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MAKING SERVICES FOR THE ELDERLY WORK:

Some Lessons From the British Experience

A REPORT

TO THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

BASED UPON A SEMINAR ON AGING CONDUCTED IN CAMBRIDGE, ENGLAND, SEPTEMBER 1971

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PREFACE

International comparisons can help the people of the United States to realize that change here may be part of more general changes that ripple in uneven circles throughout the world.

As far as aging is concerned, there are probably more similarities than differences in approaches taken by individual nations in dealing with problems and inventing new programs. In most industrial nations, the old family structure is subject to similar strains arising from mobility of individual members, changes in living arrangements that cause separation of youth and the elderly, the tensions and crowding of life in many metropolitan areas; and retirement income usually far below that of those still in the work force.

Even with more adequate income, however, many older persons would still need services which—in many ways—substitute for the help that members of an extended family quite often provided for each other. Given a regular visit by a homemaker, for example, an older man or woman might find it possible to maintain an apartment even with one or more chronic impairments. Without such help—and without access to prepared meals or regular arrivals of "meals on wheels"—those persons might find themselves needlessly in institutions. The issue, however, is not always self-sufficiency versus institutionalization. Quite often, services simply make life more livable: a goal that should not be minimized.

How does Great Britain deal with such issues, as compared to the United States? In this working paper, Prof. Ethel Shanas provides some answers that bear careful consideration as this Nation prepares to implement the recommendations of the 1971 White House Conference on Aging.

Dr. Shanas is a sociologist, a leader in the field of gerontology,[1] and the instigator of several multination research efforts which have provided the hard facts so desperately needed for international perspectives. She and her associates, have shown, for example, that there is no real evidence that younger members of a family abandon their elders. They may live in separate homes or apartments, but geographically they tend to be fairly nearby and concerned.

Despite such communication among family members, the mutual support system of the past is slowly disintegrating. A social service system for the elderly is needed.

It comes as a shock, therefore, when the Gerontological Society of this Nation announces that no community in the United States has developed a comprehensive network of services for the aging and the aged, nor has a full range of service alternatives been developed to

[1] See p. 1 for additional biographical details.

meet the varied and changing needs of the population. This criticism is echoed at virtually every conference on aging.

Great Britain is ahead of the United States in at least one major aspect. A national commitment to the provision of social services—with heavy emphasis upon the need for the provision of and coordination with health services—has been made in the form of legislation calling for development of a locally based service network.

It is one thing, however, to pass a law; it is another to fulfill all the objectives of that law. Dr. Shanas points out impressive strong points in the British system; she also describes the problems that perplex the English in much the same ways that they perplex people in other nations, including ours. She also notes that her study is based primarily upon a recent seminar which, while comprehensive, could not survey the entire field.

Despite Dr. Shanas' reservations, her report provides additional evidence on the need for fresh thinking, and occasional comparisons of progress, as people of all nations attempt to grapple with the problems that arise as men and women grow old under circumstances not known before.

FRANK CHURCH,
Chairman, Special Committee on Aging.
EDWARD M. KENNEDY,
Chairman, Subcommittee on Federal, State, and Community Services.

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Many persons helped in the completion of this assignment. Foremost among these was Mrs. Dorothy Wedderburn, the Course Director of the Seminar on Aging. Other persons whose assistance was particularly valuable include: Professor Margot Jefferys, Bedford College; Mr. F. V. H. Ramsbottom, Cambridge University Board of Extra-Mural Studies; Mrs. Barbara Shenfield, Chairman of the Executive Committee of Age Concern; Mr. Gilbert A. Smith, University of Aberdeen; and Miss Patricia Sutcliffe and Mr. Ian Bruce of the staff of Age Concern.

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INTRODUCTION

(By Ethel Shanas, Ph. D.*)

Americans give a good deal of attention to helping people live longer, but less attention to what it means to grow old.

Old people, like other people, have basic needs: enough income to live on, a decent place to live, adequate health care, and someone to whom they matter.

Unfortunately, for many people, growing old means inadequate income, poor housing, declining health, and problems of family and of community.

