Psychiatric Bulletin (1991), **15**, 374–375

The College

Chaos and confusion*

The present generation of old people are not 'complainers'. They have lived through the economic depression of the 1920s and at least one world war. They are less likely than other groups to grumble if they have to live in sub-standard accommodation or if they are 'messed around' by administrative reforms. Old people with dementia are even more vulnerable and defenceless. Not surprisingly, the 'back door' privatisation of facilities for these people has attracted relatively little comment. A variety of schemes have been imposed by managers, sometimes against the judgement of medical staff. The Section for Psychiatry of Old Age, aware of these problems, held a special meeting on 29 November 1990 at which four speakers reported on their local experience.

Nottingham

Dr Jones reported that one of two 25-place NHS continuing care wards had been closed against medical advice and effectively transferred to the private sector. The NHS unit closed had a high reputation for innovative care and was regarded as a model of multidisciplinary management. The private nursing home to which the patients were transferred had a total of 48 beds, 38 with guaranteed NHS funding (whether or not the beds were occupied). The consultant psychiatrists concerned retained sole admitting rights but had no continuing responsibility for medical care after admission. This care was provided by a local GP who received no special fees. The consultation rate with the GP and with psychiatrists was low. The NHS provided occupational therapy and physiotherapy on a daily basis. *The home was expected to recoup state benefits where possible* which were offset against health authority funding. While there was no suggestion that the basic level of care in the new location was inadequate, there was sadness at the loss of a pioneering unit and at the loss of true multidisciplinary working in what appeared to be largely an attempt to transfer costs to the social security budget.

Hove

Dr Annis discussed the vast imbalance between the NHS and the private sector in her area. There were only ten NHS continuing care beds (guidelines would suggest 72 ESMI (elderly severely mentally ill) beds for people with severe dementia in that catchment area) and half of these were occupied by 'old long stay' patients transferred from another area to hasten the closure of a large mental hospital. The private nursing home sector, with a total of 801 beds, had 54 designated for 'elderly mentally infirm' and the local authority was rapidly reducing its provision. The health authority does not support any elderly patients in the private sector, so most patients are limited to the few homes which accept DSS rates. Some of the private facilities were described as "barely adequate".

Huddersfield

Here, the situation was more hopeful. There were 96 (guidelines would suggest 99) health authority beds for continuing care of old people with dementia in the setting of a service that had an assessment ward and day hospital places for people with dementia as well as localised long stay provision. Twenty-four of the NHS beds were provided by contract to a local charity, Storths House Care Ltd. Patients were admitted only on the recommendation of a consultant and continuing medical care was by a GP paid an honorarium. The initial capital was found by the charity and continuing funding was from social security benefits where possible, topped up by a variable grant from the health authority. As in Nottingham, there was occupational therapy and physiotherapy support from the health authority and the managerial arrangements appeared to have been made in order to transfer part of the costs to the social security budget. This necessitated the arrangement whereby the consultant had no continuing responsibility for patients after admission.

Scotland

Dr Ballinger reported that even Scotland, with its tradition of greater health service provision for demented patients, had seen a fivefold increase in private nursing home places over the last five years. One health board was partially funding NHS patients in a private nursing home and another had entered into a contract with a private firm to provide long term care for demented people but with some continuing clinical responsibility for the NHS consultant. A survey of consultant opinion revealed mixed views about these developments though there was no evidence that patients were worse off in private care.

**Report of a special meeting of the Section for Psychiatry of Old Age to discuss the developments in long-term care for old people with dementia.*

Discussion

Three separate strands can be discerned in these developments. The first is a policy move by the government away from agreed guidelines for hospital provision to local arrangements. It would appear that in some areas at least this is resulting in poor provision for a very vulnerable group of people. Unfortunately they are not a vociferous group so that 'consumer pressure' is unlikely to be effective in improving their lot and there is a need for *some* central guidance to ensure adequate quantity and quality of provision.

The second strand is the move to a 'purchaser–provider' model of care with the health authority contracting provision out to the voluntary/private sectors. It is not clear what advantages might accrue from this were it not confounded by the third strand of *shifting cost* from the NHS to the social security budget. The need to make patients eligible for money from social security is presumably what dictated the situation where consultants no longer have responsibility for continuing care patients. Many consultants believe that a regular review by a psychiatrist can contribute to a better quality of care for patients and there is some indirect evidence of this from a study in the USA (Rovner *et al*, 1990).

When the community care part of the NHS Act is implemented, local social services authorities will be given a budget for future admissions of people to residential *and* nursing home care. Social security payments will no longer be available (except for those already in care) and it is not clear what will be the status of some current schemes set up to exploit the availability of these payments. More importantly, the budget given to the local authorities will not be 'ring-fenced' and may be used to augment community care (or even child care) rather than to support people in residential/nursing homes. Though there is a superficial attractiveness to improving community care at the expense of 'institutional' care, our rate of residential/nursing home care in this country is already low in comparison to the structure of our population.

In the absence of any definition of health authority guidelines for continuing care of old people with severe dementia, there will continue to be pressure on health authorities to save money by minimising facilities and pushing patients out to the voluntary/private sectors. With its limited grant, the local social services authority will be under equal pressure to re-define people with dementia as a 'health' problem. Dementia sufferers could well be caught in the middle of these conflicting pressures and be quite literally 'left out in the cold'.

Constructive plans are needed to ensure adequate provision for this vulnerable group of people, to avoid attempts to 'pass the buck' for their care and to ensure that issues such as continuing consultant responsibility are decided on clinical grounds and not dictated by financial vagaries.

Reference

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Patients, psychiatrists and the Community Charge

April 1990 (a year earlier in Scotland) saw the introduction in Great Britain of a new tax, the Community Charge, replacing the old rating system. The government's aim in introducing the Community Charge is to ensure that as many people as possible pay the Community Charge, so that a far greater number of local electors have an incentive to consider the costs as well as the benefits of extra spending. The tax continues a subject of controversy into which psychiatrists (and other doctors) are drawn in their professional role since among the limited categories of people exempted by the legislation from payment of the tax are those who are too ill to understand its nature, people who are indefinitely resident in hospital, and people who are detained by the state and so have no choice of residence. In addition, the poorest in the population are exempt from 80% of the payment, as are full-time students, and some people who previously paid rates are allowed limits on the increase in payments they make for a transitional period.

Advice has been issued to doctors by government on the exemption for the severely mentally impaired (Reed, 1990) but there continue to be uncertainties expressed by doctors. This note is intended to clarify the position.