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Access to health care in nursing homes: a survey in one English Health Authority

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Abstract

The objective of the study was to establish the arrangements for provision of general practitioner (GP), nursing advice, chiropody, physiotherapy and speech and language services to nursing homes and to establish the charging policies for those services. To this end a telephone survey of the managers of the 51 nursing homes registered with one English health authority, Merton, Sutton and Wandsworth Health Authority, was undertaken. Forty-nine homes (96%) with 1541 residents responded. Twenty per cent of homes had no regular GP visits and half the homes had no planned medication reviews. One in five homes (27% of residents) had access to all health-care services. Eight homes (10% of residents) did not have access to therapy services or nursing advice. Thirty-three homes used private or both private and NHS chiropody services and 16 homes used the NHS service only. Seventeen homes used private or both private and NHS physiotherapy services with 10 homes receiving a regular private service. Twenty homes used the NHS service and 12 homes (15% of residents) had used no physiotherapy service. None used private speech and language services. Twenty-four of the 33 homes using private chiropody charged extra for this service compared with two of 10 homes using regular private physiotherapy. The findings suggest that there are inequalities in access to health care services in nursing homes. Moreover, there has been a deterioration in access to and levels of provision of NHS nursing and physiotherapy services since the national survey undertaken by the Office Population Censuses and Surveys (OPCS) in Great Britain in the mid-1980s. The new regulatory framework for older people must include systems for monitoring the provision of health services.

Keywords: charging policies, health services access, nursing homes, primary care, therapy services

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Introduction

The withdrawal of the NHS from the provision of long-term care was accompanied by a major expansion in the private sector (Darton & Wright 1993). Between 1983 and 1994 the number of long-stay places in private or voluntary nursing homes for elderly people in the United Kingdom rose from 18 200 to 148 500 (Royal Commission on Long-term Care 1999). This was financed largely from the social security budget, which increased from £10 million in 1979 to an estimated £2.4 billion in 1992–1993 (House of Commons Health Committee 1993). The NHS and Community Care Act, implemented in 1993, sought to constrain the cost of long-term care by cash-limiting the budget and transferring responsibility for funding long-term care to local authorities. These

policies led to confusion about the role of the NHS in meeting the continuing health-care needs and the entitlements to health care of long-stay residents in nursing homes. The Department of Health (1995) issued guidance to health authorities in England and Wales (HSG(95)8), restating the responsibilities of the NHS for continuing health-care needs as including long-term rehabilitation and recovery and specialist nursing support and assessment. However, this guidance was subsequently weakened by a Department of Health (1996) executive letter, EL(96)8, which stated that the NHS should only 'contribute' to long-term rehabilitative care of someone in a nursing home or in residential care.

The NHS 'contribution' to care in nursing homes cannot easily be quantified since there is no monitoring of health care services in nursing homes (Health Advisory Service 1997). Local surveys suggest an irregular and unequal input of therapy services (Duthie & Chesson 1996) and that few nursing homes provide rehabilitative care (St George's Hospital Medical School 1999).

This paper reports the findings of a survey of health care provision–general practitioner (GP), nursing and therapy services to the nursing homes in one particular health authority area of the United Kingdom with a population of 624 000 in 1996 in Merton, Sutton and Wandsworth Health Authority. It establishes the types of provider, NHS or private, used by homes and the home's charging policy for health care services.

Method

The sample

The sample consisted of the managers of all nursing homes ($n = 51$) registered under Section 23 of the Registered Homes Act 1984 with Merton, Sutton and Wandsworth Health Authority whose registration category included the frail elderly and the elderly mentally infirm.

The questionnaire and its administration

A structured telephone questionnaire was administered by an interviewer to the home manager. Closed questions were asked about:

- number of beds and the number of residents;
- whether any resident had received an 'over-75 check' in the last year;
- policies on residents' choice of GP;
- frequency of GP visits;
- frequency of medication reviews;
- number of residents treated by a district nurse in the last year;
- use of specialist nurse advisory service in last year;
- types of provider used for chiropody, physiotherapy and speech and language services;
- frequency of visits from NHS and private chiropody, physiotherapy and speech and language services; and
- charging policies for therapy services.

The interviews were recorded manually on an interview schedule.

Data analysis

Data was analysed using Epinfo.

Results

Response rate and characteristics of the respondents

Forty-nine nursing homes managers (96%) agreed to take part in the survey. The two non-respondents were private homes, one with 10 beds, the other with 25 beds. The total number of beds and residents in respondent homes was 1808 and 1541, respectively, 1% of all nursing homes residents in England in 1996 (Department of Health 1997). Eighty-eight per cent (43) of the respondent homes were privately owned and 12% (six) were owned by voluntary organizations. This compares with 92% and 8%, respectively, for the country as a whole (Laing 1998). Sixteen per cent of respondent homes were dual-registered compared with 25% nationally (Department of Health 1997). The mean number of beds per home was 37 compared with 32 nationally (Laing 1998). When the two large homes with 150 and 200 beds were excluded from the sample the mean number of beds for the smaller homes was 31 and the median 28. The occupancy rate of 84% compared with the national rate in 1996 of 85% (Laing 1998).

