Long-term care in the UK

SIR,—Your Jan 11 editorial is highly relevant and timely. There are three points that need careful consideration.

The vast nursing home market in North America has failed to resolve the difficulties of blocked hospital beds because only a limited number of the beds were available at government expense and many people in "blocked bed" situations were unable to meet private costs and had to wait for a subsidised bed. Several reports on the appropriateness of placement within the nursing home, residential home, and chronic hospital sectors in Canada have shown that as many as 50% of those placed in nursing homes may be inappropriately placed and could have greater independence. Movement between the sectors is almost impossible, and no family willingly relinquishes a bed that is paid for by the health programme.[1]

Introduction of assessment programmes by geriatric services to determine the appropriateness of placement within the system has proved the best prospect of ensuring appropriate use of what are relatively scarce resources. In the city of Ottawa, where there is a regional programme organised for the whole of the city and its surrounding residential areas, the number of people referred to nursing home care has fallen, as has that of the waiting lists.[2]

You state that "NHS long-term care is vastly expensive" but I wonder if this is true? When the bulk of long-term care in this country was provided by geriatric units with bed availability being related to number of old people in the population, the total numbers of elderly people in institutional care of all kinds was something less than 5%, and in long-term hospital care this probably represented less than 3% of all elderly people. When the results of the 1991 census are available we may find that this number has risen substantially, which will draw attention to the question of whether all of these people now in institutional care need to be there and whether the £1·6 billion currently spent on income support to those in nursing homes and residential homes is well spent.[3] When the geriatric unit had its specific commitment to provide a service for an area within the resources made available to it, there was in fact a "ring-fenced" sum of money available for that service. In many regions this is no longer so and if, as the Social Security Committee of the House of Commons[4] has indicated, "the current requirement for Health Authorities to provide nursing care for those who cannot or do not wish to pay for it" is implemented and the Committee's further statement recommending "that this obligation should be properly enforced and that Health Authorities should not evade what are properly their responsibilities", the cost to Health Authorities may prove indeed to be astronomical.

In what is likely to become a providers' market, those who run private residential care facilities and private nursing home facilities may well become very selective of the type of patient who they will accept from health authorities. The government have chosen not to ring-fence resources for any care of the elderly in the community care proposals, as was originally recommended, and this decision may be one that will be a major embarrassment to the acute hospital services, especially in the last quarter of a financial year when both they and the local authorities will be endeavouring to meet budget targets.

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SIR,—Your editorial fails to emphasise the difficulties inherent in the National Health Service system which dates from 1948. Patients are not means tested for long-term care in hospital (but the state pension is downrated after 8 weeks), whereas such testing is necessary for all other forms of long-term care (either local authority part III accommodation [an old people's home] or income support for private and voluntary residential and nursing homes). A positive disincentive to discharging patients from NHS facilities to other forms of long-stay care therefore exists, despite Government policy espousing the role of the private and voluntary sector in providing long-term care, especially where patients have substantial capital assets or receive judicious assistance from income support (Sir George Young MP, personal communication, 1987).

The NHS and Community Care Bill comes into full effect in April, 1993. The detailed working arrangements of this legislation are being discussed at both local and national level, with particular emphasis on collaboration between health authorities, social services, and the voluntary sector. Only time will tell whether the new arrangement will neutralise the disincentive by patients in long-term care to use non-NHS facilities. One thing is certain, the same rules in terms of the funding of long-term care, whether that be in hospital, local authority care, or the private and voluntary sector, are essential. However politically painful this may be and, whoever forms the next Government, this should be a priority.

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SIR,—Your editorial suggests that health authorities should "come clean" concerning their responsibilites for long-term care.

This is a political, not a managerial, matter. Does the UK Government aim to provide long-term nursing care for those needing it free at the point of delivery or not (excluding those who are suitable for residential care in local authority homes)? The present Government has never denied this responsibility and yet it is indirectly encouraging health authorities to reduce the service, stating that this is available in the private sector (with some social security income support).

If the patient and/or the relatives are unwilling to pay the top-up fee for a nursing home, has the patient the right to stay in a National Health Service bed? Can health authorities require the patient to be moved to an agreed nursing home with or without the health authorities bearing the responsibility for the continuing funding of any top-up monies needed for the nursing home fee? This is a matter that the Department of Health must clarify.

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Knowledge-based systems for monitoring and evaluation of health services in developing countries

SIR,—Ministries of Health throughout the developing world invest substantial resources in collecting information. Up to 40% of health workers' time can be spent completing forms and reports.[1,2] Seldom, however, is this information analysed or used to improve the management of health services.[3] Data may be in a form that is inaccessible to health managers or they may lack the time and expertise to make use of them.[3,4] Many countries are now using microcomputers to improve the accessibility of information.[1,2,5,6] We have considered how computers can also help managers to make use of data.

