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Matching services to needs in the health care of elderly people

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Abstract

This paper is based on the results of a postal enquiry to health care professionals working in the care of elderly people in a Scottish Health Board. Responses fall into three main categories. The first refers to issues of process - where lack of information or delays in response create problems. Second, there are problems of scarcity - both lack of provision, and pressures on existing provision. Third, the responses relate to the impact of constrained choices, which are the consequences of that scarcity: either people who are sent to existing services because of lack of alternatives, or people who cannot be referred on appropriately because of the lack of alternatives. The process of referral is, then, affected directly by the options which are available. In the process, compromises have to be made, and this produces mismatches between needs and services.

Introduction

The processes through which elderly people are allocated particular services within the NHS are complex. Attempts to trace 'pathways' of care have proven problematic. Hunter, McKeganey and MacPherson have attempted to chart pathways of care for elderly people by examining the direction of successive processes of referral. They make the important point that pathways are determined to a certain extent by the availability of services, that is by existing pattern of service provision and by relationships between institutions, agencies and the professionals who work in them (Hunter, McKeganey, Macpherson, 1988).

In recent years, the analysis of service responses to needs has come to depend increasingly on conceptualisation of the range of services in terms of a market - or, more precisely, a 'quasi-market', because the characteristics and organisation of health and social services do not necessarily contain the same elements as other markets in economic analysis (see Le Grand, Bartlett, 1993). The literature on quasi-markets has mainly focused on changes in the pattern of development promoted as a result of government policies - the process of 'marketisation' - and the extent to which the quasi-market differs from the archetypal free market. The implication is that social services work on different kinds of criteria from markets, which leads Fairlie to argue that quasi-markets are characterised by 'institutionally embedded' characteristics, requiring the market to be interpreted from a relational perspective (Fairlie 1994).

In this paper, we take a very different perspective, considering not so much the extent to which a market has social characteristics, but the extent to which a social organisation can be interpreted in terms of a market. Part of the justification for **the policy of marketisation** has been a recognition of the way social services operate in practice. In *Mental Handicap and Community Care*, Bayley (1973) made out the case that the statutory social services offered only a limited part of the care which was necessary in the

'community'. Bayley's work can also be seen as the source of a strategy which has now been realised in the delivery of community care: the idea of the development of 'packages' of care selected for individual clients from a range of available services. The principle has informed new policy - most notably the Griffiths reforms of community care - but it is not itself new. It relies, rather, on a particular interpretation of what is possible in within the process of social service delivery. The approach is based on the idea that the same kind of selection is possible within social services as in the private market. This prompts a re-interpretation of the process of service allocation and delivery.

The argument that there is a process of selection directs attention to the interaction between the supply (or provision) of services and effective demand, or assessed need. In the terms of market analysis, the issues include scarcity, or the lack of resources; the impact of consumer and producer choice, including constrained choices at the point of access; imperfect information (where those who demand services do not know the full range of options); and priorities in allocation.

Method

The aim of this study was initially to identify possible mismatches between needs and services, and the source of such mismatches. The study was intended to identify problems arising from a set of complex processes. The first questions to ask are whether there are problems, and if so what kind of problems they are; the extent of any problem can only be considered after these questions have been answered. This calls for qualitative rather than quantitative investigation. 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 study was an initial enquiry, which used a postal request to professionals in a Scottish Health Board, asking for information on the extent of mismatch. In our experience, 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?
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. The initial mailshot went to people in the following settings:

- hospital services: medicine for the elderly
- hospital services: psychiatry of old age
- day hospital
- general hospital: selected specialities, including surgery, orthopaedics
- general practice/health centres
- other primary care, and
- social work in health service settings

The circular was sent as far as possible to named individuals, including

- consultants and senior registrars
- nurses responsible for care
- professions allied to medicine, and

managers.

After the response to the first circular, a reminder was sent, with the same questions laid out slightly differently; this produced more responses, of which the greater part were returned anonymously. 147 responses were received in total; five further notes were received from people explicitly refusing to respond. 78 responses came from people with identifiable professional roles, including

General practitioners		18
Other primary care workers	7	
Hospital medical staff (consultants and senior registrars)		26
Medical administrators		6
Nurses		14
Paramedical staff		7

67 responses were not identifiable in these terms, and two others specifically asked that their responses should not be attributed. Although the pattern of response from those with identifiable professional roles appears to indicate a much higher return from general practitioners and hospital medical staff than from elsewhere, it may also reflect the greater confidence and willingness of relatively senior personnel to associate themselves with comments. Some respondents were clearly concerned lest identification of problems might be taken as criticism of the service; one respondent, who had been particularly frank, expressed a fear of the possibility of being 'Pinked'. This kind of anxiety may more generally have affected people's willingness to respond, and we have sought to be sensitive to these concerns in the presentation of our results.

