new deal for the elderly

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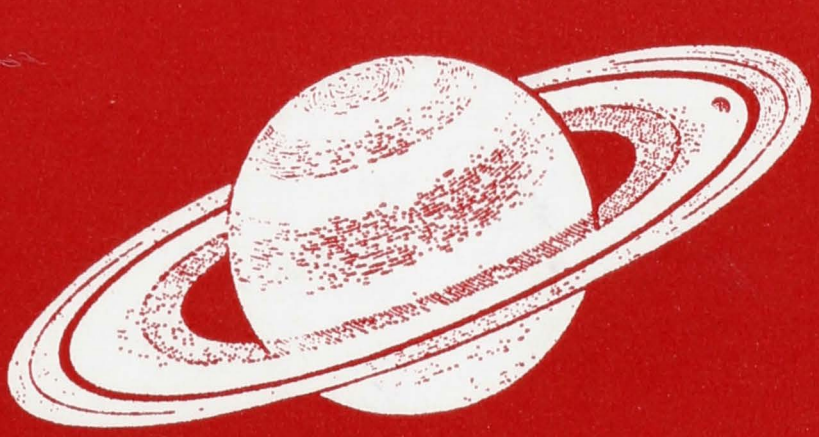

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1. introduction

There has been some public concern with the scale of public spending on the elderly but much less with its pattern. Now at last the Government is showing some will to make fresh decisions and to shift spending away from institutional care. In the most recent circular on local authority capital programmes, the Government implied that it was unlikely to give loan sanctions for old peoples homes in areas which already had more than 20 places per 1,000 elderly (Department of Health and Social Security, LASSL (74) 22).

The main theme of this pamphlet is that the shift away from spending on institutional care should go much further. Past government policy can be criticized for the extreme slowness with which the governments have acted. But the most important criticism is that we have put all our eggs into very few baskets. Certain lines of spending such as the building of old people's homes have seen a good deal of effort. Others—such as the building of sheltered housing—have been encountered by apathy. Government after Government and local authority after local authority have ignored the striking evidence about the current housing situation of the elderly.

Old age can often be a period of emotional strain through bereavement and the loss of friends, and also of physical ill health.

Yet we are expecting people who are having difficulty in coping, to live in conditions which would tax the fittest. We make an old lady with arthritis live in a house which is damp and has no heating and no internal wc. Then we are surprised when she becomes depressed and neglects herself.

The aim must surely be to get a balance of care which bears some relation to the evidence on what the problems really are. But we have instead the planning of services almost completely in isolation from each other, most notably as between old people's homes and sheltered housing. The argument has been too much about absolutes and too little about priorities at a particular point in time. Thus there can be many views about the merits of old peoples homes as against sheltered housing, but such arguments are not really very helpful.

The most important point at the moment is that we have not even built enough sheltered housing for people who would very clearly be able to live in it—for the most promising candidates.

This pamphlet starts from the conviction that the mood of gloom about the elderly has been grossly exaggerated. The real subject for gloom is how little thought we have given to the ways of giving help. To natural problems of ill health and waning alertness have been added problems of poverty, poor housing and inappropriate services which have been largely man made. Of course there is a good deal of depression and loneliness among the elderly—although one survey showed that pensioners were much less depressed and lonely than young people imagined them to be (*New Society*, 24 January 1974). Of course there are many frail old people living alone and only just managing to cope.

Of course there have been unfavourable changes in society which have made it more difficult for younger relatives to give support. Thus people have tended to move out of the centres of cities to suburbs, leaving their elderly relatives behind in poor housing. But most people who work with the elderly from day to day agree that the great majority of families do care about their elderly relatives and in fact make great efforts to help them. Natural feelings and loyalties have not been destroyed by the welfare state. But government action has done far too little to mitigate those unfavourable changes in society which cannot be avoided. Too often in the past government action has inadvertently strengthened the effects of damaging changes that were already strong. In a general way government has encouraged a belief in institutions because so much of government spending goes towards institutional care in spite of commendable expansion in some community services.

This pamphlet grew out of visits made in many parts of the country to geriatric departments, social service departments, sheltered housing developments, day centres and luncheon clubs as well as out of experience as a councillor in a London borough with many old people living alone in poor housing conditions. The author was impressed by the strength of critical opinion to be found in many places about our policies for the elderly. There is no doubt there is a widespread and deep discontent about traditional policies and approaches. But little of this has affected the ways in which the money has been spent. Many years have already been lost; let us not lose more time. It is vital that policy should reflect the best thinking in local authorities and the conclusions of research. The evidence is that far too often in the past it has not done this. The real tragedy of old age in this country is our unwillingness to jump bureaucratic barriers and to make an effort of imagination in order to help the elderly to maintain their independence.

The argument has to be conducted against a background of fiscal stringency. I have assumed that there would be at best limited amounts of extra money forthcoming and these only for well defined purposes. At worst the strategy could be adapted to a "nil growth" situation. There are great numbers of competing claims and little prospect of a fiscal miracle; hence we really must spend those limited amounts which we have got sensibly.

At a time of stringency in public spending, it becomes vital to distinguish those changes which do most to help the disabled and handicapped elderly, from changes which help mainly the more active elderly. Some of the policies that have attracted most public attention recently, such as the short lived relative rise in the pension (1974), subsidized travel and the relaxation of the earnings rule have been of most help to the active elderly. They do rather little for the very old or the chronically ill. In a time of stringency in public spending there may have to be choice between further such changes and investment in improved housing, rehabilitation and community services which really do help the more disabled. Such a decision has to be made against a background of a growing social and economic division within the retired population. Alongside the process of physical ageing there is a process of social ageing which goes further as people get older. It is the over 70s—predominantly women—who face the worst problems of isolation, of poor housing and of poor health. It is the younger retired who are married and have occupational pensions and their own homes. There is a definite cycle of social ageing. As people get further away from retirement their income drops in real terms; the stock of possessions left over from their working life wears out; their contacts become fewer. As health worsens so the need for extra income for heating and other needs increases. Support costs rise just as income falls. The need for support with domestic tasks and for companionship also grows. The "social" elderly are a substantial minority within the retired population, who need more help.

For the immediate future the priority has to be not that of more help to the active elderly, but that of improvements in sheltered housing, in the services for rehabilitation and in community services.

We have to concentrate much more on the more vulnerable among the elderly. We now turn to sketch out what these priorities might be in the social services, housing and health. The aim is to identify a small number of changes which could make a real difference and on which we could concentrate.

The Government is introducing a new pension scheme which will radically change the economic position of the elderly in the long term. This is the first part of any new deal, but other measures are needed in housing, health and social services. The Government has made a start—will it now follow it through?

2. the social services

Legislation, the legacy of the workhouse and the policy of the Department of Health and Social Security (DHSS) have all helped to concentrate attention on the old people's home. The oldest and perhaps the key piece of legislation still is the National Assistance Act of 1948. Part three of this Act enables a local authority to provide " residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them." Later legislation began to shift the balance towards the community services. The Health Services and Public Health Act 1968 enabled the local authority to make arrangements for promoting the welfare of the elderly and also for giving assistance to voluntary organizations. The 1970 Chronically Sick and Disabled Persons Act encourages local authorities to provide a rather wider range of services for the disabled including the elderly disabled. But in practice most of these are permissive powers. The main duty is to provide residential accommodation.

The language of the 1948 Act now has a curiously old fashioned ring and is strikingly lacking in the kind of advanced thinking which characterized the children's legislation of that period. The whole notion of " infirmity " has been somewhat overtaken by the development of geriatrics and rehabilitation—and also by the development of sheltered housing. Yet it is against this background of legislation that local authorities have been making decisions for more than a generation.

The concentration on the old peoples home between 1948 and 1960 did represent a practical solution to a pressing problem—how to improve the lot of people living in the old workhouses. Even now there are perhaps 10,000 places still used in old workhouses in England and Wales, with rather more in Scotland. The old workhouses were large institutions—sometimes for hundreds of people. Many of them had come to be in a poor state of health. Conditions in the new homes are obviously a great improvement on the former workhouses. But the form was set in relation to the inheritance of the past rather than possibilities of the future. The homes have come to loom larger and larger—as things that are good in themselves rather than as practical solutions to a pressing difficulty. Society having so defined the choices open to an elderly person has taken this as evidence that he is capable of no more. The pattern of institutions has tended to create a certain pattern of expectations and a certain view of the possibilities. A change in the pattern of service—such as the building of really substantial amounts of sheltered housing—would tend to change peoples view of what the elderly themselves could achieve.

The main direction of DHSS impact on local authorities, month by month, reinforces the effect of legislation and of the legacy from the workhouse. Everything centres round " loan sanctions " for capital projects, mainly for homes for the elderly. In the past this had some very important effects on local authority behaviour and thinking. It has tended to mean that numbers of starts and completions have been taken as the major measure of success in services. "Under our administration we built x number of old peoples homes " has been the major indicator of success. It has led to a divorce in peoples minds between capital projects and their revenue consequences. The idea of a loan sanction seems an attractive one—almost costless except for the interest payments. Yet once completed the revenue effects are important, until an energetic local authority can become the victim of its own success—it can find that it has so much residential accommodation with such heavy running costs, that it has nothing to spare for quite small expansions of the community services that might actually prevent people coming into residential care.