None of these problems is insurmountable, given a national commitment to a better life for the aged. What is needed is imaginative leadership, adequate allocation of resources, and *supportive services designed to maintain persons as self-respecting human beings as long as they may live.*

As is so often pointed out, however, the provision of services is given low priority or no priority at all in most communities of the United States. This subject has been explored by the Senate Committee on Aging and will be explored further in a forthcoming document. My report, therefore, will not deal with matters that will, and should be, explored in such studies and at this year's White House Conference on Aging.

Rather, it will deal with the lessons to be learned from a recent event in Great Britain.

That event was "A Seminar on Aging: Participation and Communication in the Provision of Services for the Elderly, held September 18 through September 24, 1971, at the University of Cambridge, England.

Under the auspices of the Board of Extra-Mural Studies of the University, the Seminar was arranged with the cooperation of Age Concern (formerly the National Old Peoples' Welfare Council.)[1] As director, the seminar had Mrs. Dorothy Wedderburn, Reader in Industrial Sociology, Imperial College of Science and Technology,

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[1] Age Concern is a voluntary organization with primary emphasis on the needs of old people. It has three classes of membership: national voluntary organizations interested in the elderly; more than 1,500 local Old People's Welfare Committees; and individuals and corporate members with a special interest in the aged.

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University of London. Mrs. Wedderburn is an internationally known authority in the social aspects of aging.

Two topics, both of which are relevant for the United States, received special attention. They are: problems of coordination of services designed to meet different, but essentially inter-related, needs of the elderly; and the problems of integrating the legitimate and sometimes different interests of administrators of services, professional staff, and of old people themselves. As Mrs. Wedderburn put it in her course description:

> Very similar organizational problems face the welfare and health services. The need is to be able to diagnose the most appropriate kinds of structures for the tasks which have to be performed at national, local, and voluntary levels; and to recognize and handle constructively the inevitable conflicts which arise.

As the British participants were frank to admit, the seminar did not by any means resolve nagging and emerging problems related to the provision of services.

But even though the seminar was far from conclusive, it is of significance to those in other nations who are attempting to deal with similar difficulties, for the following reasons:

—Its participants arrived at a working definition of need. Any progress in providing services for the elderly must begin with such definitions. In the United States, however, this effort lags behind that in England.

—As will be seen later, the seminar participants were fortunate in having a national statement of policy on provision of services for the elderly. That policy is expressed in a Social Services Act and a related Act which took effect on April 1, 1971. The United States has no counterpart legislation.

Of course, goals of the Social Services Act in England have not been met, any more than the 10 objectives of the Older Americans Act in the United States have been met. But, by providing a statement of legislative goals, both statutes indicate direction for national policy.

—Any discussion of service programs for the elderly in the United States inevitably turns to the issue of categorical versus non-categorical programs. How do we best serve the elderly: by improving services for *all* age groups, *including* the elderly; or do we single out the pressing and sometimes unique problems of the elderly for intensive action in hopes that some day such individual programs can become part of a more comprehensive system?

This subject, too, came up for discussion at Cambridge, with only slight variances from similar commentary in the United States.

I. BACKGROUND: THE SOCIAL SERVICES ACT

The rationale of the seminar and its implications both for its participants and for those planning and organizing programs and services for the elderly in the United States can best be understood against the background of recent British experience in the area of social services.

In December, 1965, the then Labor government of Britain appointed a committee to review the organization of social services in England and Wales and to report back its recommendations on what changes might be desirable to secure a family-oriented service. The committee, known as the Seebohm Committee from the name of its Chairman, Frederic Seebohm, made its report in July 1968. The principal recommendations of the committee were implemented by the British Parliament in the Local Authority Social Services Act of 1970. (A local authority is a geographic governmental unit.) The Local Authority Social Services Act transferred into a local Department of Social Services the operation and supervision of many public services for all age groups, including the elderly, which were previously distributed among a variety of departments and programs. Under various public programs local authorities could already provide home helps for old people, meals and recreation, residential housing for those in need of care and attention, chiropody services, laundry facilities, and for those elderly who were also handicapped and disabled, special rehabilitation services. Some or all of these services were now to be brought together, insofar as possible, in a general scheme of service.

