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Perceived mismatches between needs and services in the health care of elderly people

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A postal enquiry to professionals involved in service delivery points to a number of problems in the process of referring elderly people appropriately. These problems referred to lack of choice and constrained options, rather than mis-referral through inadequate assessment.

One of the perennial problems of providing health care for elderly people in the past has been the difficulty of matching the services which can be provided with the needs of patients. This might be attributed to inefficiencies in procedures - like inappropriate assessment and referral - but there are many other pressures affecting the pattern of provision. Una MacLean found, in a study of the pathways through care of elderly people, that

"There was no evidence that people were moving logically through a continuum of care ... On the contrary, (they) zig-zagged back and forth and in and out of different kinds of care. Service providers had scope for discretion, and consumers too were capable of exercising a fair amount of pressure ..."¹

What seems to be happen is that the allocation of health care is taking place through a kind of 'market' - or, more precisely, a 'quasi-market'². The analysis of health care systems in these terms suggests that service responses to need are likely to reflect the constraints imposed by scarce resources. The aim of this study was initially to identify possible mismatches between needs and services, and the problems associated with such mismatches.

Method

The study was intended to discover not to what extent problems existed, but rather whether there were problems, and if so what kind of problems they were. This called for qualitative rather than quantitative investigation. Responses were obtained using a postal request to professionals in a Scottish Health Board, asking for information on the extent of mismatch. The use of open-ended questions, inviting a range of responses, is an important part of such an evaluation; by not defining topics too closely, it is often possible to gain a fuller understanding of the range of problems. This establishes a basis for further research.

Postal enquiries work best with a minimal number of questions which leave open the possibility of extended commentary. The enquiry which was circulated asked three questions:

1. Do you deal with elderly people who you feel would better be placed or treated elsewhere? If so, what are the circumstances?

¹ U McLean, 1989. *Dependent Territories*, NPHT.

² See J LeGrand, W Bartlett (eds) 1993, *Quasi-markets and social policy*, Macmillan.

2. Are there circumstances in which elderly people in your care could not be referred on or placed appropriately because options were limited or unavailable? What happens in such cases?

3. Are there other problems you see in the range of services available to elderly people?

These questions were circulated generally within the health board, going to named individuals wherever possible, with further copies being made available for staff. 147 responses were received in total; five further notes were received from people explicitly refusing to respond. It is difficult to calculate the response rate, not least because a number of responses were made on behalf of a group of people or speciality. The answers received probably represented something in the region of 30% of those circulated. 56 respondents answered by letter; 36 of these appeared to speak on behalf of medical units (17) and general practices (19). 62 responses were anonymous; two others specifically asked that their responses should not be attributed.

The validity of the statements has to be interpreted in the light of the position of the respondents, who were all health care professionals working with elderly people. The material is 'subjective' in the sense that it reports their perceptions; but equally, it can be seen as reflecting professional judgment.

Results

Health services in the community

The lack of some services to elderly people in their own homes - notably night nursing and community physiotherapy - were felt to detract from the quality of the service.

Overnight care - a high proportion of patients can cope with their toileting needs during the day but often require supervision/physical assistance at night. With certain patients this may only be required for a short period of time. (Occupational Therapists)

Another area of concern is the number of elderly people discharged from hospital following accidents which may or may not have resulted in fracture. The need for physiotherapy is great in these and whilst it is possible to get physiotherapy by referring them to Day Hospitals, there is no facility for domiciliary physiotherapy to help them mobilise around their own house. (GP)

Shortages of this kind could require people to be admitted to hospital:

Trivial illness requiring hospital admission because of lack of care services (Hospital medical staff)

In many cases ... patients were inappropriately admitted to an acute Trauma or Orthopaedic unit simply because they could not cope at home and not because any injury they suffered required special hospital care (Hospital medical staff)

Similarly, there were circumstances in which admissions might be reduced if appropriate services were available to deal with a number of basic conditions, such as dermatological problems and minor trauma.

Occasionally elderly people are admitted to the ward with simple intercurrent infections such as urinary tract or chest infection which could be treated either at home if there was somebody there to care for them ... if they were in an adequate nursing home they would not need to be moved (Hospital medical staff)

There is a range of pruritic dermatoses, in particular senile pruritis, asteatotic eczema and nodular prurigo, which are a common cause of distress to the elderly. Such conditions require regular application of topical therapy, mainly emollients and corticosteroids. Large areas of the skin have to be treated and of course this is frequently difficult for an elderly person with physical handicap. Although caring relatives and district nurses try to help with the treatment application, inevitably there are problems. Such patients seem all too frequently to require inpatient care and admission to hospital that could be avoidable with more and better trained staff within the community. (Hospital medical staff).