Apart from its power to grant or withhold loan sanctions, the DHSS's other main point of impact on the mind of local government is through the " norm " for places per thousand population. The norm is currently 25 places per thousand population. This norm is not based on

careful research or scientific study. It is simply an arbitrary number set a little ahead of the current average number of places in local authorities. But by some local authorities this is taken almost as holy writ. The new Hampshire Social Services department inherited ten year plans from the three old authorities of Portsmouth, Hampshire and Southampton. All three ten year plans had laid great stress on the DHSS norm—in fact Portsmouth had even decided to increase it: that plan had "adopted a ratio of 28 : 1,000 places as compared to DHSS critical figure of 25 per 1,000 places" (Hampshire Social Services 10 Year Development Plans, appendix 3).

Of the three authorities, Portsmouth and Southampton were already quite well stocked with homes, although this did not stop them from planning to build a few more. Hampshire, on the other hand, had one of the lowest levels in the country, with about 12 places per 1,000 elderly in 1974. The old Hampshire authority had suggested a really large building programme. The new social services department inherited plans to build more than a thousand places in homes. Much of this may in fact have been delayed by the cuts in public spending, but the reasoning process in the original Ten Year Plan remains significant. Hampshire's commitment did not arise from any independent study of the needs of the elderly in that county; it was simply a reaction to the DHSS norm, such reflexes appearing to be common.

"The norm" involves a perfect circle. It is in fact simply an average of local authorities' own record. But local authorities take it as a "critical figure", which is presumably based on intensive study. There are shocked, hushed tones in committee meetings when social service committee members discover that their authority is "below" the number. One final irony is that the DHSS tends to revise the number every so often as the number of places increases. Thus the number used to be 20; since the average number rose above 20 it has been revised upwards. There are some other norms for other services but these are set in a similar *ad hoc* way, and any authority which managed to get itself positioned on all these norms would not therefore have a perfectly balanced service.

Thus the system has worked so that there have been two vital questions for each authority: how many "loan sanctions it is going to get" and where its numbers of residential places stand in relation to the DHSS norm. There have been some bold authorities that have broken away. Liverpool, in spite of being rather below the DHSS norm (with 18 places per thousand elderly) has decided once a very small number of current projects have been completed not to build any more old people's homes but to build only sheltered housing instead (Liverpool Social Services, 10 Year Development Plan, 1974-84). It has taken this decision in spite of having far worse problems of housing and isolation among the elderly than most county authorities. But few authorities have done as much as this. Most have stuck within the perfect circle of norm setting and norm hunting. Few authorities have looked at the adequacy of assessment. Many years ago, Peter Townsend condemned the inadequacy of interviews lasting sometimes only 15 minutes on which people could be uprooted from their homes and sent off to institutions till they died. How much has really changed in the quality of initial assessment ?

With their eyes fixed on the distant and ever moving grail of the norm, local authorities have not looked at the experience of old people as they go into the homes and once they get there. There is little wrong with the material conditions—food and comforts are reasonably well provided. But there is much else to be criticized. The process in which people get admitted to the homes is often rather haphazard still. There may be one or two visits from a social worker and then people are put on the waiting list.

Even within one London Borough there are extraordinary differences in the propensity of social workers in different

social service areas to put people on the waiting list. The decision is also coloured by the sympathy for and knowledge of the social work profession for the elderly, which is highly variable. People can then be sent to a home without having had a chance of a preliminary visit. But then after this rather cursory attempt to help, people are stripped of all their belongings, including their furniture, and there is very little chance of their ever getting back into the community, of active rehabilitation or even of going out to a luncheon club. It is in any case a strange and old fashioned idea that people should go "into" a home and there stay without any chance of there ever coming out again. Once in the home the experience is one of boredom and dependence, sitting around the walls waiting for meals. There are few people who would wish the experience of going into a home onto their own friends or relatives. Nor are the homes very good at coping with either physical ill health or mental confusion. Staff are dedicated enough but for the most part they are simply not trained, and they are working with overlarge numbers.

To the evidence of impression, there is the evidence of academic research—not least the work of Peter Townsend in *The Last Refuge*—work which has proved again that admission to a home leads not only to boredom but even to illness and death. One of the darker and least documented aspects of life in the homes is the frequency of quite serious epidemics. Certainly some of the worst features of the home can be improved by redesigning them so that people have much more chance of an independent life. But such redesigned homes really merge gradually into sheltered housing.

One particularly striking example of the bias towards institutions has been in the care of the mentally infirm elderly. The 1959 Mental Health Act encouraged local authorities to do more. The majority in fact did very little. But the first reaction in most others was to start special homes. Very few started special day centres and social clubs. A survey showed in 1968 that only one in eight of local authorities had started any form of day care for the mentally infirm elderly, while one quarter of them had started special welfare homes (M. Meacher, *Taken For a Ride*, Longman, 1972).

There have been many doubts about these homes for other reasons. They tend to be more remote from the communities which they serve and it is often treated as a disgrace and a disaster by relatives and their friends to be sent there. It has been argued that confusion is as much created by segregation and by being deprived of all power over their own lives, as it is a definable clinical state. But these are separate issues. The point here is the reaction of local authorities and for that matter of central government —which was towards building yet more institutions. In this case there was a similar concentration of institutional care within the NHS and a lack of active assessment.

the community services

About the role of the old person's home there has been considerable disagreement. There has been much less about the role of the community services. Both central and local governments have been in favour of a rapid expansion in these services. Now government's support for the objective of community care and for an expansion of the community social services can be applauded—but has it really been effective in practice? In spite of the general support received from all quarters, the record of expansion in the home help service—perhaps the most important of the community social services—has been rather smaller than is often imagined. Between 1959 and 1973 the number of home helps (in whole time equivalents) rose from about 20,000 in England to about 33,000. It is fair to assume that most of the time of home helps was taken up with the elderly. The rise is substantial but hardly spectacular and prospects for expansion in the immediate future do not seem bright.

The "need" for the home help service is rather less a matter of opinion than

residential care. It has been shown that there are many people living alone without anyone to do the household chores and who are getting little help from the home help service. Thus Amelia Harris showed that in Great Britain there are 2,000 very severely handicapped and 90,000 handicapped living alone and having no welfare services (A. Harris, *Handicapped and Impaired in Great Britain,* volume 1, HMSO, 1971). She shows that 7 per cent of the impaired have a home help, the proportion being 16 per cent for the very severely handicapped and 11 per cent for those appreciably handicapped. Other studies have shown that only a small minority of those demonstrably in need get home helps.

Rapid growth in the home help service would certainly pose increasing problems of supervision—of using people's time effectively. But it would also give opportunities to use the home help service in imaginative ways so that this kind of care could genuinely help to keep people in the community who might not otherwise have been able to continue living at home. For example, Liverpool is planning a special home care programme for elderly people at risk who are about to leave hospital. About one in five elderly people immediately after discharge from hospital will get a home help and meals on wheels for a four week period afterwards.

The most serious trouble has not, however, been with the overall expansion of the home help service—but with its distribution. In some generous authorities 10 to 15 per cent of the elderly are getting the home help service in a year. Elsewhere—particularly in the counties and seaside towns—5 per cent or less (CIPA, *Local Health and Social Services Statistics,* 1972-3). There is three times the chance that an old person in the Borough of Greenwich will get some home help, than an old person in Kent (CIPFA Statistics). In some places no reasonable request is turned away; in others it is very hard to get a home help for any length of time at all. Again and again the suggestion has been made that minimum standards should be set—nothing has been done.

The second important community service is the meals service. This can be of two kinds: meals on wheels in the home or meals served at luncheon clubs. Overall the number of meals has been expanding very rapidly. The main problem here is again one of distribution. Within the London area there were, on the most recently available figures—those for 1972-3—sixfold differences between authorities in the numbers of meals served. Kingston on Thames and Brent serve about 3,500 meals per thousand population; Southwark and Tower Hamlets about 20,000 (CIPFA Statistics). Elsewhere Manchester serves about 14,000 meals a year per thousand population and Halifax 2,000 (*ibid*).

There have been many doubts and queries raised about the value of meals on wheels. Research has shed some doubt both on their nutritional value and their palatability. Certainly this is not a service which could or should be expanded indefinitely; nor is it always a good idea for every client to have the service five days a week. One study in Portsmouth has suggested that people may even prefer to have the meals only two or three times a week (L. Davies *et al,* "Meals on Wheels Deliveries," *Modern Geriatrics,* November 1974).

