

suggestions as to how utilisation might be increased. Ford and Taylor have suggested, at least in the British context, that underconsultation among the elderly is exaggerated.¹ There is nothing in either of these papers to refute this proposition.

Nevertheless, both papers raise interesting questions. Is the consultation-seeking threshold similar at all ages? Although the factors which appear to account for variations in utilisation may be different, the overall propensity to consult with given symptoms may be similar. There is substantial evidence in the literature of medical sociology to suggest that people of all ages sometimes fail to consult a physician when they think they ought to. At what point does this 'failure' result from attributing health problems to the ageing process? What neither study is able to address is the extent to which patterns of utilisation are attributable to experiences of the outcomes of previous episodes of care. In order to address these sorts of questions a different type of research is necessary. Too much of existing research on utilisation of health care by the elderly relies upon analysis of crude social indicators and use data. There is a need for sociological studies which employ qualitative approaches to explore issues concerning utilisation and outcomes of primary medical care.

NOTE

- 1 Ford, G. and Taylor, R. The elderly as underconsulters. *Journal of the Royal College of General Practitioners*, 35 (1985), 244-247.

The Department of General Practice,
University of Manchester

Social Work and Social Services

David Challis

Teh-Wei, Hu, Lien-Fu Huang and W. S. Cartwright, 'Evaluation of the cost of caring for the senile demented elderly: a pilot study', *Gerontologist*, 26, (1986), 158-163.

Policy debate has been concerned increasingly with the most appropriate means of providing care for elderly people diagnosed as suffering from dementia. This paper reports a small pilot study of the cost of providing care for elderly people suffering from senile dementia. Of these 16 were male and 28 female; 25 were living in nursing homes and 19 in their own homes. Patients suffering from severe physical handicaps as well

as dementia were excluded to avoid confounding the costs of physical illness with those of serious mental impairment.

The authors state that the danger of too much costing of institutional care services is that it is focused upon the simple average costs of institutional care and has failed to take account of the variations in attention, care and treatment given to some patients rather than others. Accordingly, nurses or family members were asked to maintain cost diaries for a two-week period in order to report the costs and amounts of time which were spent by care givers to meet the needs of demented elderly people. The care needs which were covered were basic care which consisted of feeding, toileting, dressing, bathing and supervision.

It was found that in nursing homes, staff spent an average of $2\frac{3}{4}$ hours per day caring for a patient with senile dementia. The amount of time spent appeared to vary according to the degree of severity of mental impairment; for the severely impaired 40% of the time was spent in toileting activities and 15% on supervision, whereas for the less impaired these figures were reversed, reflecting the close association between mental state and problems of maintaining continence. The amount of nursing time in these institutional settings given to the demented was, as might be expected, about one-third as much again as is given to the average patient.

In assessing the costs of care at home, the authors take a 'market value' approach, imputing a nursing aide cost to the activities undertaken by family members. Home care costs appeared to vary with the severity of impairment – those at home being generally less impaired than those in nursing homes – as well as whether the person lived alone or with others. It appeared that for patients living at home, care givers spent on average over 6 hours per day compared with $2\frac{3}{4}$ hours nursing cover. In addition there was care provided by social service agencies.

The authors were able to demonstrate that costs vary both within institutions and in the community according to a variety of factors although clearly, due to the differences in impairment between institutional cases and community cases, no comparison is really possible between the groups.

COMMENT

Studies of the costs of caring for the mentally impaired elderly have tended to focus upon the psychological burdens and stress which carers experience and have tended to ignore the more tangible economic costs. The attraction of this study was that it attempted to capture some of

those economic costs. However, there were a number of problems in the approach adopted by the authors.

First, there was only an attempt to cost the provision of basic needs, and activities such as stimulation or rehabilitation designed to revive old skills would therefore tend not to be included.

Secondly, in the community group, not only were the patients not comparable with those in institutional care due to their lesser mental impairment, but in addition, very few of these were found to be living alone. Yet it is those living alone who tend to receive the highest levels of provision of statutory resources.¹

Thirdly, the factors included in the costing of home care are not readily comparable with the factors taken into account in institutional care. For example, patients at home over a time period of perhaps 6 months may require periods of institutional care to give their carers relief. The additional cost of this would have to be discounted over the time period of care, thereby increasing the costs of care at home. In addition, no allowance was made in costing the time given by carers for such costs as employment forgone. The value of this employment forgone may well be greater than the imputed value of care time. Even if the patients had been comparable, the cost elements, such as extra heating and board and lodging costs at home, to society as a whole would not have been included. The likely effect of such exclusions is to make care in the community appear artificially cheaper than it probably is. None the less, the paper is helpful because it attempts to tease out the differences in care costs within institutions of different kinds of patient. Further work is needed in this direction if we are to more coherently plan community services for such patients since it is often fallaciously assumed that being in an institution provides 24 hour care. The evidence of this study is that those in institutional care received less nursing contact than those living at home.

NOTE

- 1 Bergmann, K., Foster, E. M., Justice, A. W. and Matthews, V., 'Management of the demented elderly patient in the community', *British Journal of Psychiatry*, **132** (1978), 441-449.

