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Working Group on Appropriate Levels for
Continuing Care of the Elderly

Berlin (West), 11-14 November 1980

ICP/ADR 026/11
23 September 1980

ORIGINAL: ENGLISH

RELATIONSHIP OF THE INSTITUTIONAL AND PRIMARY
CARE SYSTEM IN HEALTH CARE OF THE ELDERLY

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1. Introduction

The deliberate use of the term "continuing" in the title of this Working Group has a significant purpose. Care of the elderly often has to do with reduced physical/mental/social functioning due to processes of aging and with their physical/mental disease or disability. Although the Declaration of Alma-Ata rightly emphasized the rôle of the primary health care system in prevention, treatment and rehabilitation of dysfunction, disease and disability, it is true that this system alone is insufficient to provide all the care needed, particularly by certain elderly people. In a relatively small proportion (5-10%) of cases temporary or lasting care in some sort of institution is definitely necessary. This fact, however, does not mean that there should be an absolute dichotomy between the two "systems" of care, although it must be admitted that too often such a separation between them does exist either in reality or in the minds of care consumers and providers.

It goes almost without saying that there should, whenever necessary, be a two-way flow between the two systems and, moreover, a range of so-called transmural services, leading to the establishment of a comprehensive system of continuous care.

Residential centres form the greater part of institutions for the majority of the aged who, without being really seriously ill or disabled, can nevertheless not take care of most household chores (cooking, shopping, cleaning, walking long distances and stairs, etc.). This paper will touch briefly upon the relationship between these and other institutions (hospitals, nursing homes, etc.) and services provided in the community by the so-called primary health care system.

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2. Institutional care

This term can easily cause misunderstanding. In this paper, what is meant, simply, is a building, often rather large, and within which a number of elderly people live for a shorter or longer time, because they themselves or professional/voluntary care providers presume (rightly or wrongly) that, outside, the care of different types that can be provided would be inadequate with regard to the needs. Admission to an acute general or mental hospital is mostly not discouraged because the patient's condition often makes medical diagnosis, treatment and rehabilitation necessary, at least to begin with. One may wonder, however, whether this is right. Sophisticated and specialized facilities, equipment and personnel are not always needed. The nursing home then offers a better solution, also in terms of continuing care as a "station" between community and hospital.

"Nursing home" in this context is probably a risky term, causing not only misunderstanding and confusion, but also giving rise to emotional and dogmatic discussion. In many countries the nursing home is viewed by the professional, patient and citizen alike as an undesirable solution to the problem of dependency in old age. There have been strong calls for alternatives to nursing home care (1). It does not seem useful to enter here into this argument, nor even to question whether the nursing home really evolved as a hybrid between the hospital and the residential home, or even between the hospital and the family. The fact that in several Western European countries, e.g. the Netherlands, with 46,000 beds in nursing homes against 65,000 beds in general (acute) hospitals, many - not all - nursing homes play an essential rôle in the chain of health care services for the elderly will probably not convince those who want to find and develop alternatives. Sound investigations are needed as to why, for what goals and reasons, alternatives are sought so vigorously (concepts of society and the family; real concern for the elderly people in need, specifically those already living in institutions; the focus on prevention of institutionalization; concern for the family members who have to provide a great deal of care day-in, day-out; cost-benefit arguments, etc.). As to this last argument: cost-benefit comparisons often merge numerous health (and closely connected welfare) benefits into an aggregate measure, disregard effects whose magnitude is not well understood and emphasize effects more readily expressed in money over those without a clear market value.(2) It seems to me that especially in old people with certain reduced functions, malaise and disease it will often be difficult to compare "quality of life" in or outside institutions, even if both types of care are optimal (which they seldom are).

3. Community health care

What has been said above is not in any way meant to reduce the very important rôle of primary health care and in a somewhat wider sense community health care. It is evident that if older persons can take care of themselves or can be helped by family, friends, volunteers and easily accessible professional health workers, and if their physical environment can be adapted to their condition, such a "system" of health care will almost always represent the "best" solution. Yet an important rôle must also be played by the older person himself: how much can he and will he comply with the advice and support given to him by the community?

So far, benefits assumed by those calling for massive expansion of home health care to include preventive, health-supportive services for the dependent aged, such as reduced institutionalization, reduced stress among family care givers, and enhanced life satisfaction for the dependent elderly, have not been subjected to adequate research and reflection, according to Dunlop (3). Just one example: everywhere the rôle of the family is stressed as one of the most important providers of community care. But, although relatively much attention is focussed on the victimization of the elderly by strangers, who prey on their vulnerability (which naturally applies partly to institutionalized old people as well), a little empirical work has been done on the maltreatment of the elderly by their own families. Studies in the USA suggest that abuse of the elderly, particularly by their children or grandchildren, may well be as severe a problem as child abuse (4).

4. Continuity of care

From the above it is clear that both institutional and community health services are needed for appropriate levels of health and social care, for certain elderly people, although the emphasis should in general be shifted somewhat to community care. It is certainly time to review the concepts of treatment (for health oriented problems) and care (for socially oriented problems). Thereby we could avoid giving too little care in some ways and too much in others(5).

To ensure more continuity of treatment and care there is a need for the allocation of more resources (financial, personnel, etc.) on the one hand and for the solution of difficulties of the interface between the health and social services on the other.