One well off authority — Greenwich reckons that it is "close to satisfying the total need for meals" (*Domiciliary Services for the Elderly in Greenwich*, Key Issue Report Programme, Planning Staffs). This recent enquiry carried out by the programme planning staff suggested that after 1975-6 there should be no further expansion of the meals on wheels service. Here there may well be a question of maximum levels, but it is clear that many authorities are way below these levels.

Many authorities are coming to put more emphasis on luncheon clubs, which provide company as well as food. There is a great danger of this relatively small scale effort being somewhat neglected, at

a time of stringency in public spending. Here again there is a need for minimum levels of provision.

So far we have been discussing services which are well known and of which the pattern of service is relatively well defined. There is also some level of service in all parts of the country. We turn now to other services—good neighbour schemes and day care which are not so widely established.

One effect of concentration on large scale capital projects has been that such a relatively small idea as a good neighbour scheme has been somewhat neglected. But these schemes can draw on the good-will which is there in the community.

By this service, people are paid a small amount to take an interest in a particular elderly person or group of people. This system has been widely used in Manchester and in the London Borough of Camden. It is not a commitment to look after, to give nursing care and to act as a cut price home help. It is a commitment to keep in touch and to spend some time with. It is a commitment to take shopping every so often, to visit and to chat and to share a cup of tea. It is a commitment to be a friend and someone who is on call in an emergency. It is just an extension of what happens anyway—so much help is given on a completely unpaid basis by neighbours. It should be most useful for people who have no neighbours and on their own. It also gets around a most undesirable feature of the services at present; it is possible for an old person in difficulties to be the target of the attentions of so many statutory services, and yet for them all to be a vague blur of half-recognized faces. Under a Good Neighbour scheme at least the good neighbour gets to know a particular old person.

Liverpool have had a good neighbour scheme for some time. As of March 1974, it had covered three areas of the city with about 150 helpers who are looking after about 700-800 old people. The organizers recruit fit elderly or retired people to the service. This idea grew up originally because they were never going to be able to expand the home help service enough to cover all the need. The good neighbours are paid about £3.50 a week plus 50p expenses to do this. It is run by Age Concern. It needed care in selecting clients and in selecting good neighbours. Not all the clients who were first seen proved to be in need of help. It has also allowed the ordinary home help service to concentrate more on people in great need. They are planning to cover the whole city. The social services then expect to have something like 5,500 old people covered by this service. (I am grateful to Dr B. Meredith Davies, Director of Social Services, Liverpool, for this information.) A report for three Liverpool postal areas showed how the service developed in a particular area. The initial publicity for the scheme came through churches, and the referrals through pensioners luncheon clubs, through social workers and also from hospitals for people who were about to be discharged. The report writes of the scheme: "It is noticeable that a bond quickly develops between a Good Neighbour and client. The success of the scheme is dependent on the qualities of the Good Neighbours who must have a real concern for the people in their care. This is frequently shown in the range of help which they give. Lighting fires on Saturday and Sunday mornings when home helps are not available, sewing for the man who lives alone, providing a Sunday dinner when Meals on Wheels are not available, visiting in the late evening and settling the old person for the night, are some of the examples of the work they do beyond their general duties" (*Liverpool Report on Good Neighbour Scheme,* Age Concern, January 1974).

Other schemes have a somewhat different emphasis. A scheme in Kirkcaldy aims that a street warden should be in touch with every single elderly person in the borough. In practice each warden is looking after about 23 old people. Obviously here the degree of personal relationship

must be fairly limited and the main purpose of the scheme seems to be to make sure that people have somewhere to go in emergency (J. W. Knox, "Street Warden Scheme," *Health and Social Service Journal,* 21 July 1973). It is supplemented by a home visiting scheme.

At present we are spending about £3 million a year in capital expenditure on day centres, but there are many authorities which have none at all. The day centres seem to be serving two rather different purposes: the need for recreation, warmth and companionship and the need for more active care and rehabilitation. A study of a day centre in Buckinghamshire (*Desborough Hall,* Buckinghamshire County Council Social Service Department, June 1974) has shown that of people who come to the day centre on their own initiative, most are younger and fitter than those who are referred by social workers. As a result of transport difficulties day centres are not likely to be accessible to the frail as much as would be desirable. Nor does the centre offer much potential for rehabilitation.

To build day centres on the present model so that they would be accessible to most old people would take a massive amount of public spending—which is hardly likely to materialise at present. Because of transport difficulties even if many more centres were built they might not be fully used. A survey for Age Concern showed that only a small number of centres could offer adequate transport; most had to make their own way to the centre. Yet day care has so much to offer—in enjoyment and in reducing loneliness (I. D. Horley, *Day Care,* Age Concern, 1974).

proposals for the future

The general objective has been clear: to give as many people as possible a chance of a normal life in the community. Can we relate the pattern of spending to this objective? The table in the next column sets out how the money is being spent. Excluding the very doubtful figures for

LOCAL AUTHORITY EXPENDITURE, ENGLAND, 1972-3	
revenue spending	£m
home helps	40.07
day centre care	2.86
meals-on-wheels & luncheon clubs	4.80
residential homes (net)	71.26
(social work visits	19.29)
capital spending	
residential homes (loan approvals)	35.68
day centres for the elderly (loan approvals)	2.42

Source: DHSS. The figure for expenditure on social work time is extremely doubtful. It is based on General Household Survey data on the number of visits made to the elderly.

expenditure on social worker time, we are spending more on the running costs of homes than we are on all the community services put together. We are spending far more on keeping 106,000 residents of homes than we are on the elderly in the community in face of evidence that the great majority even of the severely handicapped and housebound live in the community. Nor is the scale of spending on the community services impressive compared with spending in many other parts of the public sector. It is really rather difficult to relate this pattern of spending to the objective of policy which has seemed so clear and agreed.

Of course there are people who will no longer be able to cope and who will have to leave their own homes. This will require a heavy investment, to give support particularly to those who are in need of nursing care. But at present we are making this investment in the wrong place—in the social services which are ill equipped to provide nursing care rather than in the NHS. As is discussed in the chapter on the NHS, there is possibly a need for more places which could provide nursing care and which would be more like nursing homes than old people's homes. The social services on the other hand should attempt to carry through the task which they are supposed to be doing

but have never in fact fully done—that of providing a much higher level of support in the community.

The DHSS has already taken the first steps by limiting approvals for homes for local authorities with more than 20 places per thousand. What further steps could the government take to bring about a higher and more even pattern of community care and to draw on the community's own resources ?

We should stop the building of any more old people's homes except as replacements for former workhouses. The home in its present form does little to help two groups: the very frail who need nursing care and who form increasing proportions of residents and the more independent who could live in sheltered housing if it were available. It is being asked to play a role for disparate groups which it was never really equipped to play. Many of the authorities with the lowest numbers of homes and most likely to be building are anyway county authorities where old people's homes are least suitable.

This decision would require heavier investment in two directions—with the NHS and for sheltered housing. If funds can be diverted across departmental boundaries, it would be better to divert some of the money that is now being spent on homes to sheltered housing. But it should be recognized that this has implications for the community services. As residents in sheltered housing get more frail they will need a good deal of support from community services.

The decision here cannot be made in the absolute: it is a matter of priorities at a particular point in time. At this point the revenue consequences of building more homes are likely to threaten the money required for the community services. There is direct competition within the social services department budget. There are already authorities who have actually been cutting back on the home help service. There is currently a very uneven standard in the community services between different parts of the country. And there are many authorities with no sheltered housing at all and we are not even giving the chance to people who could obviously use it.

The government should set minimum standards for the home help and the meals service. This has been suggested again and again, but so far nothing has been done. But how can the present situation be defended ? Why should a pensioner who lives in Kent get so much less good a service than one who lives close by in the Borough of Greenwich ? As more local spending is financed out of central taxation, such great differences in the standards of service become even more inequitable. It is sometimes argued that recruitment difficulties are the main cause of the inequalities but this hardly fits with the experience of those authorities in active labour markets who have recruited heavily and successfully. The DHSS really must act to set standards for the home help and meals service.

We need more day care, but few people are going to get it so long as we concentrate on large capital schemes. It would produce better results to build small centres either in existing premises or in smaller purpose built premises. These premises could be the centre for a luncheon club and for social activities. They could have a much stronger relationship to a particular neighbourhood than the larger centres could have. They could be the focus for a genuine neighbourhood effort. The DHSS should draw up a blueprint for a model centre of this smaller type—which would of course be used by other groups as well as by the elderly, even though it would principally belong to the elderly. It would not be able to provide the range of services which other centres would provide—but it would be much better than nothing. Instead of concentrating our main effort on day centres costing perhaps £200,000 it would be better to go for a much smaller and more local type of centre costing perhaps £50,000. Such a centre would raise far fewer problems with the availability of sites. The provision would be fairly basic—perhaps a hall, a dining area and kitchen. But it could provide a companionable

setting, one which did not raise massive transport problems. They could also be meeting places for special clubs for the blind and the deaf. Eventually there might be one of these neighbourhood centres for each 25,000 people in urban areas. Such centres would provide a better result for spending even the present £3 million than day centres on the current pattern.