On April 1, 1971 the Social Services Act came into effect in Britain and Wales. (A somewhat similar Act had already taken effect in Scotland.) At the same time, local Authorities were directed by the Department of Health and Social Security to implement that Section of the Health Services and Public Health Act of 1968 which dealt with the welfare of the elderly. The implementation of Section 45 of the Health Services and Public Health Act was seen as assisting the local authority in its task of promoting the welfare of the elderly in the "family-oriented" service. Under Section 45 of the Health Services and Public Health Act authorities were empowered to make arrangements to meet the needs of the elderly by:

1. Providing meals and recreation in the old person's home or elsewhere;
2. Informing old people of services available to them and identifying old people in need of services;
3. Providing transportation facilities and assistance to the old person to enable him to participte in services provided by the authority or others;
4. Assisting in finding suitable boarding homes;
5. Providing visiting services and social work as needed;
6. Providing additional home facilities needed to secure "greater safety, comfort, or convenience";
7. Contributing to the costs of social work staff in residential housing, whether public or private.

Local authorities were to assume these responsibilities, within the limits of available funding and staff, in addition to services which they might already be offering the elderly.

Medical care for the elderly in Britain, as for other age groups, is provided under the National Health Services, a national scheme of government health insurance which operates through a tripartite system of hospitals, general practitioners, and local authority health services. The implementation of the new Social Service Act and of Section 45 of the Health Services and Public Health Act, places upon

the local authorities the obligation to provide for old people a variety of supplemental services directly related to medical care: home helps, home-delivered meals, sheltered care, supervision of the mentally ill, special housing for the handicapped and modifications of home facilities to meet their needs, et cetera.

In directing local authorities to implement Section 45 of the Health Services and Public Health Act the Department of Health and Social Security states the official government position as follows:

> It will be essential to secure the closest possible operational integration between the existing and new services provided by the social services departments and those provided by health departments, general practitioners and hospitals, in order to take full advantage of their contribution to the earlier identification and treatment of need.

The same document says somewhat further on:

> It will also be essential, as already mentioned, for authorities to re-think their pattern of welfare services as a whole, and to develop them on the basis of a thorough review of their inter-relationship and of the most effective use of existing and potential voluntary effort. This may lead to changes in emphasis or in priorities, and to the provision of new services (e.g. housing adaptations, regular visiting) in preference to the development of existing ones. No absolute priorities can be laid down, since different groups of the elderly will require different kinds of help most urgently. Local surveys will help in determining priorities. The most important early need may be that of skilled advice and support in seeking the best solutions available to the problems which face individuals or families. *Home help*, including laundry services and other aids to independent living, should probably be high on any priority list. . . . So should *social visitinq* organised and co-ordinated by the local authority but largely undertaken by voluntary workers or others after suitable preparatory training. Many of the elderly who can be transported will require *social centres* providing meals and opportunities for occupation as well as companionship and recreation. For the housebound and the frailer elderly, *meals-on-wheels* will also need to be developed. (Department of Health and Social Security. Circular 19/71. D/M258/8)

The national government then was directing the providers of services to the elderly, whether they be health or social service authorities, to further integrate their programs wherever possible. Emphasis was to be placed on meeting the needs of older people within a "family-oriented" program.

II. IMPLICATIONS OF THE SEMINAR FOR THE UNITED STATES

The implications of the Seminar discussion for the United States are given in this section. A summary of conference papers and discussion is presented in the next section.

A number of topics developed in the Seminar are relevant to the United States. These may be summarized as follows: (1) a definition of need, (2) integrated versus specialized services for the elderly, (3)

the range of needed services, (4) the relationship between social services and health services, (5) the use of volunteers, and (6) the role of the family and the community in the provision of services for the elderly.

A Definition of Need

Planning, programs and services for the elderly are dependent on a definition and estimation of needs. The needs of the elderly are primarily in four areas: economic, health, housing and social integration. Old people need to have enough money to live on; they must have special health needs met, including care for chronic illness and long-time disability; they need adequate housing for which they can afford to pay; and they need to be incorporated into social life. There is general agreement that these needs exist. Problems arise in the definition of these needs and in estimating their limits. Needs can be defined by program planners, by professional workers and by old people themselves. Program planners often define needs in terms of available resources. Thus, one year's necessary program may be seen as a luxury the next year. Old people, in their turn, tend to have a low expectation of services and to make only minimal demands. These minimal demands are often reinforced by the attitudes of those professional workers who see the elderly as "blocking" scarce beds, or as requiring only welfare payments to remove them from community concern. Definitions of need based solely on budgetary or program considerations must be abandoned. The needs of the elderly are those requirements which are essential to obtain the optimum quality of life for each old person.