The validity of the statements has to be interpreted in the light of the status of the respondents, who were all health care professionals working with elderly people; the material can be seen as reflecting professional experience and judgment, which is a central element of health service practice. The comments offer an insight into problems and process rather than an account of the distribution of concerns. Comments which are isolated may still point to the existence of serious issues - examples in this research included issues relating to dermatology, multiple sclerosis and terminal illness, which were relayed to the Health Board; conversely, comments which are frequently repeated may show common misconceptions. Both classes of comment have some value in the evaluation of service activity.

The numerical representativeness of comments was not an issue in the research design; it was much more important to try to extend the range of potential responses, and we sought to encourage further duplication and circulation of the questionnaire. It is difficult to calculate a response rate, not because a number of responses were made on behalf of a group of people or speciality. A number of consultants clearly responded on behalf of a unit, as did some general practices, but equally some hospital doctors replied as individuals, and in one general practice, four GPs responded. The answers received probably represent something in the region of 30% of those circulated. 56 respondents answered by letter; 33 of these appear to speak on behalf of medical units (17) and general practices (16). Clearly, those who respond outlining problems are likely to have viewed the situation differently from those who did not respond. 9 respondents to the circular answered the three questions with 'no'; one of those appended the note that 'we have an excellent service for the elderly'. One letter (from a manager of a general practice) stated that 'I am pleased to say that we are very happy with the existing service'. Where people are content with a service, there is little incentive to respond. Those who did respond may well have had particular concerns and problems which were specific to their own speciality, circumstances or area. It may also be true that people do not respond when they see little prospect of improvement.

Responses

Responses fall into three main categories. The first refers to issues of process - where lack of information or delays in response create problems. Second, there are problems of scarcity - both lack of provision, and pressures on existing provision. Thirdly, the responses relate to the impact of constrained choices, which are the consequences of that scarcity: either people who are sent to existing services because of lack of alternatives, or people who cannot be referred on appropriately because of the lack of alternatives.

The operation of the 'market'

If health services for elderly people are in any sense a 'market', the main consumers are not the people receiving the services. There are some references to choices made by patients and families, but they were few:

It is noticeable that if there is a vocal family (and often an educated, financially viable family) that there is not such a long time to wait to gain a bed in a long term unit. If you have a low profile, are poor and really in need of the NHS, things may take longer to move along. ... (Nurse)

Patients attending geriatric day hospital often are unable to cope at home but refuse further help

Many would be better placed in nursing home or residential care, but refuse to move on. Fear of 'going private' and implications for savings etc. ... They are often horrified when discharge home is mentioned and place many obstacles in the way.

We are often asked to take these patients as their carers much prefer them to be cared for locally in familiar surroundings.

The apparently limited importance of consumer choice seems to correspond with findings from the perspective of elderly people, which suggest that any sense of choice in the selection of packages of care is limited (Allen, Hogg and Peace, 1992, ch 4). Who, then, is determining what kinds of services patients receive? The decisions which feature in the responses are professional ones. The most important of these decisions are probably those made in the first instance by the g.p., subsequently by hospital medical staff, and at the point of discharge by social workers; but virtually all professionals have some kind of responsibility for referring people for other services. In some cases, the hoops which professionals have to jump through clearly affect the pattern of referral.

Home helps often have to refer to us to make contact with the social services (GP)

Hospital OTs can no longer hand out equipment to patients discharged from our wards and assessed by them. They have to be referred to community OTs for this causing a delay in supply. (Hospital medical staff.)

The pathway for referring a geriatric or psychogeriatric patient can be quite long. ... if a referral to named doctors in the geriatric or psychiatric service could be started this would certainly ... help to at least direct further enquiries (Hospital medical staff)

In the case of dementia sufferers ... the tendency is to refer them to the Psychogeriatric Service and discharge them, because it is known that this speeds up the referral ...