Day centres on the current pattern often aim to provide some element of rehabilitation. But they cannot provide the full range of medical and social help which a person in serious difficulties ought to be getting. It would be better to concentrate here on extending the role of the day hospital so that it could also serve as an assessment centre run jointly by the health and social services. At present people can be sent into homes without any proper assessment or sustained attempt to help them in the community. For ten years we have been struggling to get joint planning between the health and social services. In 1965 the HM (65) 77 circular recommended joint planning groups. Ten years later we are still struggling to set up such groups renamed "health care planning teams." Let us make a practical start on co-operation with jointly run assessment centres. If they were entirely separate from day hospitals they would be yet another competitor for extremely scarce resources, while the day hospital would continue to play the more strictly medical role it has in the past, it could also take on this new task.

The DHSS should give strong official encouragement to the growth of good neighbour schemes. These can draw on great reserves of care and interest in the community.

3. housing and the elderly

The evidence on the poor housing conditions of the elderly is clear: we are asking people who are least able to cope to live in conditions which would tax the most resilient. Overall 39 per cent of heads of households aged over 65 in 1971 lived in houses built before 1919 compared to 24 per cent of people under 44. Their houses lacked amenities—20 per cent of households over 65 were living in houses without internal wcs compared to 9 per cent of younger households (D. C. C. Wroe, "The Elderly," *Social Trends,* 1974). Housing tends to get worse as people get older and the worst conditions of all were found with the over 80s. Many elderly people are living in housing which has been little repaired for forty years and which inevitably suffers from poor wiring, damp and even from serious structural faults — conditions which cause anxiety and which aggravate chronic illness. These facts on the housing conditions of the elderly are well known but have had remarkably little influence on spending.

There are many aspects of housing policy which affect the elderly. For example it would be possible for the elderly to apply for improvement grants although in practice few have. But the most important question is whether we have made a consistent effort over a period of years to provide more sheltered housing.

The idea of sheltered housing is an old one. It began with the almshouse and even in the Royal Commission on the Poor Law Report of 1909 there are approving mentions of special housing for the elderly, particularly in Woolwich (*Royal Commission Majority Report,* 1909). Between the wars a few special dwellings for old people were built—28,000 out of 1.16 million. Directly after the war there was some degree of interest; a discussion in the Rowntree Report suggested that perhaps 5 per cent of the dwellings in any community should be for the elderly. But these dwellings were mainly distinguished by being small. "In general old people's dwellings need few special fittings" (J. Seebohm Rowntree, *Old People*). These were ordinary small houses, bungalows or flats. From 1945 to the early 1970s, considerable numbers of small flats were built: from 1945 to 1960 in England and Wales—202,384 or 10 per cent of the total; and from 1966 to 1971—379,761 or 27.3 per cent of the total (H. Mellor, *Housing in Retirement*). But not all these small flats are occupied by the elderly. The occupancy overall is not known although three-quarters are probably used by the elderly. Again there have been great differences between authorities in the numbers of flats built. A great many have done virtually nothing. Most of these units do not have the special design features advocated in a ministry circular in 1969. Currently we are building about 23,000 small flats a year.

Alongside the older concept of the small flat or bungalow has grown up the idea of the sheltered housing development. This usually has a resident warden, and a call system for residents, together with special design features which make them suitable for the disabled and frail. They may also have some element of communal provision. Progress with such grouped schemes was slow in the 1950s and 1960s. By 1958 not more than 4,300 dwellings had been built, as a special survey showed. Townsend in *The Last Refuge* suggested that a target of 50 grouped sheltered housing places per thousand elderly should be set. But little notice was taken of this in practice. This would now mean about 350,000 units for the United Kingdom in 1981. There are at most 50,000 units in existence. Perhaps 6,000 of the 23,000 small flats being built each year are sheltered.

Any figures have to be tentative because no proper survey has yet been done. The figure for 50,000 units of purpose built accommodation for the elderly or handicapped may well be an over estimate. Certainly the official survey of the housing of the handicapped by Judith Buckle showed that only 5 per cent of all handicapped and at most 7 per cent of those most severely handicapped were living in sheltered housing in 1968-69 (J. Buckle, *Work and Housing of*

Impaired Persons in Great Britain, OPCS, 1971). In spite of many years of vague encouragement and support, little sheltered housing has been built. One study looked at what happened in Scotland in the 1960s (J. Williamson, " Facilities for the Care of the Elderly in Scotland; ' Progress ' in the Interval 1962 to 1969," *Health Bulletin,* April 1971). In 1962 Scotland had no sheltered housing.

As Professor Williamson wrote: " The implication of this is that when an elderly person gets to the stage of not being able to manage in an ordinary small house . . . then she must perforce in almost all parts of Scotland accept institutional care and virtual total dependency . . . " (J. Williamson, *loc cit*). Increases by 1969 in the amount of sheltered housing in Scotland had been trivial. The annual Report of the Scottish Health Council for 1969 states that no new houses of this type were being provided.

Many surveys have presented evidence that a substantial proportion of people who at present go into homes could live in sheltered housing if it were available. Carstairs for Scotland has argued that two thirds of people who are at present in homes could live in sheltered housing (V. Carstairs and M. Morrison, *The Elderly in Residential Care,* SHHD, 1971).

The estimates made by social workers of this proportion tend to be lower. Thus Wager (R. Wager, *Care of the Elderly; a Cost Benefit Analysis,* Essex County Council, 1972) asked welfare officers in Essex to say whether people on the waiting list for residential care could in fact live with intensive support in the community, possibly including sheltered housing. About one quarter of these elderly were thought to be capable of continuing in the community with more support. All such estimates are made in a certain context which may have influenced attitudes about what the elderly can achieve. As more sheltered housing becomes available so people's expectations would change. It should be recognised, however, that increased numbers of people in sheltered housing will put an increased demand on the community services.

The building of sheltered housing serves the interests of groups other than the elderly. It releases under occupied housing for use by others. There are many elderly people living in accommodation which is too large for them and for which they cannot afford repairs or maintenance. Sheltered housing not only gives the elderly greater independence. It also helps other groups who are in need of housing.

Some local authorities have been taking much greater interest in sheltered housing. Perhaps the best study is that by Greenwich (*Key Issue Report : Old People's Homes and Sheltered Housing in Greenwich,* November 1972). This works out the demand for sheltered housing from a great deal of carefully collected information on whether people were living alone and on their physical and mental state. It argues that even in terms of a " tight " definition of need, Greenwich has a deficit of about 1,150 units of sheltered housing. Similar calculations have been made in Camden, where the deficit is reckoned at about 2,700 units.

This has been one among many authorities which until very recently had built almost no grouped supported housing at all. Manchester has carried out a study of its elderly population and now plans to build many units of sheltered housing. Liverpool has decided to build no more homes but to concentrate entirely on sheltered housing. Through active use of housing associations, Liverpool is already well towards its aim of several thousand more units.

Thus a new initiative from central government would be well in line with the actions of the more progressive local authorities.

Local studies and surveys have again and again put the priority as sheltered housing. One such study is that by Rosemary Gruer in the Scottish Border counties—the Lothians. She reports that

"In numerical terms, the greatest need is in sheltered accommodation. If the local authorities adopt a policy of admitting to residential homes only frail persons who could not live independently in sheltered houses, the present provision of residential places is adequate" (R. Gruer, *The Needs of the Elderly in the Scottish Boarder Counties*). Going to the other end of the country—to the Isle of Thanet—we find a young nursing sister writing of the shortages of sheltered accommodation: "Within the Thanet area there are eight warden-assisted flatlets schemes with an average of 32-36 flatlets in each community. To get an old person into one of these one has to apply to the housing manager, but there is a long waiting list" (Lorraine Roberts, "The Care of Psycho-geriatric Patients," *Nursing Times*, 20 March 1975). It is almost fifteen years since Townsend in *The Last Refuge* recommended the building of more sheltered housing as the major priority. But *still* there are local authorities which have no sheltered housing at all.

In central government the strongest lead has been given to Scotland. In 1972 the Scottish Home and Health Department set a target of 25 places per 1,000 elderly population. This is on the low side as targets go—understandably enough in view of the complete absence of sheltered housing in Scotland. Manchester has set a target of 32 places per 1,000; Greenwich is aiming at about 40 places per 1,000, and Townsend's target of 50 per 1,000 still has many supporters. Some authorities are trying to provide more sheltered housing through the introduction of a system by which people can call wardens in existing housing, but this although useful does not serve the same purpose as grouped supported housing.

The Department of the Environment has limited itself to descriptive circulars on design and philosophy. The first was the 1969 circular on design standards for the elderly (Ministry of Housing Circular 82/69). More recently it has issued a circular on mobility housing and a general sermon on housing the single. But it has not set any kind of target for local authorities to aim at or any minimum standard. A general circular on housing for the elderly has been promised since 1973. So far nothing has happened.

