

EDITORIAL

The new imperative of long-term care

“So my plea is that we rediscover the beneficence of the Asylum. We need institutional living – for some – in the 21st century. We need to reconstruct our thinking about institutions and to put them back in the valued spectrum of human living arrangements.”

Malcolm Johnson 2002 [1]

The report detailing the closure of nursing home beds in this issue of *Age and Ageing* by Netten *et al.* of the PSSRU, University of Kent [2] has important ramifications for many including the specialty of Geriatric Medicine in the UK, the hospital system and most importantly the frailest elderly.

Geriatricians are generally pragmatic clinicians and have long exploited the recycling of otherwise redundant facilities, such as Sanatoria and other health and care antiquities, in the quest to enable older people to have better access to diagnosis, treatment, and rehabilitation with the goal of increasing well-being and reducing unnecessary admission into long-term care. This process has historically yielded a very virtuous cycle with seemingly no limit to the number of long-term beds that can be closed. Coupling this phenomenon with an enthusiasm for compressing morbidity at the end of life could be viewed as evidence that the need for institutional care for the elderly is passing. The implications of present Care Home closures, however, need more thoughtful consideration in the context of the emerging demography and epidemiology.

The UK Government appointed a distinguished Royal Commission [3] to consider long-term care. Two factors, the funnel of doubt regarding future needs and the failure to agree on a single funding proposal, undermined the impact of the Commission's final report. Simply, if doubt exists over what needs to be purchased the resulting confusion and uncertainty will inevitably complicate commissioning care and the supportive infrastructure required. The Commission made a recommendation for the establishment of a Care Commission, not a regulatory body but one that monitored the requirements for care, more a public health role. The PSSRU data illustrates this approach and perhaps reinforces the case made for such a Commission. The reality is that whilst much new policy on assessment, funding and regulation has been developed, itself a Herculean task, there is still a paucity of understanding over who is in care now, who could be enabled to independence and what the future holds. It is indicative that a recent Department of Health workbook on discharge (which incidentally has an excellent review of recent policy developments) advises that it is

important to ‘understand your local community and balance the range of services to meet health, housing and social care needs’ [4]. It is not clear how commissioners can respect these wise words and develop appropriate service in the absence of basic epidemiological information. An absence of misplaced older people in acute beds does not seem an adequate marker for this purpose and yet that is the apparent focus. Investment into public health, structured training [5] and medical care [6], and governance remains unreasonably elusive.

The case for more institutional care is emerging from demographic projection models. With unchanging dependency rates it is predicted that the numbers of older people in institutions will rise between 1996 and 2031 from 400,000 to 670,000; that if dependency were to increase by 1% then 890,000 beds would be necessary; and that should dependency rates decline by 1% the increase would be contained to 470,000 [7].

Future patterns of morbidity may have a great impact on the nature of the care required. Endemic diseases, largely infections, have in a relatively short time been overtaken by cardiovascular and malignant diseases and the like. Neurodegenerative diseases are the now and tomorrow, with dementia, stroke and Parkinson's disease being instrumental in the majority of admissions into care, and mental incapacity the final common pathway. Simply supporting people with severe memory, and wide ranging cognitive, deficits is seldom addressed by infrequent short home visits, and many in these diagnostic categories reach a stage where the level of care required is simply not possible in the community because of affordability, risk management and the sheer practicality of finding suitable care staff. Finding institutional care for disturbed and distressed, demented, misplaced older people currently leads to quite perverse behaviour both in prescribing, and inappropriate discharge planning [8]. Another recent report [9] suggests that the numbers of people with cognitive impairment in institutional care will rise by 63% from a base of 224,000 in 1998 to 365,000 in 2031. These challenges are amenable to structured care processes in a similar manner to the protocols and pathways, and perhaps most importantly governance, that are increasingly commonplace in other medical domains. The remaining small percentage of older people whose complexity defies such an approach could redefine General Geriatric Medicine.

The case for investing in long-term care gains further urgency because of the inextricable relationship between ‘health’ beds and ‘care’ beds. In the UK, there are more than three care beds for every health service hospital bed (including specialties such as gynaecology).