However, the procedural issues are much less important than the substantive limitations on producer choice.

Options for care in the community are limited. If there is not enough cover available the patient is often referred for residential care, which may not be the patient's choice.

Patients referred for mobilising due to a decrease in their level of mobility would be ideally treated by a community Physio if service was available due to transport problems bringing these elderly people into hospital from here ... we are unable to refer out patients on (Physiotherapist)

Lack of provision

The root of many problems and constraints is the lack of available options. Respondents commented frequently on the lack of support services, both within the NHS and in the structure of community care. This is perhaps to be expected, because complaints about the level of service are endemic in the NHS: Enoch Powell once commented, as a former Minister of Health, that

'One of the most striking features of the National Health Service is the continual, deafening chorus of complaint which rises day and night from every part of it, a chorus only interrupted when someone suggests that a different system altogether might be preferable ... The universal Exchequer financing of the service endows everyone providing as well as using it with a vested interest in denigrating it.' (Powell, 1966)

Respondents to this study were conveying messages to the Health Board which sponsored it, and predictably many of the comments related to services which respondents felt should be available:

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)

Elderly and disabled patients are brought to our department (if able) instead of being seen in the community where they would be better treated ... sometimes patients don't receive any appropriate physio because we have no community service to refer patients onto (Physiotherapist)

There is a gross deficiency of physiotherapy, occupational therapy, speech therapy, dietetics, chiropody ... there is no clinical psychology (Hospital medical staff)

Where comments suggest that the response made to patients is less than adequate, it is generally because the lack of available resources reflects directly on service quality, not because the services themselves are perceived as inadequate.

We are often referred people who have had no contact with an optician for at least 10 years. Their sight in the intervening period could have been improved and problems with the eyes would probably have been picked up earlier. (Hospital medical staff)

Elderly and disabled patients are brought to our department (if able) instead of being seen in the community where they would be better treated ... sometimes patients don't receive any appropriate physio because we have no community service to refer patients onto (Physiotherapist)

People with specific needs (e.g. CVA) are not dealt with (appropriately), specifically due to lack of resources: people, place, time. ... In an ideal world, patients should be given the chance to reach their full potential both in hospital and at home.

Few responses related directly to the limited supply of medical services - there were no comments, for example, suggesting that it is difficult to get a patient admitted to hospital, or that there are lengthy waiting times.

There were difficulties, however, in moving people from acute wards. Probably the most familiar complaint relating to constraints on resources is the problem of 'bed-blocking', where elderly people in hospital cannot be appropriately discharged because of a lack of suitable alternatives. Coid and Crome describe a bed blocker as

"someone who has been in hospital for more than four weeks and who in the opinion of the medical and nursing staff no longer requires the facilities provided there." (Coid, Corne, 1986)

Estimates of the size of the problem vary: Victor's studies in London point to some 8% of acute beds being blocked (Victor, 1991, p 122), while work in Edinburgh points to an average of 19%, including 33% of beds in orthopaedics and 13% of acute beds (Namdaran, Burnet, Munroe, 1992).

A very common situation in the surgical wards relates to a patient who after the intervention has recovered, but is obviously unable, because of age or infirmity, to look after himself or herself at home and the patient has to wait some time - several months in an acute ward - before he/she can be placed in an appropriate institution (Hospital medical staff)

Mr R ... currently no evidence of distant spread of cancer ... transferred here for "convalescence". Needs supervision but not 24 hour nursing care ... [this is] a high dependency unit. Mr T ... Homeless, admitted for "convalescence" following radiotherapy ... cannot be discharged as no home to go to. ... There are endless similar examples. (Hospital medical staff).

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)

The problems are not experienced generally - they seem to refer to particular specialities and locations.

There is not really a problem locally. The service is excellent and 'blocked beds' really do not exist. (Hospital medical staff).

We have had good co-operation from Geriatricians and other colleagues in getting these patients out ... perhaps the infrequency with which we ask for help from these colleagues makes it easier for them to help us when we do! (Hospital medical staff)

One major cause of bed blocking seemed to be the lack of interim care for rehabilitation or convalescence:

Some years ago it was possible for us to get patients into long term geriatric rehabilitation prior to eventually going home ... more recently it has been impossible (Hospital medical staff)

These people frequently live on their own and need an 'intermediate' phase between being in an acute ward and looking after themselves at home. A rehabilitation ward - even for a few days/weeks - would free up the ward for acute admissions. (Hospital doctor)

[We are losing a number of beds.] These beds were being used for slow stream rehabilitation particularly stroke patients and this will have an inevitable damming back effect in that patients will require to wait longer on surgical and orthopaedic wards in order to come to our ward (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)

Another important element was the difficulty of obtaining access to long-stay nursing care.