Meanwhile housing associations relative to their size and resources have been more active than government. Housing Associations of which the most important are Help the Aged and the Hanover have been building about 3,000 units a year. All local authorities put together have been managing only 6,000.

To reach the modest target of 25 places per 1,000 by the early 1980s, we would have to at least double the current rate of building. Assuming construction and land costs of about £8,000 per unit (a reasonable extrapolation from the figures collected by Wager for 1969-70 (R. Wager, *loc cit*), this would involve an annual expenditure commitment of about £50 million. There would be effects on the community services too as the building of more sheltered houses is bound to create more work for them. To move towards any more ambitious level of provision would be helpful but probably unattainable in current fiscal circumstances. The sum at stake is then about £50 million a year over initially five years, although even then we would be well below the target.

Part of this spending could be transferred over from the capital programme for old people's homes. At the most modest estimate, 20 per cent of the places in homes are taken by people who could live in sheltered housing if it were available. While it would be unrealistic to expect an exact match of resources to individual need, the views of social workers and others on the need for places in homes should surely change a little as an alternative becomes more widely available. The current state of things is that we are not even offering the chance to people who could definitely live in sheltered housing.

Particular attention should be paid to getting a fair geographical distribution of sheltered housing—otherwise it will be the same old story over again of some

places having a great deal and others virtually nothing.

After such a critical account of the norm for residential home places, it may seem paradoxical to suggest another norm. But the argument was against having an unbalanced norm which applied to one service only rather than against norms as such. The evidence suggests that local authorities have taken notice of the norm for residential places, but there has been no comparable pressure for the expansion of sheltered housing. The argument is not about sharp alternatives but about balance. Our current unbalanced services reflect differing degrees of energy by government departments and local authorities—rather than any approach to the optimal.

Grouped sheltered housing is the highest priority for the elderly. But there is another change on the housing side which would help. At present, people who wish to move in order to be close to elderly relatives get no priority at all for transfers; nor are the elderly themselves able to transfer. In areas of great housing stress such as Central London it may be difficult to arrange this—but in most of the country the desire to help elderly relatives should surely become legitimate grounds for seeking a transfer. Families often do want to give more help to their elderly relatives, but they are not able to do this unless they can live close to them.

The story of governments and sheltered housing is a rather discreditable one for successive ministers in housing departments. For many years, it has been rather widely recognized that grouped sheltered housing could be of great assistance to the elderly. But what actively has been done by central government to encourage more building? There is rather strange absence of mind, verging on negligence.

4. the NHS and the elderly

Ill health in the elderly is often a complicated affair. It often involves several illnesses at once and it usually has social as well as medical aspects. It can also involve both mental and physical troubles. Both initial assessment and care aimed at a return to the community are extremely skilled jobs. But many geriatric departments are showing what can be done. They have greatly increased therapeutic optimism.

There has recently been more disquiet about the so-called "psycho-geriatric patient." Prevalence surveys disagree about exactly how much mental illness there is among the elderly, but there is clearly a great deal, and very little of it is treated. There is a certain amount of psychiatric illness. There are patients who are suffering from dementia. But there are a rather larger group of patients who are "confused"—a state of depression and disorientation to which bereavement, loneliness and constant struggles with difficulties in daily living all contribute.

There are people who are not going to be able to cope in the community again. Work by Dr Bernard Isaacs and his colleagues suggests that death is often preceded by a period of "pre death" in which people begin to wane in their faculties and eventually become bedbound (B. Isaacs *et al*, "The Concept of Pre Death," *The Lancet*, 24 May 1971). Help must be given to the growing numbers of people who are suffering from chronic illness and in need of nursing care.

The great majority even of severely disabled patients are being looked after in the community. The burden of looking after incontinent and bedfast patients is being borne mainly by overtaxed relatives.

What do these considerations suggest for the NHS? They suggest as first priority a high standard of assessment and rehabilitation for people with mental as well as physical troubles. They suggest that the numbers of people in need of long stay care are possibly growing. They suggest that the community based services are of great importance to the ill elderly. How sensible are the dispositions of governments seen from these starting points? Are we in fact providing or likely foreseeably to provide a high standard of rehabilitation and assessment? Are we looking after long stay patients with care? Are we building up the community services?

The care of the elderly affects many parts of the NHS. Patients above retirement age make up a third or more of patients in medical and surgical wards. They are getting much more active treatment than even a few years ago. To mention only one example: advances in orthopaedic surgery have been a great blessing for the elderly. But there are often increasing difficulties in discharging elderly patients where an effective service of rehabilitation does not exist. Significantly the numbers of in patients treated in the NHS fell in 1973 for the first time in many years. Unless we can offer the elderly a better standard of care, the NHS will become overall a less effective service.

There has been a great deal of discussion about the effects of the elderly on the hospitals. Less often discussed is the role of medical education and of medical research. But the care of the elderly should not be just a matter with which people on the wards are left to struggle. It should have the help of those who are leaders in the medical and nursing profession and it should have a reasonable share of the effort devoted to medical research.

What has been the pattern of spending on services for the elderly in the NHS? It is impossible to disentangle spending which takes place on general wards, but there are figures for spending on those parts of the service which are labelled services for the elderly. These figures are set out in the table on page 16.

Within the hospital service most of the expenditure has gone on long stay care. The spending on services which contribute directly to rehabilitation and on the community services has been small.

EXPENDITURE ON THE ELDERLY, ENGLAND & WALES, 1972-3

revenue spending:	£m
geriatric in patients	116.40
geriatric out patients	0.54
geriatric day patients	2.91
dementia in patients	33.42
home nurses	15.93
health visitors	2.15
chiropody	5.09
capital expenditure	23.24

Source : DHSS. *Note*: excludes Family Practitioner Services.

What have been the policies of governments and what have they been attempting to do? How far has it been a question of the DHSS wanting to do the right thing and not being able to do it? Part of the basic strategy has been to support the development of geriatrics as a speciality by trying to win for it acute assessment beds in the district general hospital and to achieve improved staffing in geriatrics. We first of all examine the record for those questions on which governments have taken major initiatives. But the strategy seems to have been a rather hospital based one. How far has encouragement been given to the growth of the community services?

Where have been the achievements of the last twenty years? What are the strong points on which policy could build? Perhaps one of the strongest has been the growth of the speciality of geriatrics. This gives us a very important base compared with that of many other countries. "In the beginning was Marjorie Warren." She was a pioneer of the active treatment and rehabilitation of chronic sick patients in the West Middlesex Hospital of the 1930s. She wrote of the "deplorable results of lack of initiative in chronic wards" and took the view that "there is much to recommend geriatrics as a speciality comparable to pediatrics. The creation of such a speciality would stimulate those with a leaning to this type of work and raise the standard of work done" (M. Warren, *The Lancet*, 8 June 1946). But at the beginning of the Heath Service, there were still many thousands of patients who were almost imprisoned by infirmity in long stay wards. Two registrars in the Lancet in 1949 described the situation in St Pancras Hospital, the old municipal hospital which became part of the NHS in 1948 (A. N. Exton Smith and G. S. Crockett, "The Chronic Sick under New Management", *The Lancet*, 11 June 1949). "The hospital had three 36 bed wards for men and three 45 bed wards for women, the latter being full to capacity. Most of the patients were 65 to 85 years of age, but some were under 50".

The diagnoses on the case sheets were often in such vague terms as "senility" and "myocardial degeneration"; "hypertension" was frequently used for want of a better label.

The patients were well nourished, clean and without bedsores. But almost all had painful, stiff and in some cases fixed joints in their lower limbs, which were usually held in the position found most comfortable. It is these stiff and painful joints—resulting from long continued immobilization in tightly made beds—that form the greatest problem in getting these patients walking again. The mental state tended to be one of apathy and depression. Over the years the better geriatric units (at University College Hospital, Ipswich and Hastings—to give only three examples) have come to set new standards in rehabilitation and to bring about a revolution in our expectations of what an elderly person can achieve. These better geriatric units are the most hopeful achievements on which to build for the future. Each one has had to establish itself in the teeth of hostility or at best apathy—from general physicians, from general practitioners and from the administration. They had first to show that they could treat patients actively—that they could do something. The position of geriatrics still shows a great variation locally. In some places it treats many more acute cases than in others. Its degree of access to the district general hospital also varies. Above all there are variations in attitudes to the elderly, which have been frequently commented on in the Hospital

Advisory Service Reports. But the best geriatric departments have lit the flame of "therapeutic optimism."

They have done this in most adverse conditions. There is evidence to show that geriatric departments get many more of the older and sicker patients coming from worse home conditions and living in greater social isolation. A study by Isaacs examined whether geriatric patients over 65 had a higher proportion of dependent people — whether they showed one or more of five symptoms: stroke, falls, immobility, incontinence and mental abnormality (B. Isaacs *et al, Studies of the Illness and Death of the Elderly in Glasgow,* SHHD, 1972).

