater representation of women in the private sector compared with part III homes relates both to the existence of formally designated "ladies only" private homes as well as to an informal segregation that operates more forcibly in small homes, where there is less scope for a flexible use of accommodation. Thus the average size of the "ladies only" homes is six residents, while those homes having a mixed resident profile have on average 10 residents.

The results of the comparison of the dependency scores between the private sector and local authority homes suggest that, contrary to popular belief, private rest homes are not taking a select group of the younger, fitter elderly, at least not in Southampton. An important implication is that the system of admission to private care may be self regulating; the elderly (with their carers) may be capable of assessing their own needs and will not choose to enter residential care until other available means of maintaining their "independence" are exhausted. Relatively crude measures of physical and intellectual impairment cannot make allowance for other factors that may contribute to the loss of "independence" in an old person, such as loneliness, insecurity, or loss of self esteem. Specialist assessment by a geriatrician of elderly people applying for a move to residential care in Edinburgh resulted in only 7% of patients being placed in alternative accommodation.¹⁰

The major finding of the second comparison in our study was that the level of dependency in the four part III homes surveyed had fallen significantly between 1982 and 1986. Strikingly, the elderly population in residential care, both public and private, now includes a large number of people assessed as "independent," with 47% of the 656 residents interviewed, and 65% of the 131 men, scoring A or B on the Clifton assessment procedure for the elderly. These figures bear out the impression gained from interviewing residents that for many elderly people it is not their state of health but their failing social support networks that precipitates entry to residential care, calling into question the adequacy of the available community support services. Between 1982 and 1986 few changes occurred in the pattern of provision for the elderly in the public sector in Southampton. The local housing department had already established its very sheltered housing schemes, and no National Health Service nursing homes were built in the district. Systems for intensive support of an elderly person in his or her own home by care attendants had yet to be developed.

During the 1970s the national provision of part III accommodation fell in real terms,¹¹ a change used to explain the increased burden of care experienced by people working with the elderly as only the most needy could be accommodated. In Southampton, at least, the increase in residential care places provided by the booming private sector has made the balance swing the other way. Private rest homes now make a substantial contribution to the care of the elderly and must be taken into account in local planning; a similar point has been made about private nursing homes in Brighton.¹² If the Southampton experience is repeated nationally this would contradict the declared aims of government policy. The development of care in

the community has in recent years been seen as the only economically viable way to caring for the rising numbers of elderly, and, more importantly, it is in line with the wishes of the elderly themselves. The reality has been a subsidised but unregulated expansion of private institutional care and a massive, if indirect, diversion of funds from community support that might keep the elderly in their own homes.¹³

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Provision of facilities for secondary transport of seriously ill patients in the United Kingdom

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Abstract

A survey by questionnaire of 280 hospitals with general intensive care units was carried out to find out what facilities were provided for secondary transport of seriously ill patients in the United Kingdom. Replies were received from 181 units. Extrapolating from the survey data showed that about 10 000 patients were transported each year, although many units transferred only a few patients. An appreciable minority of units reported that facilities for secondary transport were inadequate and many were obliged to send inexperienced medical staff with patients. Almost half of the respondents thought that arrangements for transfer were unsatisfactory, but only a tenth said that they delayed or refused transfer for this reason. This undoubtedly reflects a policy of "making do" despite inadequate resources.

We believe that these results support the concept of regional transport services, where each major unit would be adequately equipped and staffed and unnecessary duplication of resources avoided.

Introduction

The development of regional specialist services for neurosurgery, plastic surgery, nephrology, and intensive care, for example, has led to the need for transport between hospitals (secondary transport) of an appreciable number of seriously ill patients. The results of several studies have confirmed the relative safety of transferring patients provided certain criteria are fulfilled: careful assessment and resuscitation before transfer, continuous monitoring and life support in transit, and the presence of experienced medical personnel.¹⁻³ Thus there is no good reason for a patient being denied specialist care on the grounds of distance from a referral centre.

The provision of secondary transport facilities in the United Kingdom is undoubtedly increasing to meet demand, but no

information is available on the nature, adequacy, and distribution of existing facilities. We therefore carried out a postal survey to provide preliminary data on which national guidelines or recommendations might be based.

Methods and results

In the spring of 1987 a questionnaire (table I) was sent to the consultant in charge of 280 intensive care units in Britain with a covering letter explaining the purpose of the survey and a stamped addressed envelope for reply. The

TABLE I—Clinical shock study group. Survey of secondary transport of critically ill patients

- (1) How many patients does your unit admit per year
 - (2) What percentage of your patients are children
 - (3) What percentage of your patients come from other hospitals
 - (4) What percentage of patients are transferred to other hospitals
 - (5) If you accept a patient from another hospital do you:
 - (i) Expect the referring hospital to arrange transfer
 - (ii) Send staff from your own hospital
 - (6) How are they transferred:
 - (i) Dedicated ambulance
 - (ii) Dedicated trolley or bed
 - (iii) Staff: Anaesthetic
Medical
Surgical
Nurse
Other
 If other specify
 - (iv) Grade: House officer/senior house officer
Registrar
Senior registrar or consultant
Nurse
 - (v) Equipment available:
 - Portable ventilator
 - Defibrillator
 - Electrocardiograph
 - Direct arterial pressure monitoring
 - Box of transfer drugs
 - (7) Do you feel your present arrangements are satisfactory
 - (8) Does lack of transport facilities ever prevent patient transfer
- Please enter any comments overleaf

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units were chosen from *The Directory of Emergency and Special Care Units* (1985) (CMA Medical Data), and only general units (adult and paediatric) were selected. Because the response to the first questionnaire was satisfactory a reminder letter was not sent.

Replies were received from 181 of the 280 units, and these were