Assessment for rest home subsidy: are the elderly getting a fair deal?

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Abstract
Aim. To describe the role of a geriatric service in assessing the needs of elderly people at home or in rest homes referred for a subsidy for rest home care, and to compare this assessment with the composite dependency scale (CDS), a Department of Social Welfare assessment instrument.

Methods. A 47 item questionnaire was completed by the geriatric service at the time of assessment of elderly people in the community or in rest homes.

Results. Of 280 assessments, 100 were from private homes, 180 from rest homes. Sixty-three per cent in rest homes were referred only because private funds were exhausted, 33% for a change in dependency category. These two groups plus those at home were used as a basis for comparison in subsequent analysis. Of those at home: 90% already had a rest home bed arranged; 77% remembered being consulted about rest home care, but only 38% were sure they wanted to go into such care. The proportion of those too independent or too sick for rest home care was: private homes 14%, rest home resident requiring subsidy 6%, rest home requiring change in category status 11%. Twenty three percent of those at home could continue there with or without additional support. No significant difference was found in dependency between those in rest homes only seeking funding, and those at home, but both of these groups were significantly less dependent than those seeking an increase in subsidy. There was only a moderate correlation ($r = 0.778$) between the geriatric service assessment of dependency and the composite dependency score.

Conclusions. Many elderly people do not feel properly consulted about rest home placement, and some could be supported at home for longer. It is likely that many who can afford rest home fees are entering too early and then asking for a subsidy when their funds are exhausted. By then it is almost impossible to insist on alternatives in the community. A policy of geriatric service assessment for all seeking entry into rest home care should ensure independent consultation and consideration of alternative strategies. More research is required to examine cost implications of unrestricted movement into rest homes.

The decision to enter a rest home represents a major change for an elderly person. Reasons vary from failing health and increasing frailty, to insecurity, or pressure from family because of their concern and/or difficulties in providing physical and emotional support.

Physicians trained in the care of older people claim that there are grounds for preadmission medical and social assessments of all applicants to rest home care. They argue that such a move signals physical and/or social decline of sufficient importance to warrant an independent specialist opinion to ensure that the health of that person, and effective support, cannot be improved upon. Previous studies have already established the effectiveness of this strategy in Great Britain and recently in New Zealand. Others, frequently those who have an interest in the business side of rest homes, have argued for freedom of choice without bureaucratic intervention especially if the new resident can pay from private income or capital.

Geriatric services are expected to assess and produce a category recommendation for residents already in a rest home: for private payers whose funds are exhausted, for recategorisation of residents whose level of dependence is increasing, or for patients moving to another rest home. Categorisation however, has not been compulsory before entry into a rest home. Physicians for the elderly have long argued for the need for assessment before entering institutional care. If the person involved was uncertain that they wished to make the move, if reversible pathology was present, or if other support systems could be put in place, this was the time to discuss alternatives.

For those needing care and who cannot pay the rest home fee the Department of Social Welfare (DSW) will pay a subsidy. In 1987 the Old People's Homes regulations underwent significant change which included the introduction of three levels of subsidy according to the assessed dependency level of each resident: category 1: some dependency; category 2: moderate dependency; category 3: appreciable dependency.

In November 1988 two rates of payments were introduced for two grades of old people’s homes (rest homes): Stage 1 rest homes: homes assessed as providing care for residents in dependency categories 1 or 2 only. Stage 2 rest homes: homes assessed as being able and equipped to retain or admit category 3 residents.

In 1992 stage 3 rest homes were introduced, being homes with dedicated areas for elderly patients requiring special psychogeriatric care.

The present study was undertaken to establish the role of a geriatric service in these assessments, and to identify the strengths and weaknesses of the present system of assessment of elderly people seeking rest home care or DSW subsidy in Auckland.

Permission for the study was given by the University of Auckland human subjects ethics committee.
Method

Referrals requesting assessment for a rest home subsidy are received from the community by the geriatric units at public hospitals in Auckland. All such referrals received by the North Shore and Middlemore hospitals between June 1989 and January 1990 were included in this study. For each a 47 item questionnaire was completed by a member of the geriatric team, usually the consultant geriatrician. Referrals from acute public hospital or rehabilitation wards were not included, nor were those who were seeking a change from one rest home to another.