Not infrequently a patient's discharge is delayed by lack of placement in Nursing Homes or long-care beds (Hospital medical staff)

There is often a significant delay in finding nursing home and occasionally residential home placement for patients. (Hospital medical staff)

Occasionally elderly people stay in the assessment unit far longer than necessary because there are no long-stay beds available. (Physiotherapists)

There is often a wait of months for hospital continuous care of the elderly placement ... placements can take upwards of six months.

This squares with previous findings: the main cause of bed blocking is the lack of long term care, and as the availability of long-stay geriatric beds has fallen, an increasing number of people who are waiting to move are waiting for residential and nursing care (Namdaran et al, 1992). The 'need' for continuing care is, of course, the response which professionals think of as appropriate; the appropriateness of long-stay nursing care as a response has been disputed. 'Needs' are generally interpreted in the light of available responses; because long stay nursing care has been the main response available in the past, and assessments made in health services are still interpreted in that light, there is a perceived shortfall in provision.

Rationing

Scarcity of provision implies that there must be some form of rationing, either by restricting supply (e.g. through waiting lists or the dilution of a service) or through limiting demand (e.g. by deterrence or the imposition of costs) (Scrivens, 1980). The respondents tended to comment on rationing not as a considered policy, but as an inevitable response to pressure.

In continuing care wards, the patients ... need input from physio and occupational therapists and this service is sadly lacking. It is such a pity that once patients are moved into this type of ward the nurses are expected to carry on maintaining these services, when short staffed and pushed for time.

They wait on the ward until social work dept have the manpower available to look at their case

With free home help service it almost seems to have caused a reduction in home help hours.

Scarcity can itself act as a demand inhibitor: people will not refer if no response is likely (Coid, Crome, 1986, p.1295).

The main problems where patients had had to wait a long time for services were for services which were complementary to health care:

There are always problems with the time you have to wait when you have referred a patient to another service, e.g. dental, optician, orthotics etc.

People wait in our wards (for) residential, private nursing care or long stay hospitals. Places always come up for them eventually but obviously there is a prolonged waiting period. (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)

Similarly, the pressure on paramedical and support services, and other services in the community, was considerable.

Chiropody ... the waiting lists for domiciliary visits are horrific (GP)

Long waiting list for meals on wheels. Demand outweighs supply of bathing aids, which in some cases would lead to independence and allow services to be directed elsewhere. (District Nursing Sister)

Restricted availability of occupational therapists and the waiting time for even simple equipment (GP)

There was, however, no reference in the responses to the rationing of medical care itself. This may reflect the culture of the NHS, which is supposed to offer a universal response to need, but waiting lists for entry to hospital have become so much a part of the profile of services that it seems surprising that they were not referred to as an obstacle.

The impact of constrained choices

The main implication of scarcity is not that there are no options, but that compromises have to be made. Where professionals describe their response as inappropriate, it is because they have had to make some kind of compromise.

I treat medical inpatients, many of whom have had a CVA. In order for them to receive intensive therapy they have to remain in an acute medical bed long after they could be in, for example, a rehab ward ... (Hospital medical staff)

If these people do not get their place in a residential home then they are often referred for geriatric or psychogeriatric assessment, which in many case I would feel inappropriate (Hospital medical staff)

Younger people, particularly those aged 50-65 ... land up receiving care under our unit because this is the only department that meets their needs, for instance if they have had a stroke. (Hospital medical staff).

Responses have to be selected from the services available. Where there are few options, the choices which have to be made are those which are most appropriate within the particular circumstances.

In several cases, the effect of these choices was to shift demand from one part of the service to another. The lack of community services had the effect of requiring people to be treated in hospital if they were treated at all.

Community paramedical care is in many areas lacking as it has not been given the same priority as, for example, community nursing. Without more paramedical input into the community the elderly will increasingly require more expensive forms of care, e.g. admission to hospital. (Medical administrator)

Some elderly people are brought in from residential/nursing homes, these admissions may be prevented by community physio, OT and some alternative therapies. Preventative medicine/screening and better information might stop admissions too - plus more extensive community care.