A. Scharlach and C. Frenzel, 'An evaluation of institution based respite care', *Gerontologist*, **26** (1986), 77-82.

Respite care, whether provided by hospitals through a 'rotating bed' system or through short stay care in a residential home or day care

services, is seen as one of the means of providing relief and enabling informal carers of frail elderly people to cope more effectively with the burden of care. This study reports on a follow-up of users of extended respite care services in the United States based in a nursing home facility. Use of relief beds was possible for care givers once every two months, for periods of up to 14 days. The average length of stay on each occasion was 7 days. Care givers were interviewed after the service had been operating for some 18 months.

The main reason given by care givers for using the service was emotional and physical rest, and other reasons noted included the opportunity to visit family, obtain solitude or simply put the household to rights. In health terms carers felt that they experienced subjective improvements which were related to the opportunity to catch up on lost sleep and relief of physical and emotional exhaustion. There was not any evidence of adverse effects upon the patient using respite care in terms of physical, mental or emotional well-being, although this may be in part attributable to the apparent exclusion of seriously mentally impaired elderly patients. The effect of respite care upon care giver/patient relationships was less clear cut, 56% of care givers reporting improvements and 38% deterioration attributable to the use of respite care. The negative effects took the expected forms of resentment and fear of abandonment and rejection. However, most care givers reported that respite care made their task easier, although only one in three saw permanent residential care in the following year as less likely due to receiving this form of help. Another third of care givers felt long-term institutional care would be more likely, since their fears of residential care had been reduced and they themselves had experienced relief from the daily burden of care.

The authors conclude that respite care is probably not the simple alternative to institutionalisation that it is often claimed to be, although clear benefits to care givers were evident. They also suggest the need to determine how certain care giver or patient characteristics are most likely to yield the best use of respite care services.

COMMENT

As the authors conclude, respite care has been too frequently seen as an easy solution to preventing the institutionalisation of very frail elderly people, and careful evaluation is clearly required. However, the need is to undertake more systematic comparative studies focusing upon which form of respite care can suit which family situation and set of patient needs. For example, as a means of avoiding further

disorientation, 'in home' day care was suggested over 20 years ago for the elderly mentally infirm,¹ but reports of implementing this are relatively few. Furthermore, the reported benefits of respite care may not be entirely due to the specific service of respite care, since others have indicated that simply the presence and availability of support for care givers such as a respite bed, although rarely used, tends to improve carers' ability to cope in the knowledge that back-up is available to them.

NOTE

- 1 Rosin, A. J., 'After care of elderly patients discharged from hospital', *The Medical Officer*, 29 January 1965, 62-64.

J. Coid and P. Crome, 'Bed blocking in Bromley', *British Medical Journal*, 292 (1986), 1253-1256.

This study examines the extent to bed blocking and prolonged stay in acute medical and surgical wards. Bed blocking was defined as a patient staying in hospital for 4 or more weeks and who, in the opinion of medical and nursing staff, no longer required the facilities provided. The aims of the study were to ascertain the extent of bed blocking, to examine the differences between 'bed blockers' and long-stay patients and to indicate ways of reducing the problem.

A survey of all patients occupying acute beds in medical, surgical and orthopaedic wards was undertaken, and detailed information gathered on each patient who had occupied a bed for 31 days or more. Of 503 patients, 145 (29%) had been in hospital for 31 days or more. Only about one-half of these (14%) were characterized as bed blockers, the majority of whom were in medical wards. Whereas long-stay patients were likely to be bed-bound due to serious illness or requiring traction, bed blockers were more likely to be non-ambulant, unable to dress, incontinent and to suffer from dementia. Discharge of 'bed blockers' was prevented by a combination of clinical, social and administrative factors. Clinical problems included dementia and multiple handicaps following strokes. In 21% of bed blockers, no clinical reason appeared to prevent discharge and in nearly half of these (49%) a major social problem prevented transfer. These social problems included difficulties in providing appropriate or adequate domiciliary care (16%) and the refusal of relatives to have the person at home (16%).

The authors suggest that home ownership and unwillingness to sell the property to pay for private care was a reason for prolonged stay

in a number of cases (15 % of bed blockers). The need to sell a property to pay for care was seen as a major disincentive to elderly people and their families to enter residential homes. Local authority policy not to recommend an arranged placement in the private sector was seen as exasperating this problem.

COMMENT

The study identifies the need for mechanisms to bring health and social care services closer together if elderly people are not to receive care in less than appropriate settings. However, it highlights one of the many administrative difficulties in so doing, namely the influence of different charging policies by different agencies. This has been a problem for the DHSS 'care in the community' initiative, where patients are to move from hospital care, where no charge is imposed, to community services run by local authorities, where charges are imposed both for residential and domiciliary services. It is likely to continue to act as a disincentive for patients to be discharged from hospital to residential care and may indeed be a growing problem as the NHS develops community services which may not only complement but at times substitute for local authority services. This area is clearly one that is ripe for much further investigation.

Personal Social Services Research Unit,
University of Kent