Integrated Versus Specialized Services for the Elderly

Services for the elderly, whether medical services or social services, may be integrated with services for other age groups or developed separately. Proponents of integreated services argue that in this way elderly persons have their fair share of available resources; proponents of segregated services argue that unless special provisions are made for the elderly the low status of this group among professional workers and the general public will result in their being ignored in program planning and resource allocation.

The national government must provide the necessary leadership in giving old people both a fair share of resources and equal priority with other age groups in accordance with their needs. If an integrated service is to be developed in any area of need, provision must be made so that the elderly will have access to necessary services. Some needs of old people, however, require specialized services. These services must be developed and staffed on an equal priority with the attention given other age groups.

The Range of Needed Services

Services for the elderly must develop not only in terms of present needs but in terms of anticipated future needs. The present emphasis on community care and community health services must be encouraged. Community care and good residential and institutional care must be developed side by side, not competitively.

Old people should be kept in the community as long as possible.

Needless institutionalization can and should be avoided. On the other hand, in the United States, as well as in Britain, the very old, those over 85, are increasing faster than other segments of the older population. The need for hospital beds and institutional care for this very old population should not be underemphasized. The grandparent population cannot be expected nor is it able to undertake the physical care and supervision of the great-grandparent population.

Special efforts must be made to seek out the very old, to determine their special needs, and to meet these needs with a broad program of services.

The Relationship Between Health Services and Social Services

Health services and social services cannot divide the old person between them. Every old person is an individual, and his needs rather than the structure of services should determine the services available to him.

In Britain, the British National Health Service makes special provision for the elderly within the Hospital Service with the appointment of geriatric consultants and the use of geriatric wards for long-term care. At the same time the elderly, like other age groups, have access to general practitioners, specialists, and the medical ward for acute illness. The local Authority Health Services, the Social Services and the Housing Authority provide old people with home helps, meals and recreation, various types of residential housing for those in need of care and attention, transportation facilities, chiropody services, laundry services, and for those persons who are substantially handicapped, special rehabilitation services. These services are not equally developed from Authority to Authority. Many of them are patchy and fragmentary. Integration among them is not always adequate. It is a governmental goal, however, that there be better integration of services for the elderly.

A full range of community and institutional provision for older people drawing upon and integrating the various professions and disciplines must also be an American goal. The social services, the housing authorities, and the welfare establishment must give old people equal priority with other age groups. The provision of minimum income may be all that is required for some old people. Many others, however, need a broader range of services including health care. Both practicing physicians and those responsible for medical education must realize that unless a practitioner is specialized in pediatrics or obstetrics, a substantial proportion of his patients will be older people. The physician as well as other health professionals must be educated not only to cure but to care, to know about community resources and to call upon them as needed.

The Use Of Volunteers

Citizens from all walks of life must be encouraged to participate in voluntary services for the elderly. Services to old people can use a whole range of volunteers from the friendly visitor to the well-trained professional. Volunteers are not lower-grade staff or staff replacements and should not be viewed as such. They are people who want to help and they should have an opportunity to do so.

Volunteerism needs to be encouraged, developed, and adequately supervised so that the volunteer and the old person may mutually benefit from their association.

The Role of the Family and Community in the Provision of Services

Planning and provision of services to the elderly is a task for family, community, and for old people themselves as well as for legislators, administrators and professional workers. Old people are integrated into society through family and community relationships. The interest and concern of families for their older members must be encouraged not overridden by the providers of services.

On the other hand, there are many situations in later life in which professional assistance is urgently required. Those most concerned about the elderly are sometimes the least able to help them at such times. The integration of family interests, community concern and professional expertise in the provision of services is not easy, but it is only through such integration that we can fulfill our responsibilities to our older citizens.