This can be seen as a call for a better range of services in the community, and in that respect it is not dissimilar to the arguments usually made for prevention - that better resources at an earlier stage would be more effective. But there is a further dimension here: the argument that the lack of community resources directly requires the use of hospital admissions.

In many cases patients referred ... could have been dealt with at home or discharged back home after appropriate examination and treatment had home circumstances been suitable. Unfortunately most of these old people were living alone and were either generally infirm, or suffered from multiple problems related to old age, and were thus required to be admitted to acute surgical wards ... i.e. 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)

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)

A number of comments also refer to 'social' admissions, for circumstances in which it is the lack of community support rather than health needs which requires admission to health care in hospitals:

Some patients are admitted for purely social reasons

We do not have local facilities for day care ... we are often asked to take these patients as their carers much prefer them to be cared for locally in familiar surroundings.

Both via A and E and the orthopaedic wards, [there are] some 'social' admissions without adequate home back up and thus requiring an alternative form of care

Some patients are admitted acutely under some spurious pretext because support on which they depend has become unavailable, sometimes through illness. ... Furthermore there are many patients who have disabling disease, classically dementia, on account of which they or their relatives are barely coping, a relatively trivial medical problem is used as a pretext for admitting them to hospital and it has subsequently proved impossible to discharge them back to the community. (Hospital medical staff)

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

Many patients attending day hospital benefit just as much from day care with regular professional review but again there would be a need for more flexible and varied day care options. (Occupational therapists)

Some patients at Day Hospital appear to be sent purely for social reasons ... more day care is needed as opposed to medical intervention at a day hospital (Physiotherapist).

There are occasions when clients are present at Day Hospital because of reasons other than requiring psychiatric assessment/treatment. Examples of this are when social care is required but the client concerned has had previous psychiatric care. The same applies when the home circumstances may be problematic, e.g. the carer becoming less able to cope. ... Problems have been experienced ... where the elderly with dementia cannot be discharged following assessment to other, more appropriate services, such as day care, due to non-availability of places locally, or reluctance to accept such clients due to the stigma of a psychiatric 'label'. ... Where this happens, unnecessary dependence is created. (Nurses)

Acute wards and rehabilitation wards were being used for respite care, which was not otherwise available:

Patients for respite/maintenance are receiving same high level of staff, e.g. senior physios, as rehab patients ...

Respite care admissions are not best placed in acute Assessment Wards for the Elderly. Respite care would appear to have been reduced due to lack of financial resources ...

Two comments also suggested that in the absence of rehabilitation facilities, patients were being referred directly to continuing care:

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.

If these are correct, they have important financial implications: referral to continuing care is among the most expensive decisions that can be made.

It appears that people may well receive higher levels of care because lower levels are not available. In circumstances where people were receiving a lower level of service than needs merited, this could be thought of as the consequence of rationing decisions, rather than of constrained choices within a quasi-market. But these people are receiving more care than they are supposed to be. The kinds of decision reflected here do not, then, seem to be rationing decisions - if they are, they are bizarre. The simplest explanation is that effective demand is shaped directly by what is supplied.

Packages of care

The principle behind establishing a diverse series of options is that it improves the robustness of planning for individual cases: a service for any individual can be selected from a range of available services. This constitutes a major part of the approach to community care enshrined in the government's White Paper (Cm 849, 1989), and subsequently in the practice recommendations of the Social Services Inspectorate and Social Work Services Group (1991). A number of responses suggested that the range of current services is not adequate to the purpose.

Range of services appears to be constricting not expanding (Hospital medical staff)

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)

Elderly people fall into different categories, but because options are limited, people with a wide range of disabilities and from varied backgrounds are thrown together - e.g. confused people with those who are mentally alert (Nurse)

Options for care in the community are limited. If there is not enough cover available the patient is often referred for residential care, which may not be the patient's choice.

This reflects on current attempts to introduce quasi-market procedures into health and personal social services. The success of such attempts depends crucially on the development of systems for selecting the range of services for the traditional approaches to rationing. If, however, the range is restricted - as it must be in all conditions of scarcity - the effect of the process of selection will be to require compromises to be made. This will produce mismatches between needs and services.

Notes

This study was undertaken with the support and co-operation of Tayside Health Board.

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