"The results showed that the two groups of old people differed sharply. Two thirds of the medical patients had none of the five chosen presenting symptoms. Two thirds of the geriatric patients had two or more and one sixth had four or five. A state of dependency was defined as the period in which one or more of the last three symptoms—immobility, incontinence and mental abnormality—was continuously present. A state of dependency before admission was absent in all but 18 per cent of medical patients, and in half of these the state of dependency lasted for less than one week, while in only 8 per cent did it exceed one month. By contrast three quarters of the geriatric patients were dependent for more than one week at home before referral; three fifths for more than one month, and one quarter for more than one year. Nearly all the medical patients were discharged within three months. By contrast less than one third of the patients admitted from home to the geriatric unit were discharged within three months of admission; one third died in that time; and the rest remained in hospital" (B. Isaacs, *op cit*). There was one group among the geriatric patients who hardly figured at all among the medical patients. These were people who were admitted because of "insufficient basic care" who made up 26 per cent of the geriatric group. Numbers of these isolated patients had in fact been kept at home mainly through the devoted efforts of the home help service. But the service was able to give rather little help to relatives looking after the bedfast. Only a minority of people were using any community services. Only 31 per cent of incontinent patients had had any help from the district nursing service and "no use was made of the incontinent laundry service." Glasgow may be a somewhat extreme case and other studies in the London area suggest that geriatric departments are taking slightly more of the curable cases. But from the basic picture it is clear that geriatric departments are taking a very high proportion of the more difficult cases.

Another success has been the clearing away of some of the worst of the old buildings that were inherited from the Poor Law. There are still far too many workhouses in use: but the more extreme situations which Sheldon found in his report on geriatric services in the West Midlands have mainly disappeared. (I am grateful to the librarian of the Birmingham RHA for lending me one of the few surviving copies of this report).

Sheldon's report in 1961 was illustrated with vivid photographs of bags of fouled linen waiting collection in a main corridor. "The odour may permeate a building" of acutely angled stairs in a hospital, of long steep stairs to a dormitory for Part Three patients, of a small ward kitchen in the basement with the two floors above and of bed pans being stored for the night (under Dettol). Other photographs showed a building constructed on the lines of a prison with tiers of inner balconies overlooking a central wall, of an outside bath house for 84 men and of an outside entrance to an upstairs ward. Wards were severely overcrowded and generally without day rooms. At the end there was a photograph at a hospital of the "mortuary and the pig sty in the same building." At least some of the most extreme cases have gone—although it was still possible for a committee of geriatricians to write in the South East Metropolitan Board Area that: "No one will envy the Regional Hospital Board's

inheritance of ancient monuments and general Dickensiana. Nearly all the hospitals used by geriatric departments are old buildings which were out of date and unsuitable for the treatment of the sick before the turn of the century. They long ago reached the limit of their usefulness and demand replacement at the earliest possible moment" (South East Metropolitan RHB, *Development of Services for the Elderly and Elderly Confused*, 1971).

We turn now to the DHSS's policies for the hospitals. The DHSS has intervened in four main ways through circulars, through setting norms and guidelines, through control of capital expenditure and through attempts to improve medical and nurse staffing in geriatrics.

circulars

One major theme has been the need to set up proper geriatric departments. This was first enunciated in 1957, in a circular which like so many was a sound enough statement of doctrine. "The Minister considers that hospital authorities should give high priority in the allocation of resources to the establishment in every hospital centre of a geriatric department under the charge of a specialist physician" (*Geriatric Services and the Care of the Chronic Sick*, Ministry of Health, HM (57)86). It was emphasized that these should have assessment beds in general hospitals. It also urged the value of day hospitals. The Department's views were based on a special survey carried out by one of its medical officers, Dr Boucher. Much later in 1970 the Department issued another circular setting out in much more detail where hospital geriatric departments should be, and urging that 50 per cent of the beds should be in general hospitals (DHSS, DS(329) 71).

The most authoritative judgment on the effects of this policy comes from the Hospital Advisory Service (HAS) which has visited most geriatric departments in the country. In its 1969-1970 Report, the Director wrote that "The team has noticed how little change there has been in many hospitals compared with the situation described some fifteen years ago in the Summary Report prepared by Dr C. A. Boucher (*HAS Annual Report, 1969-70*, HMSO, 1971). The Report went on to say that "although the Department of Health has advised on the need for day hospitals for the elderly, there are still far too few in the areas we have visited, often have a limited function and even new ones have been built incomplete."

In its Report for 1971, the HAS commented with surprise about geriatrics that "so little priority is being given to developing this branch of medicine" (*HAS Annual Report 1971*, HMSO, 1972). Even in planning for future general hospitals it is common to find that far too few beds are being allocated to a geriatric service and in existing hospitals it is almost always the case that the geriatrician is given the worst accommodation and the rejects from other specialities. Some new district general hospitals and teaching hospitals have been built without any geriatric provision.

There are cases of new blocks being hastily designed and stuck on the back of new buildings, to fill the gaps. At best it has been a desperately hard struggle to win a place for geriatrics—at worst a losing battle against intolerable conditions.

norms

The second main initiative of the DHSS has been in setting norms. The 1957 circular was sceptical about whether it was possible to set such norms (HM/57 (86)). But by the time of the Hospital plan of 1962, the Ministry was less agnostic. They came down for a norm of 10 beds per 1,000 over 65. Their advocacy of this was somewhat cautious. "It appears . . . from studies conducted by the Ministry of Health that in areas where the whole range of services outside hospital is well developed, the necessary hospital provision is being achieved with about 10 beds per 1,000 population" (*NHS: A Hospital Plan for England and*

Wales, Cmnd 1604, HMSO, 1962). As services for rehabilitation improved, it might even be possible to reduce the number of beds. The basis of research for this judgment was not at all explicit. But nearly fifteen years later this number was still being taken as writ. There was official concern that the ratio was in fact only 8.8 rather than 10 and some people spoke worriedly about a shortfall in bed provision of 12 per cent.

The bed norm had a mixed reception. There were two main lines of criticism which the norm attracted. There was the complaint of the HAS that "the exaggerated importance attached by hospital authorities to bed numbers continued to plague the service . . . A large number of beds does not necessarily mean an active and effective service . . . It is clear that the success of a department does not depend on the number of beds but on the way those beds are used" (HAS Annual Report, 1973). This seems to reflect the experience of some of the better departments of geriatrics.

For example two geriatricians and an administrator from Oldham write of their experience over a 16 year period: "The increase in turnover is accompanied by an increase in the number of vacant beds and a decrease in the average length of stay. The virtual absence of any waiting list, the reduction in the number of available beds, and the consistent increase in discharges and deaths indicated that the proportion of 'chronic' longstay beds to 'acute' short stay beds has fallen over the years. In January 1955 for instance, 66 per cent of the beds were occupied by patients in hospital for more than one year . . . but in October 1972 only 23 per cent of the beds in the unit were so occupied." They conclude that "higher turnover can be achieved by better use of existing beds rather than by an increase in the number of beds" (T. D. O'Brien, D. M. Joshi and E. W. Warren, "No Apology for Geriatrics," *British Medical Journal,* 3 November 1973). Their hospital is in a district with 9.2 beds per 1,000 population—that is, less than the current "norm" of 10. Another major point of criticism is that the norm does not take enough account of the special needs of the over 75s. One unpublished study has shown that the use of hospital beds is six times higher for the over 74 age group as it is for the 65-74 age group. Use of this adjusted norm would mean some increase in the number of geriatric beds in some areas particularly along the South Coast. This has in fact been suggested by a working party of the Wessex Regional Health Authority. It would however mean a decrease in the number of geriatric beds elsewhere where there are smaller numbers of over 75s.

capital allocations

A third way in which the DHSS has intervened is through special allocations of capital. Sir Keith Joseph allocated some extra finance for spending on geriatric and psychiatric hospitals. This of course came at the end in most regions of a long period of low spending as the Report on the South East shows. "Out of a total of £34 million allocated to the Board for capital works between 1948 and March 1971 about £2 million has been spent on new and upgraded geriatric accommodation. In this Region at least there was a substanital improvement and over the period 1972-73 the Board was planning to spend some £1.8 million.

It was by no means certain that there would generally be a net increase in the amount of money being spent on geriatrics as a result of the government's move. It may well be that Regional Boards eliminated plans for spending of their own, in face of the department's special allocation. There was some quantitative evidence of low response in regions where the geriatric problem was at its worst. For instance, the capital programmes for 1972-3 in the Wessex and South Metropolitan Regions showed for 1972-3 less than 5 per cent allocated to the geriatric services compared with over 16 per cent in the highest spending regions.