III. A SUMMARY OF THE SEMINAR

The speakers recruited for the Cambridge Seminar included academicians, social service administrators, physicians and members of Parliament. A list of lecturers follows:

Dr. J. A. D. Anderson, Director of the Department of Community Medicine. Guy's Hospital Medical School, London.
Dr. H. Faulkner, Group Practice, Camden; Lecturer at National Institute of Social Work Training, London.
Mr. D. Hitch, Deputy Director, Social Services; Cambridgeshire and Isle of Ely County Council.
Mr. D. Hobman, Director of Age Concern.
Mr. T. H. F. Raison, Member of Parliament for Aylesbury.
Mr. F. V. H. Ramsbottom, Deputy Secretary, Cambridge University Board of Extra-Mural Studies.
Mr. G. F. Rehim, School of Cultural and Community Studies; University of Sussex.
Mr. G. A. Smith, Centre for Social Studies, Department of Sociology, University of Aberdeen.
Mrs. S. Williams, Member of Parliament for Hitchin.

The participants in the Seminar, reflecting its focus, represented a wide range of interests. They included administrators of local authority social service departments, social workers of widely different backgrounds, voluntary workers with the elderly, and physicians.

Summaries of the papers follow:

THE NEEDS OF THE ELDERLY AND THE IMPLICATIONS FOR THE SOCIAL SERVICES

Dorothy Wedderburn

Mrs. Wedderburn began the Seminar by restating its goals in terms of identifying the needs of the elderly and the tasks involved in meeting these needs. She raised three questions for consideration: how can the needs of the elderly be identified; how can scarce resources be allocated between the different services meeting these needs; and how can the benefits of the services provided the elderly be measured.

In Britain, today, 18 percent of the population is over retirement age (60 and over for women, 65 and over for men). While the proportion of the population in these age groups is expected to remain virtually unchanged until the year 2000, the group aged 85 and over is expected to increase in size by two-thirds. It is obvious that in discussing needs, more attention must be given to these very old people.

Britain, like the United States, faces (1) a lower age of people leaving work, (2) an increase in urbanization, and (3) a decline in public transportation. All of these interrelated factors affect the elderly. Retirement from work results in reduced income; urbanization often results in housing problems, problems of family social support, and other problems related to social change; the decline in public transportation results in old people being virtually stranded in their own homes in both villages and cities. In discussing needs these implications of social change, as well as many others, must be considered.

While one cannot isolate one need from another, one may summarize four areas of need among the elderly. These areas are: economic, health, housing and social integration. Poverty remains a serious problem among the elderly in Britain; health problems of various kinds affect many old people; housing continues to be in short supply; and while familes may help old people to the best of their abilities, one must consider the quality of family relationships and the special situation of old people who have no families.

Seminar participants in discussing how the needs of old people might best be met might also consider the extent to which old people might be integrated with professionals in the shaping of services which affect their own lives.

In summary, Mrs. Wedderburn saw the participants in the Seminar emerging from their week's sessions better equipped to identify the needs of the elderly and more able to identify and to work with organizations meeting those needs.

A CRITIQUE OF THE PHILOSOPHY OF SEEBOHM

Gilbert A. Smith

The stress on "generic" social work and generic social services in the Seebohm report was ultimately implemented in the Social Services Act of 1970. It was therefore appropriate that the opening formal paper, that by Gilbert Smith, was devoted to the Seebohm report.

The Seebohm report, according to Mr. Smith, focussed on (1) the case for organizational change in the social services, and (2) the case for a particular form of change. As the Seebohm Committee reviewed the operation of social services in Britain they found defects in the lack of coordination of services, in the uneven access of clients to services, in the rigid concepts of need of the individual services and the lack of adaptability demonstrated by the services. The Seebohm Committee related these defects to the administration of the social services, to the patterns of services offered, and to the provision of services at primarily a local government level.

Seebohm recommended a Department of Social Service in each local authority. The Committee felt that a Social Service Department on this level would be both more "unified" and more powerful. Such a Department could (1) better coordinate services, (2) reduce uneven access by clients to services by increasing knowledge of services among both clients and practitioners, and (3) increase the adaptability of the services both in recognizing and in meeting needs.

The basic principles which lay behind the recommendation for a Department of Social Services on the local authority level were the beliefs of the Seebohm Committee that social services should be "family-oriented"; social services should be "community based"; and that social services should meet social need.