The questionnaire gathered demographic details, information on levels of independence such as mobility and self care, and levels of dependency such as incontinence, orientation, vision, hearing, and need for night care. Applicants still in their own homes were also asked whether the move to a rest home had been discussed with them, and whether they did wish to make the move.

Once the full assessment had been completed by as many members of the assessment team as necessary a recommendation was made on the future care of that person. This could be agreement that rest home care was the best option, but alternative arrangements such as staying at home with support, undergoing further investigations to establish the reason for any deterioration in health, or even to enter private hospital care. If rest home care was the preferred option an appropriate DSW category level for care required was determined.

Information from the questionnaires was keyed into a desktop personal computer and analysed using SAS. Three groups were identified, then compared: those assessed in their own homes (before entry into rest home), those already in rest homes but only seeking subsidy, and those in a rest home seeking a change in categorisation. Specific comparisons between the groups included the reason for assessment, functional disability level, and the outcome of assessment. Much of the discussion in this paper is centred on the distinction between these three groups. Chi-square tests for independent samples were used to test for differences between groups.

Each dependency assessment made by the geriatric service was compared to that allocated under a computerised model of the composite dependency scale (CDS) which is an assessment instrument devised by the Department of Social Welfare but not currently used in Auckland. The scale comprises three sub scales: scale 1 - self care and mobility (mobility, dressing, feeding, bathing, toileting, care of patients); scale 2 - incontinence (urinary and faecal); and scale 3 - cognitive function (memory, orientation to time and place, awareness, behavior).

Comparisons were made between these two indicators of dependency and also with the recommendation for care made by the geriatric service.

Results

A total of 280 (210 women, 70 men) consecutive referrals meeting the criteria outlined above were received. Missing data due to incompletely filled questionnaires accounts for slight discrepancies between numbers reported and actual numbers studied. The majority of people, 187 (female 82%, male 18%), were already in rest homes. Seven of these had moved from a private home only a few days previously and were therefore grouped with those at home for the purposes of comparing the private home and rest home groups. Therefore 100 (62 women, 38 men) were essentially from private accommodation, 72% living in their own homes and 28% with relatives.

For the 180 in rest homes two main reasons for assessment enabled two groups to be distinguished: those who had expended their private funds and now required a subsidy, and those whose deteriorating health suggested a higher level of care should be recognized by a change in category. Where this distinction was not obvious, individual forms or charts were examined so that all rest home patients were categorised into one of these two groups.

One hundred and fifteen (64%) of rest home patients were therefore placed in the group requiring subsidy because private funds were exhausted, and 65 (36%) in the group requiring reassessment of level of care (category) because of deteriorating health.

These two groups, plus the home-assessed group become the three distinct groups on which further analysis is based.

The median age of those in private homes was 83 yr (range 58-96) and of those in rest homes 84 yr (range 45-100). Within the rest homes both those seeking a subsidy and those seeking categorisation had a median age of 84 years.

Fifty seven percent of those in private homes sought rest home categorisation because of deteriorating health, and 24% because support systems were not coping. Others were referred for reasons of sickness or death of a carer (5%), insecurity/isolation (5%), or a mixture of other reasons (8%).

Of those at home 77% said that they had already been consulted about going into a rest home, 14% said they had not, and the remainder were either not sure or were judged to be too forgetful to give a reliable answer. However only 38% were sure they wanted to go into a rest home, 31% were undecided and 27% indicated that they definitely did not want to go.

Thirty percent (n=30) in private homes however already had rest home accommodation arranged prior to referral. The assessment service agreed that for 27 this was the right option although of these, three remained undecided and three did not want to go. Two others were judged to be too confused to understand the implications of such a move.

Fifty-five per cent at home, 76% in rest homes seeking subsidy, and 97% in rest homes seeking a change in category were judged to have medical problems which alone could justify rest home placement should this option be in the best interests of the person involved.

