problem actually encountered and the large figures often quoted. The film appropriately draws attention to the "constant exaggeration and alarm"[3] over the AIDS problem in Africa. The scientific response to th film should therefore be a mor critical study of the problem, rather than outright condemnation without properly looking at the issues raised.

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Long term care of elderly people

Hospital should remain an option

EDITOR,—John Kellett's paper paints a bleak picture of the present state and future of long term care in the NHS.[1] He is right to present this situation for debate.

The new arrangements for care in the community were intended to offer greater choice to people needing care. However, the "perverse incentives" alluded to by Sir Roy Griffiths in his paper on care in the community[2] have been preserved between "hospital" and "community" care because the responsibility for funding has remained with two different bodies, the health authorities and the local authorities.

In our old age psychiatry service, patients are assessed for long stay care in hospital on the basis of their medical and psychiatric needs (but with half an eye on what they can afford and what is available to them in the community). The absolute position of a patient near to the boundary between "needs to stay in hospital care" and "could be reasonably cared for in a nursing home" is often not easy to determine and may change considerably over short periods of time. Relatives have approached me to ask for a patient to remain under our care in hospital, offering to pay for this service. They trust the clinicians and nursing staff they know, believing quite rightly that supervision of the quality of care will be high. Under present arrangements their offer must be politely declined.

A rough calculation indicates that the cost of a long stay bed in our service is about the same as the cost to the public purse (now via the local authority) of a bed in a nursing home. Recently we have seen a reduction in our long stay beds in our trust because we cannot "earn" additional money, except from the health authority, for these facilities. We would have no difficulty identifying who was being offered long stay care because the assessment beds and long stay beds of our service are clearly demarcated as such.

It seems to me that, whatever one's views about means testing and who should pay for long stay care, the "perverse incentive" to make provision not in hospital but in the community (for which read "in the nursing home") only on the basis of who foots the bill, should end.

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1 Kellett J. Long term care on the NHS: a vanishing prospect. *BMJ* 1993;306:846. (27 March.)
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Different balance of provision in Scotland

EDITOR,—J Grimley Evans suggests that provision of institutional care for elderly people in Britain has not changed greatly despite the flourishing of the private institutional sector.[1] Others have reported a different view and have noted a rising age specific rate of institutionalisation for those in residential or institutional care.[2,3] The most up to date figures available suggest that in 1991 there were an estimated 546 400 places in homes and hospitals for the long term care of elderly, physically disabled, and chronically ill people in the United Kingdom.[3] On the basis of the estimated population in 1990 this equates to a rate of availability of institutional care of 5·8% for the population aged 65 and over. In Scotland a similar rate of provision is seen with 43 954 places available in 1991, again equating to 5·8% of the population aged 65 and over.[4]

In Scotland and perhaps elsewhere, however, the pattern is for nursing homes to have a lower dependency population. In a recent audit in Aberdeen patients discharged from hospitals to nursing homes were significantly less dependent (that is, with a higher Barthel score) than those moving to continuing care in hospital. Major differences in the types of institutional care provided between England and Scotland occur not only in the numbers of NHS continuing care beds but also in the overall balance between provision of nursing and residential care. In the United Kingdom 59·2% of institutional care provided is in the residential sector.[3] In a study in Leicester in 1990 the proportion was 62% (excluding acute beds).[5] In Scotland, however, the residential sector is less developed and contributes just 40·2% of the total provision.[4]

The reasons for these differences are historical and included the far greater and earlier expansion of private residential care in England. This may partly explain the lower dependency of some residents moving into nursing homes in Scotland, where such homes are meeting unmet needs for residential care. This will make implementation of the Community Care Act in Scotland difficult, with an apparent shortage of lower cost residential care for people with low dependency and the only available places for some such residents being in higher cost nursing homes.

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Innovative options for funding

EDITOR,—John Kellett offers three possible solutions to the problem of long term care on the NHS. The first—inpatient care in hospital for all who need nursing care—is, regrettably, a pipe dream. The second—that hospital inpatients should be charged hotel costs—which "may appeal to politicians," in my experience is not acceptable to them. I have raised this issue many times over the years with various MPs and ministers. The answer that I am invariably given is that it would cost too much to administer. In these days of computerisation this can no longer be valid, if it ever was. As it is, long stay geriatric patients contribute to their care through contributions from their pensions. I have yet to meet a patient (of any age) who would not agree to pay something towards his or her keep while in hospital, and why should they not do so? Kellett's third solution—three months' free residential treatment followed by a fixed fee (with the usual financial help for those who patently cannot afford to pay)—has its attractions, but his figure of £500 a week seems excessive.

I suggest a combination of Kellett's second and third solutions, but with a shorter free period of, say, two to four weeks. I appeal to the health minister to consider these suggestions seriously and urgently if care in the community is not to flounder through lack of funds, with more elderly people needing care and fewer taxpayers footing the bill.

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1 Kellett J. Long term care in the NHS. *BMJ* 1993;306:846-8. (27 March.)

Residential homes challenge GPs

EDITOR,—How good it is to see at last an acknowledgment of the need for more medical input to residential homes for elderly people.[1] My practice now cares for patients in 13 residential or nursing homes, each with anything up to 37 patients. Dependency levels are high: the patients are discharged from hospital in a moribund condition with catheters and stomas (one patient has been unconscious for over a year and is being fed through a gastrostomy) and with multiple diagnoses, and they receive multiple treatments by every conceivable route.

We find ourselves in effect acting as unpaid house staff to a moderately large geriatric hospital which has the inconvenience of being spread across several hundred square kilometres and has neither resident medical staff nor a pharmacy department. Small wonder that night calls have doubled in the past 10 years.[2]

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Dependency increasing in Manchester

EDITOR,—Like Leicestershire, Manchester has witnessed a relentless rise in the level of dependency of people in residential care.[1] During 1990, 688 people in residential care and hospital continuing care beds were surveyed with the Crichton Royal behaviour rating scale.[2] The findings were compared with those of a similar survey in 1976, when private provision was scant.[3] The level of dependency in local authority homes had risen dramatically. In 1976 only 10% of residents of local authority homes had scores in excess of 17, indicating need for nursing care, but the figure was 58% in 1990.

The survey in Manchester in 1990 also supports the contention of Morag Campbell Stern and colleagues that there is now considerable overlap in dependency across different care settings.[1] Multiple comparison statistics showed three distinct pairs, each with equivalent dependency. These were private residential care homes and a group (n=41) of maximally supported elderly people at home; private nursing homes and local authority homes; and geriatric and psychogeriatric continuing care beds. Local authority homes had the lowest staffing levels; in effect they were nursing homes on the cheap.

The inclusion of an intensively supported home care group in the survey in Manchester in 1990 suggests that private residential homes care for people of similar dependency to those maximally supported in their own homes. People maximally supported in their own homes, however, were characterised by more "deficit" problems (inability to dress, mobilise, etc) and fewer disruptive ones