The Seebohm Report, said Mr. Smith—and by inference its implementation—has simply replaced one administrative structure by another: it has generated no new concept of social need. It has been assumed in the report that changes in organization structure will make it easier to identify new kinds of needs. But, does organizational structure define "need"? In concluding his presentation, Mr. Smith raised three questions. They were: what is the basic unit of social need, what are the causes of social need, and who is going to assess need. Was the basic unit of social need the individual, the family, or the community? Were the causes of social need psychodynamic, material, or moral? Was the assessment of need to be made by the referral agent, the social worker, or the client himself?

NEW ROLE OF SOCIAL SERVICE DEPARTMENTS IN THE CASE OF THE ELDERLY

Denis Hitch

Mr. Hitch is an Administrator in a Social Service Department. As such he shares with other administrators the responsibility of implementing the Social Services Act of 1970. Mr. Hitch began his presentation by reminding the group that the Seebohm report describes services to the elderly as under-developed, limited and patchy. Under the previous legislation, services to the elderly tended to be concentrated in the provision of residential homes, clubs and recreational

facilities, and meals. The new Departments of Social Service have a much broader mandate for service. They can give more services and they can more easily integrate their services with the services of health departments and voluntary bodies.

The new Departments need a clear statement of their objectives in services for the elderly. While these objectives must be practical in terms of available resources, they should also be far-reaching and imaginative. The local authority Social Service Departments must provide a comprehensive service for the elderly which must be based both on proper identification of needs, and linkages with other services, particularly the Medical Services.

Mr. Hitch then illustrated his points by describing new residential schemes for the elderly in his area. The design and operation of two such projects, one for the frail aged, and one for confused old people, were presented.

During the discussion following his talk Mr. Hitch responded to a comment that social workers did not like to work with the elderly. As he saw it, irrespective of the personal inclinations of social workers, the magnitude of the old age problem in sheer numbers and in the variety of presenting needs, would ensure that the care of old people would "come forward" within every local authority.

THE ROLE OF THE GENERAL PRACTITIONER

Dr. H. Faulkner

Dr. Faulkner was the first of two physicians to speak to the group. Dr. Faulkner is a member of a Health Center Group practice in London. The Center has five general practitioners on its staff, two health visitors, and a local authority social worker. Dr. Faulkner emphasized that he spoke as a general practitioner and that the Camden Health Center was not a practice of specialists.

A general practice is a good place to discover not only disease but social need. The elderly patient is segmented within the present tripartite health system with its separation of hospital, general practice and local authority units. The general practitioner who refers an old person to a hospital is seldom informed that an old person is coming out of the hospital. Decisions to place old people in geriatric wards for long-term care are often made by hospital consultants without consideration of the social aspects of the patient's situation, particularly his family situation and his living arrangements.

Dr. Faulkner advocated a hospital-health center team to meet the needs of the elderly. In such a team the general practitioner acted as a primary physician. The decision whether to hospitalize the old person or to use other residential facilities could then be reached after consultation with both a hospital geriatrician and a social worker. The team would have available to it an assessment of the living arrangements of the old person and of the possible supportive care which could be delivered by family and community.

Dr. Faulkner emphasized that in some instances old people do not need the services of the general hospital but instead need a bed in a facility supervised by a general practitioner.

THE ROLE OF THE HOSPITAL IN THE CARE OF THE ELDERLY

Dr. J. A. D. Anderson

Dr. Anderson, the second of the physicians to speak, is a hospital-based physician. In Britain, Dr. Anderson reminded his audience, the elderly patient usually gets to the hospital through a general practitioner. The hospital has two services for the older patient—the regular medical ward for care for acute illness and the geriatric ward for long-term illness. In general, old people in the regular medical ward are viewed as "blocking" a scarce bed.

Dr. Anderson envisaged an expanded role for the hospital in meeting the needs of older people. He stated that:

1. Geriatric and other consultants should be prepared to go outside the hospital to consult in Health Centers or group practices.
2. The general practitioner should have open access to laboratory and other special services of the hospital.
3. Some form of "bed" should be available to the general practitioner either in or near a Health Center.
4. A day hospital should be an automatic feature of every geriatric unit.