Thirty-nine per cent (19) of the respondent homes were registered for frail elderly people, 20% (10) for elderly mentally infirm people, 8% (4) were for elderly mentally infirm people and frail elderly people and 24% (12) had registration which included elderly mentally infirm and frail elderly people as well as other client groups.

Primary care services

Access to GP services

All respondent homes had a GP whom they considered to be the home doctor. All homes said that they allowed residents to register with a practice of their choosing but nearly all (47/49) reported that residents registered with the home doctor. One 30-bed home had a link with a local geriatrician who liaised once a month with the home GP.

Table 1 Frequency of GP visits

	% of homes (no.)	Average number of beds
No regular visits: requests only	20 (10)	24
Less than once a month	4 (2)	14
Fortnightly	18 (9)	29
Weekly	44 (22)	35
Twice a week	8 (4)	38
Daily*	4 (2)	175

*Two homes, one with 200 beds and the other with 150 beds.

Table 2 Frequency of planned medication reviews

	% of homes (no.)
No planned review	47 (23)
> 3 months	6 (3)
3 monthly	22 (11)
2 monthly	2 (1)
Monthly	20 (10)
More than once a month	2 (1)

Table 3 Use of specialist nurse advisers in last year

	% homes using service (no.)
Continence advice services	22 (11)
Stoma care nurse	10 (5)
Tissue viability nurse	31 (15)
Diabetic nurse	25 (12
Palliative care	22 (11)

The frequency of GP visits is shown in Table 1. Eighty per cent of the homes received regular visits from their GP, 20% had visits by request only. Daily visits occurred in the two largest homes with over 150 beds.

Over-75 check

The over-75 check, introduced as part of the 1990 GP contract, was carried out in only one in five homes (10).

Medication reviews

Table 2 shows the frequency of planned medication reviews. Home managers in 23 homes with a total of 553 residents (36%) could recall no planned medication reviews in the last year. Regular reviews were carried out in about half the homes (26/49).

Community nursing services

Home managers reported that during the year of the survey (1997) only 10 residents (< 1% of all residents) had received 'hands-on' care from a district nurse. Of these 10 residents three were catheterized, and for the remaining residents the nurse dressed leg ulcers, wounds and burns.

The use of specialist nursing advisers is shown in Table 3. Seventeen homes covering 19% of residents (350) did not use any of these services during the year (see Table 4). A further 15 homes with 418 residents only used one specialist nursing service. No home made use of all the services. Table 4 also suggested that larger homes are likely to access to a wider range of specialist nursing services.

Therapy services

There are three possible types of arrangements for providing therapy services. Homes can access the NHS service only, use private providers only or use both the private and NHS providers. The number of homes using these different types of provider arrangement is shown in Table 5.

Chiropody

All homes had access to chiropody services, with a third using the NHS services only, a third using private services only and a third using both NHS and private chiropody. Homes which used private services rather than the NHS service tended to be larger. The median number of beds was 31 compared with 22, $P = 0.004$.

Physiotherapy

The NHS provides no regular 'hands-on' physiotherapy service to nursing homes but patients can be referred by GP, consultant, district nurse or other therapist for assessment and advice. Homes can also purchase private physiotherapy services, with some homes purchasing a regular private service or *ad hoc* physiotherapy services.

For 12 homes (24%) with 227 residents (15% of all residents) there had been no referrals to NHS physiotherapy service and no private service in the last year. Twenty homes (41%) used the NHS assessment and advice service only, 11 (22%) used private services only and six (12%) used both types of provider.

An *ad hoc* private physiotherapy service operated in seven homes with a total of 209 residents (13% of all residents) and a regular private service operated in 10

Table 4 Number of specialist nursing services used by homes

	Number of home (%) $n = 49$	Average no. of beds
No services	35 (17)	23
1 service	31 (15)	31.6
2 services	27 (13)	53*
3 services	6 (3)	66.7†
4 services	2 (1)	37
All services	0	

*includes one home with 200 beds; †includes home with 150 beds.

homes covering a total of 543 residents (35% of all residents). Two of the homes with a regular service had full-time physiotherapists and the other eight had physiotherapists who provided between one and three sessions per week. For the NHS service, a total of 97 residents (6% of all residents) in 26 homes were seen by an NHS physiotherapist for assessment and advice. This included one home where 39 residents had physiotherapy from an NHS trust purchased by a GP fundholder. Larger homes were more likely to use a private service. The median number of beds for those using private physiotherapy was 41 compared with 28 for homes not using any private physiotherapy service ($P = 0.04$).

Speech and language therapy

Thirty homes had no referrals to the NHS service and no private speech and language services in the last year. No home used a private speech and language therapist. Nineteen homes had used the NHS speech and language service to assess and advise 35 patients. Therefore, 2% of the all residents received this service. No regular speech and language service was provided to any home.