Whilst the two groups in rest homes were generally more disabled than those in private homes, a breakdown of selected functional abilities, shown in Table 1 shows that those in rest homes seeking financial help were significantly less dependent than those seeking a change in category (p<0.0005) and were not significantly different from those assessed at home.

### Table 1. Comparison of selected aspects of functional disability.

<table>
<thead>
<tr>
<th></th>
<th>Rest Homes</th>
<th>Subsidy only</th>
<th>Change in category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=100)</td>
<td>(n=115)</td>
<td>(n=66)</td>
</tr>
<tr>
<td>Mobile without aids</td>
<td>49</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Wheelchair or bedfast</td>
<td>3</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Continent of urine</td>
<td>77</td>
<td>71</td>
<td>31</td>
</tr>
<tr>
<td>Orientated to place</td>
<td>89</td>
<td>79</td>
<td>42</td>
</tr>
<tr>
<td>Orientated to time</td>
<td>70</td>
<td>67</td>
<td>34</td>
</tr>
<tr>
<td>Independent at night</td>
<td>69</td>
<td>62</td>
<td>9</td>
</tr>
</tbody>
</table>

*p values found when comparing groups*

<table>
<thead>
<tr>
<th></th>
<th>Groups 1 &amp; 2</th>
<th>Groups 2 &amp; 3</th>
<th>Groups 1 &amp; 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile without aids</td>
<td>0.080 ns</td>
<td>0.960 ns</td>
<td>0.127 ns</td>
</tr>
<tr>
<td>Wheelchair or bedfast</td>
<td>0.124 ns</td>
<td>0.113 ns</td>
<td>0.004 *</td>
</tr>
<tr>
<td>Continent of urine</td>
<td>0.314 ns</td>
<td>0.0005 *</td>
<td>&lt;0.0005 *</td>
</tr>
<tr>
<td>Orientated to place</td>
<td>0.055 ns</td>
<td>0.0005 *</td>
<td>&lt;0.0005 *</td>
</tr>
<tr>
<td>Orientated to time</td>
<td>0.056 ns</td>
<td>&lt;0.0005 *</td>
<td>&lt;0.0005 *</td>
</tr>
<tr>
<td>Independent at night</td>
<td>0.327 ns</td>
<td>&lt;0.0005 *</td>
<td>&lt;0.0005 *</td>
</tr>
</tbody>
</table>

ns = not significant. * = significant at 0.05 level

The table shows chi²-p-values found in comparison between the three groups in the study. Group 1 = those in private homes, group 2 = those in rest homes seeking DSW subsidy, group 3 = those in rest homes seeking recategorisation.

Table 2 compares the outcome of geriatric assessments of dependency between those at home and those in rest homes seeking a subsidy or change in category. Thirteen per cent in private homes, 5% in rest homes seeking a subsidy, and 12% in rest homes seeking recategorisation did not qualify for rest home care, among the either too independent, too sick or needing further investigation into their decline. The remainder were considered frail enough to justify rest home care.
The Spearman rank correlation coefficient is calculated as 0.778 (asymptotic standard error = 0.024): a score of 1.00 would be a perfect positive correlation, and 0 as sign of no correlation. Wide discrepancies exist and with the exception of those needing higher levels of care, the assessment service frequently regarded a person to be more dependent than the composite dependency scale score indicated.

**Discussion**

The results of this study suggest that many older people in Auckland may be entering rest homes too soon and that a number who do enter probably did not need to. Some may even be going into rest homes against their wishes, without proper counselling, without expert assessment or without advice as to the alternatives, simply because they can afford to pay the fee in the first instance.

Assessment is not a statutory requirement before entry into a rest home unless the subsidy is required. Not doing so and remaining in the rest home category level imply that that person can no longer live at home. Two-thirds were already in rest homes and of those more than half (61%) were referred solely because private funds were expended and in terms of dependency levels this group was somewhat similar to those assessed at home prior to entry. As expected, those in rest homes referred for a change in category status were significantly more dependent than the other two groups.

Of the 100 in private homes, 23 were considered to be able to continue at home for the time being with or without additional support, but for only one of those in rest homes was it possible to recommend discharge back to the community. A further nine were recommended for assessment in hospital, one for private hospital care, and two for assessment elsewhere. Twenty-six percent of those at home who were recommended for rest home care for reasons other than health, compared to 18% and 3% for the other two groups.

