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Private rest homes: answers needed

"Why let the burdens of old age get on top of you . . . live in complete luxury . . . [we] enable you to enjoy your well earned retirement . . . offer life's much sought after pleasures and allow you to relax in comfort while expert staff attend to your every wish . . . if your capital is £3000 or less the DHSS will fund the average fee." Not Saga Holidays offering winter breaks in Spain, or even soft words from the Minister of Health to octogenarian general practitioners, but excerpts from a feature in a local paper[1] by the Hampshire Registered Rest Homes Association, entrepreneurs helping the government to spend its money. In the past six years Hampshire has seen a 150% expansion in the number of places in private rest homes, which now exceed the total in part III homes.[2,3] Yet most of that increase has been funded by the Department of Health and Social Security as a result of changes in 1980 and again last year[4] in the regulations for payment of supplementary benefits which authorised social security offices to pay out extra allowances sufficient to cover fees in private homes for elderly people presenting as in need of care.

Rest homes in the south of England were quick to latch on to this change in the law and spread the word, and many individuals saw the new climate—with its advantageous grants and rebates—as a rapidly profitable one in which to set up in business. Many large houses were converted for use as rest homes. Though undoubtedly it took much of the pressure off part III waiting lists and blocked hospital beds, this expansion also short circuited less costly forms of domiciliary support and reduced incentives for the rehabilitation of patients with reversible disability. The influx of new inmates, therefore, included many people for whom residential care was unnecessary.

This issue of the *BMJ* contains two articles bearing on this matter. In a survey of a small group of private rest homes in Manchester, Andrews (p 1518) was reasonably impressed by the overall level of care and rightly drew attention to the homely atmosphere that these smaller units can offer. At their best rest homes do indeed add usefully to the choice of residential care available to old people, but the less satisfactory end of their quality range extends well below that of the worst in part III. Despite talk of an improved system of registration and inspection[5] the powers of local authorities are quite inadequate. Discussing the place of the DHSS subsidy to rest home residents, Andrews emphasises its relation to demand rather than need and urges that payment should be subject to assessment by the same criteria as those for part III admission. This point is again taken up by Smith in his article on the care of the elderly in Australia (p 1515). In this and the first two of the series on Denmark[6] and Holland[7] Smith has described the strenuous efforts in all three countries to reduce their volume of residential and nursing home care in favour of domiciliary provision.

Most European countries have traditionally invested more (in quality as well as quantity) in residential care than we have in Britain, and with particular emphasis on nursing homes, whose buildings and staffing levels enable them to combine the care provided by our part III and long stay hospitals. Indeed, the Danes went through a phase of subsidising private rest home care very similar to our own—but they abandoned the scheme because it was merely sucking in the mildly disabled and not catering adequately for those with nursing needs.[8] They turned instead to their present system of nursing homes funded, usually run, and with prospective clients carefully assessed by the social services departments (subject to standards laid down by the central government). In Australia nursing homes are predominantly privately run, profit making concerns but with the bulk of fees reimbursed by the federal government. These have mushroomed over the past few years far in excess of the actual need to the point that they house almost one in five of all those over 75 years old. The government is engaged in an uphill struggle to gain some control over the activity and size of this sector by introducing formal preadmission assessment as well as by encouraging alternatives in domiciliary support. Smith testifies to the obstacles it has encountered.

Must we then in Britain repeat other countries' mistakes—or is there still time to copy the things that they did right? The long incubation of the pilot NHS Nursing Home projects suggests that we are too late to embark on a wholesale drive along Danish lines. As I have argued previously in these columns, however, we could achieve much in that direction by closer collaboration between our part III and long stay hospital sectors with a radical shift in the way the clientele is split.[9] If social services departments had access to some of the funds currently soaked up by private residential care they could increase the scope of the part III homes (towards the nursing home model) as well as supporting some of the schemes now

available for sustaining very disabled people in the place they generally prefer—their own homes. Each district ought to be given the opportunity to plan its strategy in the light of local provision and need and to generate growth in the areas most appropriate to these.

Sadly, the room for manoeuvre has largely disappeared, with health, social services, and housing departments all caught in the straitjacket of government spending and manpower restrictions, and with joint finance mortgaged further and further into the future. This frustration is compounded by the sight of large amounts of money being siphoned off into an area (low dependency residential care) to which few would have given priority, and with an absence of cash limits which seems farcical compared with those having to be met in other parts of the NHS.

Given that the rest home boom will not remain restricted to the affluent south, surely the cost of it spread throughout Britain will be prohibitive? Was a decision really taken that this was judged the area of the care of the elderly in which growth would be most cost effective in the long run? How does that affect the rest of government strategy on the elderly? Experience here and abroad has shown that public subsidy of this sort will improve private sector care only if it is coupled with effective monitoring and enforcement of standards and a proper system for assessing need among prospective clients. When and how will these be introduced? If district planning and participation are to have any meaning should not the responsibility for this audit and the decision on the amount of private care to be employed be handed down, complete with funds, to local social services departments? Whether as planners, NHS waste watchers, taxpayers, or future consumers, we require some answers from the ministers concerned.