We have developed software that will help managers to monitor immunisation services in Papua New Guinea. It uses data from the provincial health information system that has already been computerised.[5] The software highlights difficulties that need attention, suggests reasons why they occur, and actions that can be taken. It is called a knowledge-based system (KBS) because it uses the knowledge of people who are experienced in interpreting health information. Such information has been obtained from personnel in the Department of Health, Papua New Guinea, and has been encoded into a series of rules and implemented with the expert system shell 'Crystal,' which has already been used to develop an expert system to analyse health service indicators in the UK.[4]

The KBS starts by showing a list of health facilities with immunisation uptake rates for each vaccine. It focuses attention on

health facilities that need attention by ranking them. It also shows major changes in immunisation rates since the last reporting period. A menu allows any health facility to be selected for more detailed analysis. The system then summarises the major characteristics of immunisation uptake for the selected health facility in a series of one-line statements that are arranged in order of importance. If required, an explanation of any statement can be requested, together with suggestions for management response.*

The system searches for twelve categories of difficulty, ranging from total programme failure to differences in rates for oral poliomyelitis vaccine (OPV) and triple antigen. The criteria used to detect difficulties are very simple. For example, a high dropout rate from 1st to 3rd dose of OPV is indicated by an OPV3 rate that is 25% less than the OPV1 rate when the absolute value of OPV1 is greater than 30% (this condition is used to prevent the conclusion being drawn when uptake rates are very low). Each difficulty that is identified is associated with a set of explanations and suggestions for action. Although the system is simple in design it seems to operate very effectively.

Work is under way to extend the system to cover other health service programme areas and to make its conclusions more specific. However, it already seems possible to develop software that will not only process numbers but also provide guidance in problem solving. The information systems of many developing countries are very similar and the use of microcomputers is increasing. KBS could have wide applications in bridging the gap between data collection and its appropriate use.

*Detailed illustrations available from *The Lancet*.

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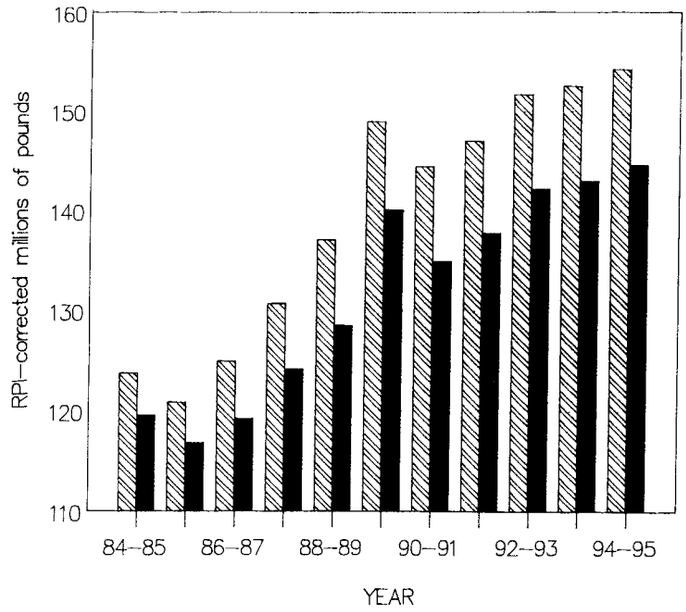
MRC funding

SIR,—When the Medical Research Council's (MRC) 1991 corporate plan was established in March, 1991, you aptly described it as a "gloomy prospect for UK medical research"; in the words of the MRC Secretary Dr Dai Rees it was "a plan for contraction".[1] MRC income was 3% less in 1990–91 than it had been in 1989–90, and by November, 1990, a £3·5 million deficit was being forecast.[2] But, in fact, the latest annual report shows a surplus of £1·86 million for 1990–91, and the allocation for the present year gives additional relief in real terms. The Government's allocations for the next 3 years also provide annual increases above inflation.[3] The figure shows the inflation-corrected sums for 1984–85 to 1994–95 (at constant 1984–85 values, assuming the usual amounts from sources other than the grant-in-aid from the present year onwards). Since 1985–86, only the year 1990–91 shows a decrease with respect to the preceding year, but that was caused by the atypically good award for 1989–90. Real income in 1994–95 will be almost 25% greater than it was in 1984–85.

These financial details raise some questions. First, was it really necessary to produce such a depressingly negative corporate plan? Many will judge that the Government and the Advisory Board for



Government allocation (inflation corrected) to MRC, 1984–85 to 1994–95.

RPI = retail price index Hatched bars = total funding, solid bars = government funding.

the Research Councils (ABRC) would have been at least as responsive to a positive plan, emphasising the exciting projects that could be added if more resources were made available. The ABRC insists that "rigorous prioritization remains a central part of each Council's planning process",[3] so the principal theme of the corporate plan was not really poverty, but rather the supremacy of central planning,[4] as a part of which current programmes that "have fully passed the test of peer review but are of lower priority"[5] are selected for the axe. The predicted contraction of funding provided a justification for this policy, but that rationale has now evaporated. Yet the intention to reduce current MRC direct expenditure by 20% over the 5 years 1991–92 to 1995–96 remains. The second question is therefore, "is such a policy justifiable now?".

It is clear from the 1991 corporate plan, the 1990–91 annual report, and recent statements by Rees that the MRC plans to continue its expansion of strongly managed, centrally planned initiatives, notably the interdisciplinary research centres (IRCs). It is significant that new building works now consume more than twice as much, in real terms, as they did in 1984–85 and seem likely to demand even more in the coming years. Four new IRCs are listed in the annual report, yet it is still unclear whence the temporary scientific guests at these research hotels will come, or whither they will depart when their research holiday is over. Are scientists really going to find IRCs more attractive than emigration to North America?

Centrally planned endeavours could absorb almost any amount of money. It may be reasonable to make specific proposals to government to fund such plans, but it is an entirely different matter to impose an arbitrary 20% cut on existing units and external scientists, sparing the major institutes, in order to supplement a steadily improving government grant. Those making these decisions should provide far more convincing justification. They should also be especially wary of the effect that their policies are already having on scientists' perception of the MRC.

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