Overall access to health services

Nine homes, one in five, with 418 residents (27% of all residents) had access to all services – regular GP services, either NHS or private physiotherapy, speech and language therapy and a district nurse advisory service. A further four homes with 93 residents had access to all these services except specialist nursing advice.

Two homes with 43 residents received no regular GP visits, no specialist nursing advice or therapy services. In other words, residents of these homes appear to have had little or no contact with any health services other than the nursing provided by the home. A further six homes with 109 residents received GP visits and chiropody service only and no other nursing or therapy services.

Charging policies for therapy services

Charging policies for private chiropody services were variable. Of the 33 homes receiving a private chiropody service 24 levied an extra charge on patients and six did not. In two homes, policy varied according how the resident was funded. Self-payers in both homes were charged and publicly funded patients were not. If publicly funded, residents paid for their chiropody from their weekly personal allowance.

Of the 10 homes who received a regular private physiotherapy service two provided a basic level of physiotherapy without charge but if residents wanted more they were charged; one levied an additional charge for all physiotherapy and the other seven levied no extra charges.

Discussion

The survey shows inequalities in access to health services, variations across homes in the types of providers used and in charging policies.

In the absence of any routine data on access to health care in nursing homes, a survey is the only way of obtaining this information. The NHS community information systems do not record the input to nursing homes and there are no systems which capture the level of input of private services. The telephone survey was used to achieve a high response rate (96%). Respondent homes were representative of the national picture for ownership, size and occupancy. The study has limitations. Its accuracy is reliant on the recall of home managers. This may have affected the accuracy of the results for service provision but was unlikely to influence the findings in relation to charging policy. In the latter case, it is unlikely that managers would claim to charge their residents for private therapy services if

Table 5 Types of providers for therapy services

	Chiropody % homes (no.)	Physiotherapy % homes (no.)	Speech and language therapy % homes (no.)
NHS only	33 (16)	41 (20)	39 (19)
Private only	37 (18)	22 (11)	0
NHS and private	31 (15)	12 (6)	0
No service	0	24 (12)	61 (30)

they did not do so. It is also possible that some responses were based on the willingness of managers to provide unbiased responses. This may have been the case in question on choice of GP and frequency of medication reviews, especially as it is the policy of the health authority's registration and inspection unit to promote choice of GP and medication reviews. This was minimized before the survey by telling managers that the survey was an investigation into access to health-care services rather than an investigation of the quality of care in nursing homes.

The findings suggest that access to NHS nursing and physiotherapy services for nursing home residents has deteriorated in the last 10 years. In 1987, the Office of Population Censuses Surveys undertook a survey of use of services by residents in communal establishments in Great Britain as part of a programme of surveys on disability (OPCS 1989). Data were obtained from approximately 900 residents in private establishments, nearly all of which were nursing homes. Seventeen per cent of elderly residents of private homes in the OPCS survey had seen an NHS physiotherapist in the last year, compared with 6% of residents in our survey, and 25% had been treated by a community nurse compared with less than 1% in our survey. In both surveys 2% had seen an NHS speech and language therapist. The low uptake of physiotherapy services is confirmed in another study of physiotherapy in private nursing homes in the Grampian region of Scotland (Duthie & Laing 1998, Laing 1998) where only 5% of residents received this service from the NHS in a 6-month period.

The deteriorating levels of provision of NHS services must be a cause of concern. A recent audit (Laing 1998, St George's Hospital Medical School 1999) identified stroke, immobility and falls as the reason for 50% of admissions to nursing homes, suggesting high levels of need for rehabilitation, yet over 90% of the records in their sample of nursing-home residents contained no physiotherapy reports. The diminished role of the NHS in the direct provision of long-term care and the dilution of Department of Health policy guidance has given health authorities scope to interpret continuing care guidance as optional not mandatory. The health authority where this survey was undertaken advised:

> Paramedic staff are available to support residential and nursing homes but they are few in number and demands on their time are great. In practice, some homes contract for their own support in this area, recognising its significance to good quality care, MSW strongly commends this to other providers (Merton, Sutton & Wandsworth Health Authority 1996).

In an inquiry into contracts in the care home sector, the Office of Fair Trading (1998) concluded that insufficient information was provided to potential residents about what was included in the fees and what services were charged as extras. The Royal Commission on Long-term Care (1999) recommended that personal care which would cover all direct care such as personal toilet, eating and drinking should be publicly funded. Without monitoring, it will be impossible to know whether access to care will improve or whether elderly people are receiving the services they need. Few health authorities have carried out audits of access to NHS and other health services and the charging policies of nursing and residential care homes.

The regulatory framework for long-term care is currently undergoing a major review (Department of Health 1998). Our findings suggest that a monitoring system of regular national surveys of residents needs and access to health care is needed as part of the information strategy for the NHS. The government may have devolved its function to provide long-term care to nursing homes but it still has a responsibility to ensure that health care is provided, and provided free at the point of delivery, rather than leaving its provision to the discretion of the health authorities, community trusts and home owners.

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