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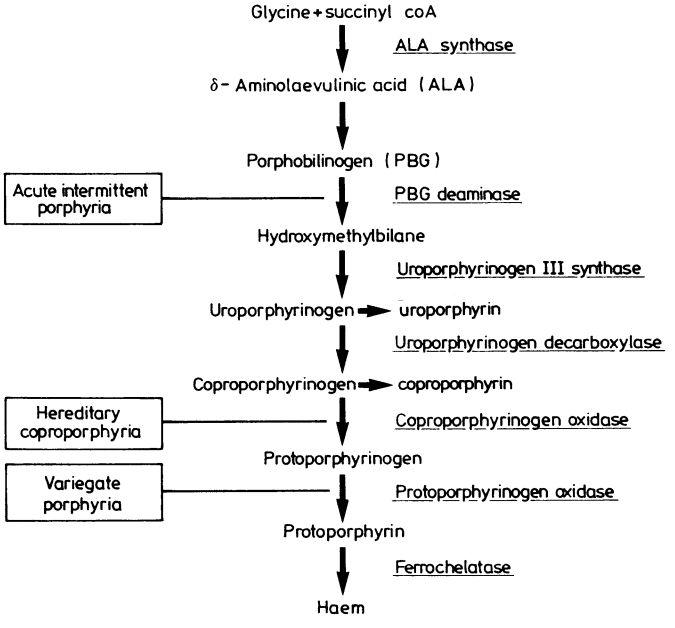
[1] Hampshire Registered Rest Homes Association. Leaving the rat race for a life of luxury. *Southampton Advertiser* 1984 Feb 16:10.
[2] Godber C. *The health services* 1983;No 50:14.
[3] Director, Hampshire Social Services Department. Services for the elderly: a quality improvement programme. *Report to the Social Services Committee* 1983;April.
[4] Regulation 9, Supplementary Benefit Requirement. *Resource and Single Payment Amendment Regulation.* 1983:circular 7/143.
[5] Welsh Office. *A good home.* Consultative document. 1982.
[6] Smith T. Denmark: the elderly living in style. *Br Med J* 1983;**287**:1053-5.
[7] Smith T. Care of the elderly in the Netherlands. *Br Med J* 1984;**288**:127-9.
[8] Ammundsen E. The transition from private to public provision of missing homes in Denmark. *Dan Med Bull* 1982;**29**:151-5.
[9] Godber C. A happier old age in Denmark. *Br Med J* 1982;**284**:1729-30.

Drugs and porphyria

The rapid onset in a patient of alarming symptoms such as severe abdominal pain, paralysis, mania, or coma due to undiagnosed porphyria may alarm the anaesthetist, surgeon, obstetrician, neurologist, or psychiatrist. Such drug induced attacks occur in three types of porphyria: acute intermittent porphyria, variegate porphyria, and hereditary coproporphyria.[1-4] The second and third of these, distinct biochemically but not clinically, may show diagnostic "porphyric" skin lesions. Acute intermittent porphyria always lacks skin symptoms and biochemical diagnosis is mandatory. All three conditions have autosomal dominant transmission, and latent disease is frequent. Fortunately none is common, excepting variegate porphyria in white South Africans, for acute attacks have carried a relatively high mortality. Fortunately, too, the "bedside" diagnostic chemical test for the acute attack (for excess urinary porphobilinogen with Ehrlich's reagent) is simple though not without pitfalls.[5] Why acute systemic reactions to drugs occur in these three porphyrias is still not entirely clear. Some advances have been made, however, in our understanding from studies of experimental porphyrias in animals and tissue culture.[6]

What we have for long recognised as the human porphyrias were syndromes of clinicobiochemical abnormalities; but now these can be explained to some extent as the result of deficient activity of one or other specific enzyme of haem biosynthesis together with reactive hyperactivity at the rate limiting enzymatic stage. This leads to accumulation of intermediates behind



Pathway of haem biosynthesis. Shown in boxes are points at which specific enzymatic deficiency is associated with the three types of porphyria susceptible to drug induced systemic attacks. (Modified from Moore and Disler[2]; with acknowledgment to Oxford University Press.)

the point of block (see figure). Thus in acute intermittent porphyria there is primary deficiency of the enzyme porphobilinogen deaminase. Excess porphobilinogen and δ-aminolaevulinic acid (ALA) are formed; these increase in concentration in both plasma and urine, and their assays are valuable in diagnosis and monitoring.[7] There is also overactivity (secondary) of the initial enzyme of the pathway ALA synthase—the all important regulator and rate limiting enzyme of haem synthesis. In variegate porphyria the primary deficiency seems to be of protoporphyrinogen oxidase; in hereditary coproporphyria of coproporphyrinogen oxidase. Again there is secondary overactivity of ALA synthase with aggravation of the biochemical defect; it may be this overactivity that precipitates the acute systemic attacks.[2]

Nevertheless, a precise explanation of the attack is not easy. The idea of supposing that all the symptoms are of neurological origin is compelling, and one suggestion is that accumulation of ALA is neurotoxic.[1] Alternatively, haem deficiency