

## EDITORIAL

### Residential care of the elderly in Britain today<sup>1</sup>

The British Department of Health and Social Security is committed to the publication during 1979 of the first ever White Paper dealing with 'general strategy towards elderly people' (DHSS, 1978). This comprehensive approach represents a radical departure from existing practice in planning services for this age group. The discussion document (DHSS, 1978), published as a preliminary to this White Paper, recognized the importance for future policy of predicted demographic changes. By 1986 there is likely to be an increase of 24% in the proportion of the UK population aged over 75. Every year 50000 people will be added to this age group, which in 1976 consisted of 2.8 million (Age Concern, 1977). Since it is this group which currently makes greatest demands on health and social services, the importance of this trend for policy formation is clear.

The major services for the disabled members of this age group are administered by the parallel structures of Health and Social Services authorities. Each of these contributes provision which can be regarded as part of a 'continuum' of care. Services range from those taken to the recipient's home – such as 'meals on wheels', home helps and district nursing – via day care offered in day centres and day hospitals, to full residential care whether in hospitals or homes. The existence of such a system is creditable. However, those using the system have to deal with organizational rigidities resulting from the separation between health care and other forms of social provision which the legislation of the late 1940s did not create but solidified and perpetuated. Since there is considerable ignorance of the aetiology and treatment of some of the most disabling disorders of old age – in particular of senile dementia – the best response to the needs of an individual frequently cannot be determined by informed professional judgement. Whether it falls into the nominal category of 'health care' or 'social service' is often dictated by resource constraints and the extent of inter-professional cooperation at local level. The implications of this situation are most apparent at the residential end of the 'care' spectrum.

The 1948 National Assistance Act, which is the legislative *raison d'être* of local authority residential homes, placed on those authorities a duty to provide accommodation 'for those who by reason of age or infirmity are in need of care and attention not otherwise available'. A subtle distinction was thereby drawn between one group of disabled elderly who are 'in need of care and attention' and another group who are 'sick' and hence the responsibility of the National Health Service. As Townsend (1962) has pointed out, this attempt to distinguish two distinct groups very rapidly 'proved to be an uneasy one'. The administrative boundaries of residential care were never congruent with the reality which they sought to define.

Over the past 30 years there has been a considerable change in public and professional opinion about the role of residential institutions in society. In 1948 the Ministry of Health announced 'The workhouse is doomed... Instead local authorities are busy planning and opening small, comfortable homes where old people, many of them lonely, can live pleasantly and with dignity.' Since that time the work of Goffman (1961) and others on the sociology of institutional life and, more specifically, Townsend's (1962) study of the real nature of that life as it existed for British old people in the late fifties have had profound effects. It is no longer respectable to institutionalize people as a solution to loneliness. The commitment to community care – to keeping people out of institutions, however benign – was by 1977 sufficiently well established to be expressed thus by the then Prime Minister (Callaghan, 1977): 'Our policies will be based upon the need for older people to stay in the community, active and cared for as long as possible, near treasured family and friends'. The inevitable

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outcome of a policy decision to make residential care a last resort is that it will be the last resort of the most disabled elderly.

There is evidence (Roe & Guillem, 1978) that to an increasing extent these disabled elderly – to many of whom the label ‘sick’ might just as easily be applied as the label ‘in need of care and attention’ – are receiving long-term care in local authority homes. The observations of Jolley (1977) and Shulman & Arie (1978) that the demented receive long-term care in increasing numbers outside psychiatric hospitals are given further confirmation by the findings of the Anglo-American Cross-National Study (1979). For this study a random sample of the institutionalized elderly in New York and London was the subject of psychiatric assessment. In the London sample it was found that approximately one third of those in local authority homes were too severely demented to be interviewed. This proportion was very similar to that found among those in the sample receiving long-term hospital care.

Since long before the formation of the National Health Service, hospitals have tried to define their role in terms of active treatment of acute disorders, rather than long-term maintenance of the chronically sick. Modern geriatric medicine emphasizes active intervention and rehabilitation as much as any other speciality. Efforts to prevent long-term hospitalization (institutionalization) are evident here too. Consequently, there is pressure to discharge ‘to the community’ for long-term maintenance, and in this context the local authority home is seen as one aspect of community provision, or at least as a lesser, or cheaper, form of institution.