5. Some possibilities for improvement

One general solution would be to bring health and social services, in the realm of institutional care as well as community care, together in one and the same organization; at the national level in a ministry or department of public health and social welfare (or similar body) and at the regional or local level in a health and social service system. This has been done in some countries, but has by no means solved all problems in securing continuity of care. To solve interface difficulties there is also a great need to establish a system of objectives, criteria and facilities which have been jointly developed and agreed upon, and a procedure by which disputed decisions can be reviewed (5). For that purpose both "parties" have to clarify the objectives of the two types of service (health and social) and the fundamental difference between the two, as well as the difference between treatment and care. Naturally both cannot work well separately.

Many other specific solutions are in various stages of development (planning, experimentation, demonstration and widespread application), including the following:

5.1. Education and training

The various providers of health and social care for the elderly should be educated to think and trained to act according to the concept of continuing care. They must learn to cooperate more closely.

The consumers of care, for their part, should also learn to accept the concept of continuing care; in other words, the transition from community care to institutional care and vice versa is often possible and beneficial. Of course the family members need to know this as well.

5.2. Legislative and regulatory provisions

Clear and strict qualifying conditions, benefit formulae and assessment policies - as instruments for implementation and administration of legislation and other regulations - can help, but certainly not in an absolute way. This does not mean that no legislation or regulation should be tried. Moreover, some financial support from central funds should be used to encourage implementation.

5.3. Community participation

Much more success in providing a continuum (a closed circuit) of care can often be obtained to allow the local community to organize and supervise a comprehensive service system. Admission to local hospitals, nursing homes, residential homes and sheltered care housing, assessment of need for various sorts of "open" (domiciliary) care available in a particular community, and the planning and development of new or additional services, should in general also take place at the local level.

5.4. Transmural facilities

Various transmural provisions should be developed or expanded. Some of these are more or less institution-based; the majority, however, are community-based.

The first category of facilities includes:

- Outpatient clinics (polyclinics, dispensaries, etc.) and particularly geriatric departments of general hospitals. Sometimes large nursing homes (for physically/mentally disabled old people) may also have outpatient clinics. An important function of the outpatient clinics - and of other hospital facilities - is to assume responsibility for cooperation with extramural services in coordinating treatment and care so as to ensure its continuity. In some countries this also involves extensive mobile out-reach services (e.g. home visits and consultations by geriatricians or other physicians, nurses, physiotherapists, social workers from and based in the hospital/nursing home), while in other countries providers of extramural care participate in certain intramural activities. At present the former system is still predominant. Long-term care by a well-organized medical outpatient department can often be essential and supplementary to care provided at home and at the community level (6).
- Day-care units (day hospitals, day centres) connected to hospitals, nursing homes or residential centres. Such units can also be used for diagnostic and therapeutic purposes and for medical and social home care. Major activities within day-care units include physical, occupational and recreational therapy, dietary treatment, institution and supervision of drug therapy, and health education and information.
- Health centres (sometimes more or less exclusively for the elderly). Such centres, which are often independent from a hospital or nursing home, may provide the same services as day-care units, while sometimes their activities are more limited to screening and health education.

As regards residential institutions (residential centres, homes for the elderly, etc.), growing attention is already paid to using them more extensively in the continuum of care. Such homes can also serve old people living in the district in which the home is located, e.g. by providing day-care, opportunities for participation in social, cultural and sociomedical activities for residents, and hot meals; serving as a centre for an alarm-system; and making it possible to admit on a strictly short-term, temporary basis certain elderly persons in case of emergency or to allow family members to go on holiday. (Sometimes nursing homes offer the same opportunity for more seriously ill/disabled old people, who are taken care of by their families). Nursing homes and residential homes can, moreover, occasionally admit a few old people for night care only.

By integrating a residential centre more closely in the community services, residents may also participate to a greater extent in community service centres, clubs, outings, etc.

Other community-based provisions of importance in promoting continuity of care are:

- Community service centres, which in principle provide more social services than health services, including the provision of hot meals, recreational activities, counselling; assistance with bathing; home-help; chiropody; gymnastics; health education. Often they operate as a sort of social day centre.

5.5. Community services

A specific community service is the provision of sheltered housing. Old people living in this sort of accommodation receive some assistance (e.g. hot meals, cleaning, janitor, alarm-system), but less than in a residential centre. A similar provision is service flats, i.e. a building with apartments, where the occupants may (but do not have to) obtain services such as those in sheltered housing.

The special houses for old people are small units designed in such a way that old people can live more easily, and often with less support, than in "normal" houses.

Well-organized and functioning home-nursing and home-help services are of considerable importance at community level. In this connection, the essential rôle of the general practitioner (primary physician) should be stressed, although quite often the home-nurse has an equally important rôle.

6. Final remarks

There is often no clear-cut distinction between transmural and extramural services. Although this sometimes leads to administrative difficulties, easy transition between the two will often ensure more continuity. A fundamental need remains that of developing an integral comprehensive system of health and social care, both intramural, transmural and extramural for the whole population including the elderly, especially at the local level. Naturally self-care and self-help should be included in this system. The real potential of this type of care and that of volunteers has, however, only sketchily been studied so far.

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