There was no significant difference in category levels between those assessed in private homes and those already in rest homes only seeking government funding (Table 2). Both of those groups were however significantly different to those seeking care in a rest home (asymptotic standard error = 0.0005 for both comparisons).

**Table 3.** Comparison between assessment using the DSW composite dependency scale and assessment by a geriatric service.

The length of stay in the rest home until assessment was not recorded although this would have provided useful information such as age at entry, period private funds are used, and the time from previous assessment to further deterioration (category change). Not all patients in the community referred for assessment for rest home categorisation are necessarily in need of a subsidy at that time. Some rest home owners and general practitioners use the assessment service routinely before recommending entry to a rest home. Those at home with a rest home place arranged prior to assessment create a real predicament for geriatric services if rest home placement is not thought appropriate. On the other hand once people have been in a rest home for some months or years, and have used all of their capital assets to remain there, it is usually quite unrealistic to insist that they leave.

The role of a geriatric service and its value to those it assesses is demonstrated in this study. A rest home option was not considered the most appropriate option for 35% of people in their own homes: 23% could be maintained there for the time being with increased support and/or adjustment in medical management and a number required either further investigation through admission to a public hospital, or long-term nursing care as provided by a private hospital. This shows the value of a geriatric service in detecting reversible pathology, and/or recommending services and facilities available to help recipients to continue living at home, at a time when deteriorating health or circumstances appear to be forcing a change in residential status. Our experience supports the results of a recent Christchurch study which found that of all patients referred from the community or hospital wards for rest home care 64% were able to remain at home and that 50% were still there at follow up after six months. Although over three quarters of those at home who had been consulted about rest home care prior to the geriatric service visit, only just over a third were quite sure that they now wanted to go. This raises an ethical issue as to who makes the decision about rest home placement of a frail elderly person. It is not possible to be sure from this study whether all had the opportunity to discuss a move to rest home care, but the majority were unsure about going. Whilst it likes to be accepted that for many rest home placement may be the only realistic option it is of great importance to ensure that every effort is made to work through the process of loss of a home with the person involved. If the person clearly does not wish rest home accommodation, and could be supported at home, respect for autonomy would suggest that there is an obligation to support her or him as best as possible there. In that case relatives, friends, and neighbours may require detailed explanation and counselling. This is often a time-consuming process and frequently best dealt with by Social Workers within the wider based community services for the elderly.

In 1988 a comprehensive survey of all residents in rest homes and hospital care in Auckland was undertaken. This survey found that 58% in rest homes had their fees paid by the Department of Social Welfare and 57% were paying privately. A more detailed breakdown of this study showed that over the previous seven years available beds in rest homes had increased from 44 to 67 per 1000 of the region's population over 65 years while national guidelines were for 30 per 1000 of population 65 years and over. The present study and the
Christchurch study\(^3\) suggest that substantial savings to the elderly client and to the taxpayer may have been possible if all had been assessed before entry into the rest home.

In May 1993 the Department of Health launched a new assessment protocol in the hope of standardising assessment procedures for subsidised community services including rest home placement. Unless guidelines for entry to rest homes are formulated which are stricter than those applying at present, the new protocol will not prevent entry for those who pay privately and will require them to use their capital assets before receiving a subsidy.

With careful assessment and consideration of alternative strategies more elderly people could be supported for longer in the community. Given that the average cost per person per annum of rest home care exceeds $20,000, specialist assessment at the time of proposed entry would also be expected to reduce the overall cost of subsidies currently borne by the tax payer through the Department of Social Welfare. We suggest that if all people enter rest homes only after full consideration of the options available, both the elderly and the tax payer will get a better deal than at present. Further research is required to estimate the size of the problem, and the cost implications.

Acknowledgements. The university geriatric unit, North Shore Hospital, is funded by the Order of Freemasons of New Zealand. The authors acknowledge gratefully the assistance of members of geriatric services at North Shore and Middlemore hospitals who assisted with data collection.

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