Thus there is some evidence that the Department's drive has met with less

than full success. However it is likely that even less would have happened if there had not been such strong pressure, from the DHSS.

staffing

Finally the DHSS has attempted to improve staffing in geriatrics. It has tried to create more consultant posts and more of the training posts leading towards them. But it has proved most difficult to fill these posts. There are now 40 consultant vacancies in geriatrics and there were recently about 40 District General Hospitals without a geriatrics department. There is no doubt that this reflects the unpopularity of geriatrics as a field for doctors to work in. There has been sympathy and support from the Royal College of Physicians. This recommended in a Report more chairs in geriatrics, dealing with staff shortages and improved contact with general physicians (*Report of the College Committee on Geriatric Medicine,* Royal College of Physicians, 1972). But studies of the attitudes of young doctors showed that they tended to become a good deal *less* favourable to geriatrics in their first years in practice (J. Gale and B. Livesey, *Age and Ageing,* 1974). They seemed to be more favourable to geriatrics as students than they became as young doctors. It also seems to be the case that attempts by geriatricians to set up rotating posts involving some experience of geriatrics and some in general medicine have met with great opposition from many general physicians. The HAS has also criticized very strongly this matter of medical attitudes. "Unfortunately hostility to geriatrics and to geriatric staff can be found at all levels in the hospital service, and I am sorry to say that prejudice and lack of understanding can occur among the most eminent in a teaching hospital as well as in the most isolated rural group. For example a professor of a well known teaching hospital was heard to say that 'medical students should not be contaminated by contact with geriatric patients' and Dr Baker goes on to write in heavy type that 'I am emphasizng this matter of attitudes because there is little doubt that it underlies many of the difficulties now being experienced'" (*HAS Annual Report, 1972,* HMSO, 1973). These medical attitudes no doubt explain the very pessimistic projections made by the DHSS for the numbers of consultants in the geriatric service, from about 400 today to 495 in 1978 and to 720 in 1984.

The Ministry has set minimum standards for nurse staffing which has had some good effects though there has been worry about whether they would be taken as the norm rather than the minima. Nurse staffing remains a great need. As the report in the South East has argued: "Women in their late seventies, eighties and nineties generally get up during the night to empty their bladders at least once and often two, three or more times. When admitted to a hospital ward with only one nurse at night in charge of 30 or more patients, there is no chance of the elderly disabled patients being assisted out of bed during the night for this purpose. Inevitably they must allow their bladders to empty in the bed and become incontinent. This not only creates more work for the nurse (and expense for the hospital) but is quite inhuman and demoralising for the patient." Generally however there has been rather little attention to geriatric nursing. The Briggs Report hardly mentions the subject. There has been some attempt to include geriatric nursing modules in nurse training: but apart from this there has been virtually no time or money spent on training for geriatric nursing.

Another kind of care on which governments have taken initiatives is on the care of the mentally infirm elderly. This need seems to have become apparent quite early on in the NHS. Thus on 1 April 1950, the Ministry of Health issued a tersely written circular on the "care of the Aged Suffering from Mental Infirmity." This recommended short stay psychiatric units "within geriatric departments." "It is contemplated that geriatric departments will be developed in at least the larger hospital centres in the future and that such a department will normally be established in a general hospital. The

purpose of the short stay visit is to diagnose, to provide short stay treatment and to sort these elderly mental cases" (Ministry of Health HMC/50 25). A little short of twenty years later the Ministry (or Department of Health) re-issued almost exactly the same circular. By this time the short stay units had been renamed "psycho-geriatric assessment units", but the gist of the document was the same. "The function of such a unit is to enable a precise diagnosis to be made, to initiate treatment and to make suitable arrangements for further care when necessary" and the document said that "normally the psycho-geriatric unit should be situated in the geriatric department of the district general hospital" (DHSS, HM 70 (11). Since then little has happened.

For the community services there have also been general injunctions, but little practical guidance on how to build them up. From the celebrated survey of Williamson *et al*, onwards (J. Williamson *et al*, "Old People at Home: their unreported needs," *The Lancet*, 23 May 1964), it has been well known that many old people are suffering from many completely unreported and untreated disabilities. A high proportion, even of severely handicapped and housebound patients have not been recently helped by their GP or by a district nurse. One particularly important time is that directly after discharge from hospital: Brocklehurst has studied the fate of people in Kent immediately after discharge (J. Brocklehurst and M. Shergold, *The Lancet*, 23 November 1968) and the Age Concern Report, *Care is Rare*, (June 1973) has looked at discharge in Liverpool; both with worrying results.

As with the local authority social services there are great geographical disparities in the community health services: there is a clearer division between North and South than in the case with the social services (J. Noyes *et al*, *The Lancet*, 30 March 1974). Studies have brought out again the value of the district nursing service to the elderly—when they can get hold of it. The contribution of health visitors seems to be much more sketchy. A few places such as Camden have trained geriatric visitors but health visitors are mainly interested in young children and their families. The attitude of GPs has been strongly criticized by some family doctors such as Dr Thompson of Croydon and Dr Pike of Handsworth who have taken a special interest in the elderly. There have been from the early 1950s many attempts to start screening programmes for the elderly but these have not caught on. Generally the picture is of many bright ideas but little carried through to help large numbers of people.

There are now 6 professors of geriatrics in English medical schools, 4 of them very new. They represent one of the most hopeful developments of the last few years, but they face grave difficulties at a time when all university funds are being restricted. Such restriction is particularly affecting new and struggling departments which need more staff. Nor are we likely to see more new departments in such a climate. Some other medical schools have perhaps one or two staff teaching geriatrics, but without the resources of a full department. Those departments of geriatrics are centres of undergraduate teaching and where they exist they have been successful in interesting medical students. They are centres for post-graduate training of future specialists and again they are having success in attracting applicants of good quality. They are also centres of research, and they are carrying out some most important work. For example one new department is carrying out the first study of the effects of sleeping tablets and other drugs on the elderly.

It is ironic that at a time of such rapid expansion in medical education as we have seen in the last few years, so little of it should have been concerned with the health problems of the elderly. It is particularly ironic because so much of the work of the NHS is concerned with the elderly. The DHSS has little direct voice in decisions on the medical curriculum, and on the balance between university departments. These are the province of the Department of Education, of the

University Grants Committee and of the General Medical Council. But it is surely time for the DHSS to take a stronger stand, in favour of a larger share of resources for geriatric departments. They need much more help to build up their teaching and research and we need more new departments in the many medical schools where they do not exist. The balance between academic freedom and requirements for particular kinds of skilled manpower is a delicate matter. But this is one case in which *laissez faire* is not likely to produce the right answer.

An even more delicate issue is that of direction in medical research. Since the Rothschild Report, there have been three main groups of people concerned with medical research (apart from the drug companies). There is the DHSS itself which carries out research directed to service need. There is the Medical Research Council, which sponsors units and particular research projects. There are also university departments. The Medical Research Council has designated certain priority areas on which it is keen to sponsor more work. It also gives fellowships for training in these areas to encourage more research workers. The problems of aging are not one of its priority areas. Of course some of the general research being sponsored may produce results which are important for the elderly. But the MRC Annual Reports do make it clear that very little direct work is being done on those problems which are of greatest importance for the elderly. There is no work being done on incontinence among the elderly or on the causes of dementia, to give only two examples. Now obviously useful research cannot be produced quickly any more than results can be guaranteed. But certain steps could be taken to remedy the known shortage of interested research workers. The DHSS could set an example by using some of its own money for training fellowships, and by commissioning more work. It could also negotiate with the MRC.

The picture for long stay patients is also pretty gloomy. We are asking inadequate numbers of staff to do an impossible job in antiquated buildings. Within the social services, staff are ill equipped to look after increasing numbers of frail residents who are in need of nursing care. At present the DHSS is aiming to get long stay patients looked after in community hospitals, but it is far from certain, whatever the merits of the idea in principle, that health authorities with all the other claims on their resources are going to get these going in the near future.

proposals for the future

What can be done? We need to define a small number of changes which could make a real difference and to state quite clearly how these are to be brought about. There has been no shortage of sound doctrine and of meritorious circulars—but little has been done in practice. The one great strength and great gain of the last few years is the growth of geriatrics as a speciality. Governments have to represent the public interest. This becomes difficult when, as here, there is a considerable gulf in attitude between successive governments and most of the medical profession. It is also difficult when intentions have to be expressed through an administrative machine which has become rather famous for inaction. Nevertheless in spite of all the difficulties, some attempt has been made to ensure that the interests of elderly patients and of those staff who do work with them are not further neglected. We have to recognize that the timetable for change may well have to be a lengthy one. If there was a real difference within five years, this would be a considerable achievement. What changes might be useful?

We should give immediate additional help to departments of geriatric medicine within universities. There is evidence that these as new and struggling departments are being particularly affected by the current stringency in university budgets. But where they have got started they are having remarkable success in attracting new talent into geriatric medicine. The DHSS should intervene with the Depart-

ment of Education and the University Grants Committee over this. This would be the single most important step in improving medical recruitment into a speciality which has had constant difficulty in recruiting good people. Looking forward five to ten years, the most important change for the elderly would be a change in medical attitudes. We should build on those points of strength which exist—the new geriatric departments certainly are these.