There were other indications that elderly people may be referred to higher levels of care in circumstances when lower levels of care are not available. The respondents commented, for example, that the specialist services provided by Day Hospitals were being used for people who might appropriately be dealt with through a lower level of service:

There are some elderly people attending a day hospital. On the whole they need little or no medical treatment (other than usual ailments that come with old age) but come for company/socialisation ... (Occupational Therapist)

We find a definite gap in provision in this area ... As a result of this, such clients are reluctant to discontinue Day Hospital, which again creates unnecessary dependence. (Nurses)

Services in hospital

Patients who are admitted to acute wards cannot always be conveniently discharged once their acute needs have been dealt with. Complaints about 'bed blocking', frequently reported in other surveys,³ were not made everywhere, but there did seem to be recurrent problems.

Elderly patients who are admitted to the medical (as opposed to 'geriatric') beds are likely to remain in the medical ward for a prolonged time waiting for placement, where the care they receive is often inappropriate ... The medical ward, good as it is, is unsuitable for geriatric long stay patients, with inadequate long term physio, OT etc. These patients may deteriorate as a result. (Hospital medical staff)

We frequently have patients who cannot be placed ... and have to wait in NHS beds until a place becomes available. Waiting time can be several months. (Nurse).

Many patients have to be admitted to acute medical beds because places are just not available quickly enough in residential homes for the elderly or long-term or respite. ... The problems of the elderly would be minimised if the speed of transfer out of hospital could be maximised. ... patients remain in hospital with the danger that they will become more and more institutionalised (Medical administrator)

This is consistent with previous research, which attributes bed blocking mainly to the wait for long-term care, and which has found increasing problems in movement to nursing and residential care as long-stay geriatric places have been restricted.⁴ The effect of recent reforms in community care had proved particularly problematic:

At present delays in (1) initial response by SW department and (2) action by SW department are leading to longer stays in hospital which is affecting patients physically and psychologically. I find their self-care skills deteriorating probably due to lack of motivation and depression with their long stay in hospital. (Nurse)

One cannot but be dismayed at the delays to assessment that seem to be built into the new Community Care Act. I do not blame social work for that but the bureaucracy is quite intimidating. (Hospital medical staff).

³ See e.g. F W Murphy, Blocked beds, British Medical Journal 28.5.77 pp 1395-1396; J Coid, P Crome, Bed blocking in Bromley, British Medical Journal 10.5.86 pp 1253-1256; F Namdaran, C Burnet, S Munroe, Bed blocking in Edinburgh hospitals, Health Bulletin 50(3) 1992 pp 223-227.

⁴ F Namdaran et al, 1992.

This squares with experience elsewhere, reported in the press and in a BMA survey⁵. However, it does not account for all the problems, because even if assessments were speedier there would be limited opportunities for appropriate placement. Concern was expressed about the limited availability of convalescent and long-term nursing facilities.

These are patients whose acute medical problem has been dealt with as best as possible but are in need of convalescence, prolonged rehabilitation or some form of long term residential care. ... The options are always present but because they are limited there is often a long wait before appropriate placement. (Hospital medical staff)

As a high turnover unit we would benefit greatly from the provision of a fast reception service for elderly patients who have no continuing need to be on an acute urology ward but whose health or whose home circumstances make immediate discharge impossible. (Hospital medical staff)

There was also a suggestion that some patients might be referred directly to continuing care because of the shortage of rehabilitation facilities.

Patients are often admitted to continuing care wards when they would have gone to a rehabilitation ward. They are sometimes transferred there when a bed becomes available.

Some more short stay rehabilitation beds could be made available - in some instances patients are referred to us (long stay) very quickly mainly because of pressure on acute beds.

This reinforces the impression that patients are likely to be referred to higher levels of support when lower levels are not available.

Conclusion

The responses to this enquiry point to particular problems in matching services to needs within current constraints. If the range of options available for patient care is limited, then people referring patients on have to compromise, choosing second-best options; similarly, if there is no adequate alternative, services have to accept patients who might better be helped in other ways. The current reforms in community care have been concerned with other issues, notably co-ordination and effective management of resources; they do not in principle address the problems of constrained choice, which can be expected to continue⁶. There were no responses here to the effect that people were being mis-referred through inadequate assessment. The sources of inappropriate referral and placement which were identified by respondents related to unsatisfactory alternatives, and limited service options for responding to needs.

⁵ See report in the Independent, 27th October 1993, p.8; and BMA, Survey on the impact of the implementation of the Community Care Reforms, Nov. 1993.

⁶ P Spicker, 1992. Packages of care, University of Dundee.