Dr. Anderson felt that old people would be discharged more readily from both medical wards and geriatric wards if alternates to regular admissions were available to them, and if their family and those responsible for community services had some assurance of immediate readmission on demand for old people in crises.

He argued the case for "social" beds to be in the control of general practitioners, with consultants available to them. The hospital service, including day hospitals, has specialist consultants, sophisticated diagnostic facilities, skilled nurses and intensive care. Not all of these may be needed by some old people. An effective liaison between local authority Social Service Departments and a team of general practitioners would help sort out those people who need a full range of hospital services from those who need only a "social" bed or who could be cared for at home if supportive services were available.

The health assessment of an elderly person should be a psychogeriatric assessment. It should consider four aspects of the person: physical, intellectual, emotional and social.

THE ROLE OF VOLUNTARY SERVICES

David Hobman

DISCUSSION—JUDY WILSON, NOTTINGHAM OLD PEOPLE'S WELFARE COUNCIL

Mr. Hobman of Age Concern discussed the role of voluntary organizations in the provision of services.

Voluntary bodies have a variety of primary functions ranging from those bodies organized for self-help and mutual aid to those organized to coordinate operations of other bodies. The National Old Peoples'

Welfare Council, now Old Age Concern, has been primarily a coordinating body, but in response to perceived need, will endeavor to become a more militant advocate for old people. Mr. Hobman pointed out that voluntary organizations usually come into being as "flexible" organizations responsive to need, and then quickly become institutionalized. For a voluntary organization to fulfill its function it must be sensitive to changes in need.

Mrs. Wilson in her discussion spoke of her experiences as a local community worker with the Old Peoples' Welfare Council in Nottingham. The Nottingham experience served to illustrate Mr. Hobman's theme. The Old Peoples' Welfare group in Nottingham was not successful as a coordinating body. Representatives of organizations attended meetings intermittently or not at all. The Nottingham group was most successful when it operated as a pressure group for specific causes.

DIFFERENCES IN VALUES AND ATTITUDES IN DIFFERENT PROFESSIONS

George F. Rehin

Mr. Rehin focussed on the general topic of professionalism, illustrating his comments with research findings from studies of health visitors, social workers, and general practitioners.

Mr. Rehin began his discussion by stating that the professional, irrespective of discipline, needs both colleague and social esteem. The professional not only wants to believe in himself and what he is doing, he wants his colleagues to believe in him.

In Britain, medicine is an established profession, social work an emergent profession. The reorganization of social services in Britain, however, has increased both the status and power of the social worker. The profession has increased its command of resources. Some of this increase in resources of the local authority Social Service Department has been at the expense of the local authority Medical Office of Health.

Mr. Rehin then discussed health visitors, social workers and physicians and their roles in dealing with the elderly. The health visitors whom he studied saw themselves as the links between the elderly and other services. The social workers, for their part, held work with the elderly in low esteem. They preferred to practice "casework" rather than "welfare". Physicians tended to report little satisfaction from treating elderly patients. Physicians are oriented toward curing. Work with the elderly implies an orientation toward caring.

All these professionals are now called upon to redefine their roles in relation to the elderly client and to decide amongst them who should have primary responsibility for the mobilization of care.

COMPETITION FOR SCARCE RESOURCES

Mrs. Shirley Williams and Mr. T. H. F. Raison

Mrs. Williams and Mr. Raison are both members of Parliament, the first, a Laborite and second, a Conservative. Mrs. Williams began the

discussion by enumerating some factors effecting the allocation of resources to the elderly. These were:

1. The proportion of the population over retirement age is steadily increasing.
2. More and more men are retiring as soon as they are eligible for retirement benefits.
3. People are becoming more "sophisticated" in demands on the health services.
4. The dependency ratio, the proportion of children and persons of retirement age to persons of working age, is approaching its maximum of the post-World War II period.

Mrs. Williams stated that low income is the major problem of the elderly. That group with the lowest income must be identified and its income supplemented.

In the health field scarce national resources must be allocated to maximize returns in services whether for the elderly or for other groups. Sixty-two percent of expenditures in the National Health Service are now being made for the Hospital service. There must be a shift within the Service toward the provision of community care. This means a reassessment of the role of the general hospital and a strengthening of local community health and welfare services.