In conjunction with geriatric departments of universities, the Medical Research Council should be urged to sponsor a much larger programme of research into the medical problems of old age. The Medical Research Council is rightly an autonomous body which makes it own decisions. But it does seem strange that it is doing so little work on the health problems of the elderly, which are having such a major effect on the NHS as a whole. The DHSS has research funds of its own, but it should also make special representations on this point to the Medical Research Council.

Within the hospital service the major emphasis for the next five years should be on staff recruitment and on staff quality rather than on number of beds. Even in 1973 there were only 275 geriatricians in England and forty vacant posts. The total number of geriatricians is rather less than the increment in the numbers of anaesthetists and pathologists over the last ten years. The only sure way to improve recruitment in the longer term is to give scope to centres of professional excellence—hence the recommendation for additional money for geriatric departments. But in the short term we should have a special recruitment effort and special training arrangements to attract a small number of people who are already established in other specialities including general practice into geriatrics. This would also require special provision to allow previous pay to be maintained during the training. The recruitment advertising should set out the imperative reasons for this special appeal. The selection of at most 50 people would be carried out nationally by a panel mainly nominated by the British Geriatrics Society. At present it is very difficult for a person once established in a particular field of medicine to make a transfer; it is likely that a fair number of good applicants would be attracted. The selected candidates would be attached to university departments of geriatrics and would then apply for posts in the service.

At present we are spending virtually nothing on the training of nurses to work with elderly patients. Here again the longer term answer is to arouse professional interest and to change training. But it would be worth starting some special post-qualification courses to give people a chance to find out about working with the elderly.

The DHSS should use some of its development monies for financing special work with long stay patients—to give some idea of what could be achieved. At present there are very few places in the country about which people are proud. Why not centres of excellence here too and not just in clinical specialities ?

So far we have been looking at changes which are brought about by new commitments of money and by a new emphasis on staff training and quality. But there are other questions which are even less amenable. These are the questions on which the DHSS has had little success in getting the service to follow it. One prime example is that of geriatric assessment beds in District General Hospitals. These have often been recommended but still new hospitals can open without geriatric departments. Nor has the DHSS had much success in getting hospitals to provide a service for psycho-geriatric patients. On both these points the government should take a more executive stance than has been customary in the NHS. It should be mandatory within two years for geriatric assessment beds to be within the general hospital.

For the psycho-geriatric service a special financial incentive is needed. Health authorities should be asked to

submit plans and they should be financed by a special earmarked allocation of funds. Otherwise the DHSS will very probably be re-issuing the same document in 1991 as it issued in 1959 and 1971.

Within the community health services there is exactly the same case for setting minimum standards as in the social services. This is particularly so for the district nursing service which plays such a vital role in the case of the elderly. Could not, too, the interest of more health visitors be won for the care of the elderly? The "geriatric visitor" experiment has been a success and could be repeated more widely.

We need more good purpose-built homes for long stay patients. Perhaps one or two for the present homes for the elderly in each community should concentrate on the more frail and should be administered jointly by the health and social services. We need NHS Nursing Homes. This is the right aim—a substitute for home for people who cannot return fully to the community and who need nursing care. We have to get away from our heritage of the large "long stay hospital," which at the best of times is a rather strange idea.

Our present arrangements for people with chronic illness are becoming increasingly unsatisfactory. We have reduced the numbers of long stay places in the NHS.

At the same time we are looking after more people who are frail and in need of nursing care in the setting of old people's homes, as surveys of residents in Buckinghamshire and Coventry have shown. The homes are not really equipped to give such care. In these circumstances the idea of an NHS nursing home has a good deal to offer. It can provide nursing care but in a home rather than a hospital setting.

These proposals together would contribute to the immediate aims of the service as we defined them—a high standard of assessment and rehabilitation, better care for psychiatric and for long stay patients and stronger community services. Under present dispositions we are not likely to see these aims achieved in the present century.

5. summary and conclusions

The story of governments and the elderly has a wider significance for our democracy and for our parliamentary system. It shows the extreme difficulty of subjecting to informed scrutiny the actions of the executive on those matters which are generally thought to be uncontroversial. Much of our politics has come to be about the economy and about those few issues which have come to be highly controversial. The attentions of parliament tend to be on these issues and on the routine of economic management. Debates on other matters tend to be infrequent and perfunctory. This leaves government departments in a position of immense and virtually unchecked power. This is a great paradox for democratic socialists. Here, in the heart of government we have the complete absence of any form of regular democratic scrutiny. Information is hard to come by and there is a virtual absence of public or parliamentary debate.

Socialists have always wanted to see increases in public spending, but the moral here is that we have to be more concerned with the distribution of such spending and its pattern—not just with its aggregate rate of increase. Of course this concern with patterns becomes even more important at a time of financial stringency.

There has been remarkably little public debate about the different ways in which governments might help the elderly. Yet there are alternatives. There is a great deal of opposition among many people to our present policies, but it is very difficult within our present framework of government for these different approaches to get a fair hearing. This pamphlet has set out one set of alternatives.

The aims of policy have been to enable the elderly where ever possible to lead a full life in the community, but the actual pattern of spending is in many ways strangely unrelated to this aim. The services as we have them do not reflect an "optimal" pattern. Principally they reflect differing degrees of lethargy or energy among government departments. The issues which are seen officially as important and as requiring action have not changed very much over the last fifteen years. There has been a curious absence of mind on a number of points. There has been no effort to set minimum standards for the community services such as the home help service. There has been little attention to the housing problems of the elderly. Within the NHS the focus has been on the bed norm and much less on the question of quality and training among staff. Some things have been done but equally important issues have been neglected.

Our effort to help the elderly is now distinctly unbalanced. We really cannot continue to make decisions about one kind of help in isolation from others. The aim of this pamphlet is to arouse some questioning and some debate about alternatives—about ways in which the actions of governments might serve more human ends.

Our lives are increasingly influenced by giant bureaucracies. Is it possible for this kind of society to avoid a slow ebbing of humanity and fellow feeling? Is it possible for governments to move away from the lowest common denominator of official caution? As far as the elderly are concerned these are still unanswered questions. The aims of our policies are fairly well agreed. We now look at these different ways of achieving them in the social services, housing and the NHS.

the social services

A large part of the concentration here—and most of the spending—has been on old people's homes. The community services have expanded although patchily. There has been far too little effort to tap the resources of good will and neighbourliness that are there in the community. Our services have been too institutional and too colonised by professionals. We need a more community based service which is more evenly spread across the country. We also need a much greater priority to sheltered housing. The government should (a) stop

building more homes for the elderly except as replacements for former workhouses. The spending should be carried over to the building of sheltered housing, recognising the implications that this will have in terms of extra demands on the community services. At present we are not even providing enough places in sheltered housing to serve the needs of the most promising candidates. (b) set minimum standards for the community services in order to remedy the present grossly uneven distribution. (c) concentrate on a new type of small neighbourhood centre. (d) encourage good neighbour schemes. (e) start joint assessment units as between the health and social services.

housing

Governments have managed to ignore the rather shocking evidence about the housing conditions of the elderly. The facts are well known—but they have had remarkably little influence on spending. We have done little to provide more sheltered housing. We are expecting people who may well be suffering from chronic illness to cope in circumstances which would tax the fittest. Central government in England and Wales has been very lethargic—but some local authorities such as Greenwich, Liverpool and Manchester have begun to take an interest. In fact housing associations have a rather better record than central government.

It is time for a new initiative to get more grouped sheltered housing built. The case is argued for a norm and for additional spending of about £50 million a year. We also need changes in the local authority transfer system to make it more possible for people to give support to their elderly relatives.

the NHS

The pattern of illness found among the elderly suggests the need for a high quality of assessment and rehabilitation and for better community services. Governments have had some of the right ideas—but they have had great difficulty in getting them put into practice. The time scale for change has to be a long one and has to concentrate on changes which have some realistic chance of coming off.

We also need to broaden our focus. We have been concerned with numbers of beds—but not with the quality and training of staff. We have been concerned with care on the wards but not with the commanding heights in the medical schools and the Medical Research Council. We need to back heavily the new geriatric departments in medical schools and to spend much more on medical research, where little is spent at present. The most important change which we can make in the longer term is to build up centres of excellence in the care of the elderly. But we also need new short term initiatives in staffing and training to meet a desperate situation.

On some points such as the placing of assessment beds in District General Hospitals and the care of psycho-geriatric patients, the government is simply going to have to take much firmer executive action than has been customary in the NHS. Finally we need new help to long stay patients and the case is argued for introducing the concept of an NHS nursing home.

The plans suggested here are financially realistic. Many of them involve not new resources but a re-allocation of existing ones. The total sum of new resources required is less than £100 million a year —which is a good deal less than the cost of the travel concessions to the elderly nationally. The plans suggested here would really concentrate effort on those services which are of greatest help to those least able to cope. They would add up to a " new deal " for the elderly.

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