BRITISH MEDICAL JOURNAL

SATURDAY 9 JUNE 1984

LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NO 6432 BRITISH MEDICAL JOURNAL 1984 VOLUME 288 1709-1776
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.
WEEKLY. ISSN 0007-1447
ASTM CODEN: BMJOAE 288 (6432) 1709-1776 (1984)

CORRESPONDENCE

We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Private rest homes

SIR,—Dr Colin Godber is to be congratulated on drawing attention to the error made by government in encouraging the growth of private care through supplementary benefit (19 May, p 1473). The following government figures show the increase in the number of residents in private and voluntary residential care and nursing homes in England, and the average amounts of supplementary benefit to meet their charges from 1979 to 1982.[1] They exclude residents sponsored by local authorities or supported by health authorities under contractual agreements (table).

Number of residents in private and voluntary residential care and nursing homes from 1979 to 1982 and average amount of supplementary benefit received

Year	No of residents	Average amount of benefit in payments (£)
1979	9 000	18·89
1980	11 000	29·33
1981	11 000	36·69
1982	13 000	47·98

This means that in 1982 "entrepreneurs helping the government to spend its money" were in receipt of just over £32m. In view of the mushrooming numbers of private old people's homes the 1983 figures are eagerly awaited.

The state, which has traditionally supported the poor, the homeless, and the aged in local authority homes and the sick in hospitals, is now also maintaining the sick in a wasteful and inadequate manner in private care. In so doing it is turning its back not only on the elderly sick but on the trained staff of the National Health Service. The medical profession has an urgent duty to insist that this money should not be used to subsidise unmonitored, low calibre, and inappropriate care in the private sector. It should be used instead to support the National Health Service.

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[1] Pike P. Parliamentary written answer. *House of Commons Official Report (Hansard)* 1984 February 20;**54**:col 431.

SIR,—Dr K Andrews gives a timely reminder about the way in which residential facilities for the elderly are being developed by private enterprise (19 May, p 1518). Together with Dr C Godber's leading article (p 1473) his article highlights the potential problems associated with this trend.

A key issue that Dr Andrews and Dr Godber have identified is the question of licensing and supervision in these homes so that an acceptable standard is maintained, as well as ensuring adequate physical safety for the residents. Some years ago, having felt concerned about this matter, I wrote to every director of social services in England and Wales asking them about their method and frequency of inspection of homes which they licensed. I also inquired about the number of licenses revoked in the previous three years. There was no consistent approach to the question of inspection, and the frequency was very variable. Not surprisingly, no licence had been revoked in the previous three years and in one case the director admitted that it was for the very reason identified by Dr Andrews: if a home was closed the local social service department would be left with the responsibility of accommodating the residents.

Independent inspections are clearly needed and should be pursued as a matter of urgency.

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SIR,—Your three articles on institutional care of the elderly (19 May, p 1473, 1515, and 1518) raise some important points. There must be adequate assessment of a proposed resident before admission and this may mean a period of investigation or rehabilitation. There must also be continuing supervision of the needs of the resident while in care. If there is inadequate assessment people will be admitted who have remediable disease or who could be cared for adequately at home. It is often assumed that all old people prefer to remain at home, but some do prefer the attention they receive in residential or nursing homes although they do not need it. In many cases, however, inappropriate institutionalisation is the result of pressure from worried neighbours, relatives, and professional workers.

Many countries have already learnt the cost of inadequate assessment. In Wellington, New Zealand, all patients have a full medical, nursing, and social work assessment before entry into nursing homes. This may mean referral to the geriatric service for consideration of rehabilitation. Entry to private nursing homes and health service long stay beds is by a common register. Placement is determined by the needs and wishes of the patient. There is a limited number of "continuing nursing care" beds in each region determined by the department of health on the basis of population figures. Each patient in a home is subsidised according to his income. There is a capital