Mr. Raison, in turn, pointed out that peoples' expectations in the social services—health, education, housing, pensions, social work—were rising. Like the Laborites the Conservatives felt that special attention should be paid to that group among the elderly who were most at risk—those over 80 years of age. The government was concerned about the low incomes of this group and was prepared to give special pension benefits to the over 80's.

In the area of health, Mr. Raison, like Mrs. Williams, felt that more stress must be given to community care for the elderly. Mr. Raison raised the question of whether local authority health services and social services should be administratively united. Such a change is not practical at the present time but it should be considered and evaluated.

The old, as defined by the calendar, include a great variety of persons. The categories of social needs of the old must be better defined and their limits assessed. Old people should have more voice in their own affairs, both in the determination of service priorities and in the design of service delivery.

COURSE DIRECTOR'S COMMENTS AND REPORTS OF DISCUSSION GROUPS

At the beginning of the course several questions and problems were suggested as topics to be considered by the participant discussion groups. All groups, however, chose to discuss the same question:

> What are the problems in conceptualizing the "needs" of the elderly in such a way that it can be used for planning purposes. How far are concepts of needs influenced by the existing form of provision of health and welfare services?

In her concluding comments Mrs. Wedderburn pointed out that in considering "needs", participants must distinguish between immediate and long-term goals. Any discussion of needs must face the question

of what new needs are likely to emerge as the result of changes in the age composition of the elderly population, increased urbanization of the elderly population, and increased sophistication among the elderly as they become more knowledgeable about available social services.

Practical efforts have to be made to define needs and the limits of need. In the competition for resources, agencies and staff as well as advocates for the elderly must have good estimates of services accomplished, and clear formulations of the contributions expected from needed services. The discussion groups agreed that in order for rational planning to take place it is necessary to quantify needs or to select objective equivalents of needs. Unless such conceptualization occurs there will be a lack of accurate detail for administrative planning.

To this stage the needs of the elderly have been defined in terms of their demands for services. It may be necessary to reformulate the definition of needs in terms of the rights of the elderly. Local authorities in Britain put too much stress on what they can and cannot do. They should give more attention to what they ought to do. The reorganization of health and welfare services gives authorities an opportunity to experiment and to work out new links between various services. Such efforts should be encouraged. Voluntary organizations can act as "watchdogs" for local authorities in this and other areas.

A definition of the needs of the elderly was given by one of the group members: The needs of the elderly are those requirements which are essential to obtain the optimum quality of life for the old person.

REFERENCES

BUCKLE, JUDITH R.
1971—Work and Housing of Impaired Persons in Great Britain. Office of Population Censuses and Surveys. London: Her Majesty's Stationery Office.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
1970—The Future Structure of the National Health Service. London: Her Majesty's Stationery Office.
1971—Welfare of the Elderly. Implementation of Section 45 of the Health Services and Public Health Act 1968. Ref: D/M 258/8, 29 March 1971.
1971—Strategy for Pensions. The Future Development of State and Occupational Provision. London: Her Majesty's Stationery Office.

HARRIS, AMELIA I., assisted by ROSEMARY CLAUSEN
1968—Social Welfare for the Elderly. 2 volumes. Government Social Survey. London: Her Majesty's Stationery Office.

HARRIS, AMELIA I., with ELIZABETH COX and CHRISTOPHER R. W. SMITH
1971—Handicapped and Impaired in Great Britain. Office of Population Censuses and Surveys. London: Her Majesty's Stationery Office.

HER MAJESTY'S STATIONERY OFFICE
1970—Local Authority Social Services Act 1970. Chapter 42. London.

HUNT, AUDREY, assisted by JUDITH FOX
1968—The Home Help Service in England and Wales. Government Social Survey. London: Her Majesty's Stationery Office.

NISSEL, MURIEL (ed.)
1970—Social Trends. No. 1. 1970. A Publication of the Government Statistical Service. London: Her Majesty's Stationery Office 1970.

REPORT OF THE COMMITTEE ON LOCAL AUTHORITY AND ALLIED PERSONAL SOCIAL SERVICES
1968—London: Her Majesty's Stationery Office.

SUMMER, G., and SMITH, R.
1969—Planning Local Authority Services for the Elderly. London: George Allen and Unwin.

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