Local authority homes are thus at the stress point of the care system. Many staff working in them today would regard as absurd the suggestion that they do not provide any of their residents with nursing care as extensive as that which thousands of old people receive in long-stay hospital wards. Nonetheless, there are attempts to reaffirm the residual role of the local authority sector as *not* being concerned with care of the ‘sick’. In 1977 the Department of Health and Social Security (DHSS, 1977) published a document entitled *Residential Homes for the Elderly – Arrangements for Health Care* which reveals some of the prevailing confusion about what local authority homes are supposed to provide. It maintains that the care provided in residential homes ‘is limited to that appropriate in a residential setting’. This includes ‘help with washing, bathing, dressing; assistance with toilet needs; the administration of medicines and, when a resident falls sick, the kind of attention someone would receive in his own home from a caring relative’. It does not include ‘the professional kind of health care that is properly the function of the primary health care services. Nor should residential homes be used as nursing homes or extensions of hospitals’. An analysis of nursing staff activity in geriatric wards would reveal that a great deal of time is spent in providing the personal care of patients which the first list describes. For the most part, caring for disabled old people is not the ‘high technology’ enterprise which, it seems fair to assume, is what is meant by ‘professional...health care’.

That local authority homes are, in fact, being asked to perform a ‘health care’ role for which they are inadequately equipped is suggested by the recent work of Roe & Guillem (1978). Their medical screening survey of 183 residents in 4 homes found a high incidence of unmet medical need, including 464 ‘previously unrecorded abnormalities’ of which 51 conditions were of sufficient importance to warrant immediate notification to the resident’s doctor. A general practitioner writing in *Modern Geriatrics* (Lawrence, 1977) commented that ‘elective retirement (to old people’s homes) is a thing of the past...because of the steadily increasing level of morbidity...it is becoming necessary for some of the staff to have nursing training. It can no longer be believed that old people’s homes should have no part in medical treatment.’

In recent years the response of the local authority sector to the perceived need for change in the traditional style of residential care seems to have taken two opposing forms. Of the first type, there is the example of the segregation of ‘confused’ persons into homes for the ‘elderly mentally infirm’. This development, which became popular during the mid-sixties, can be seen not as a positive attempt to provide better care for the ‘confused’ but as a means of removing one kind of ‘sick’ person from the ordinary residential home. Meacher (1972), in his critical study of this policy of segregation, points out that ‘as long ago as 1957 a Ministry of Health circular referred to the re-

sponsibility of local authorities in providing for “the care of the senile or disturbed patient who is, owing to his mental condition, unfit to live a normal community life in a welfare home”. This was a subtle form of near-recognition that local authority homes were being asked to care for the “sick”.

The second type of development is illustrated by experiments in ‘small group’ living, of which examples in Cambridgeshire (Simpson, 1971), Northamptonshire (Marston & Gupta, 1977) and Yorkshire (Dearman, 1977) have been described. These emphasize the benefits of encouraging co-operative self-care by groups of residents. The Yorkshire example differs from the others in that it used an adapted ordinary house, without resident staff and was regarded as an alternative to and not a form of residential care. This highlights the main question arising from this development – namely, the extent to which it does not assume serious disability in the residents.

There are indeed many questions which remain to be answered before future policy can be satisfactorily planned. Are we prepared to stop short of full community-based and day care services for some moderately disabled people so that a balance of disability is preserved in residential homes? If residents are able to care for themselves in small groups can they not, as in Yorkshire, do so in ordinary houses (or sheltered accommodation) rather than in staffed homes? What is the role of the hospital service in the provision of long-term care? If there are substantial numbers of people requiring continuing and considerable direct physical care – but not highly technological medical treatment – should they have to receive this in the impersonal and comfortless atmosphere of a hospital ward? If residential homes are not to be concerned with care of the ‘sick’, what is their role to be in the era of community care?

Could it be that the future will see local authority homes providing a new model of long-term care, combining high quality medical and nursing care with the emphasis on privacy, comfort, individuality and dignity which is to be found today in the best residential homes? If this is to come about, a recognition will be needed that, in this context, nursing need not have a monopoly of the skills of physical care, nor residential work a monopoly of concern for the dignity of the individual. An important implication is that a new type of training will have to be provided – one which equips long-term care staff with a basic understanding of physical and mental pathology and a real awareness of the social and psychological impact of institutional life upon the individual.

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