Clearly, should the present closure rate of care beds become a ‘meltdown’ the impact on health service beds will produce a complete gridlock of the British hospital service through the overwhelming demand from elderly community refugees seeking care asylum in hospitals.

An unavoidable reality for providers of institutional care is the achievement of a fair rate of reimbursement, that is one that more than covers the costs of managing increasingly dependent older people and is sufficient to attract, retain and reward care staff adequately. This financial fundamental is not further considered here, but the key issue for professionals is who provides and who is responsible for care. Two reports are helpful. ‘The Health and Care of Older People in Care Homes, a Complete Interdisciplinary Approach’ [10], – a working party report endorsed by the Royal Colleges of Physicians and Nursing, and the British Geriatrics Society, at its heart recognises the potential for professional nurses to become case managers with the medical role becoming facilitative and advisory. The key to developing the nursing role is that care staff have access to training, support and recognition, and the Care and Support worker inquiry from the King’s Fund [5] makes clear that much remains to be done.

Articles in learned journals concerned with care generally document failures of care, but seldom are there positive reports – this has to change. Care Home closures will need to cease and new homes will be required but how should they be configured? The importance of a social model of care is widely accepted but the increasing dependency in institutional care and size of the population requires much more structured support (commissioned services) and understanding (evidence) than at present. For example, does an ensuite bathroom really address the needs of someone who is completely dependent? The UK policy of shifting commissioning to primary care makes planning particularly difficult with often a remoteness from geriatric specialist support. Governance and inspection should ensure that matters in Care Homes do not become lost in competing priorities, the Commission for Health Improvement report into deficient prescribing practices in a community hospital [11] contains much wisdom and many parallels with long-term care. The re-engagement of specialist care may require several further uncomfortable reports, but it will occur if patient centred care, the fundamental running through the National Service Framework for Older People [12], has real currency. Now would be a good time to develop how the specialist can best facilitate the health and care of the frail in long-term care and perhaps a starting point would be for specialists to collaborate with the increasingly engaged

and responsible primary care trusts using the PSSRU work to aid strategic planning. The clock is ticking.

CLIVE BOWMAN
 Medical Director,
 BUPA Care Services, Bridge House,
 Horsforth, Leeds LS18 4UP, UK
 Fax: (+ 44) 0113 239 0332
 Email: bowmanc@bupa.com

References

1. Johnson M. Committed To The Asylum? The Long Term Care of Older People. Leveson Lecture, 2002. (www.rps.gn.apc.org/leveson/study-publications.htm)
2. Netten A, Darton R, Williams J. Nursing home closures: effects on capacity and reasons for closure. *Age Ageing* 2003; 32: 332–7.
3. Department of Health. With Respect to Old Age. The Royal Commission on Long-term care. London: Department of Health, 1999.
4. Department of Health. Discharge from Hospital: Pathway, Process and Practice. London: Department of Health, 2003. (www.doh.gov.uk/jointunit)
5. Henwood M. Future Imperfect? Report of the King’s Fund Care and Support Inquiry. London: King’s Fund, 2001.
6. Black D, Bowman C. Community institutional care for frail elderly people — time to structure professional responsibility. *Br Med J* 1997; 315: 441–442.
7. Wittenberg R, *et al.* Demand for long-term care for older people in England to 2031. *National Statistics Quarterly* 2001; 12: 5–16.
8. Bowman C, Stokes G. Registries charting epidemiological trends and benchmark options are required. *Br Med J* 2001; 323: 1427.
9. PSSRU, LSE Health and Social Care. Cognitive Impairment in Older People: Its Implications for Future Demand for Services. Discussion paper 1728. London: PSSRU, LSE Health and Social Care, 2003.
10. Royal College of Physicians. The Health and Care of Older People in Care Homes a Comprehensive Interdisciplinary Approach. A Report of a Joint Working Party of the RCP London, RCN and BGS. London: Royal College of Physicians, 2000.
11. Commission for Health Improvement. July 2002 Investigation into Gosport War Memorial Hospital. WHERE? Commission for Health Improvement, 2002. (http://www.chinhs.uk/eng/organisations/south_east/gosport/index.shtml)
12. Department of Health. The National Service Framework for Older People. London: Department of Health, 2001.