The elderly at home: service needs and provision

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SUMMARY. This paper arises from research to develop a profile of the elderly living in the community. Data are presented from interviews with a stratified random sample of 1406 elderly people living in the Trafford area of Greater Manchester. The findings suggest that in reality community care for the elderly means care by lay carers. Assistance with all tasks ranging from intensely personal care, for example bathing and dressing, to the practical household tasks, such as cooking and cleaning, was more often provided to the elderly by spouses and daughters/daughters-in-law than by the statutory services.

It is suggested that some form of eligibility criteria may be used either consciously or unconsciously by general practitioners and other health care workers when referring elderly people to the nursing and social services which may mean that the statutory services do not complement the care given by lay carers. Furthermore, the presence of a lay carer may prevent the situation coming to the attention of the primary health care team.

Introduction

THE increasing number of elderly people as a proportion of the total population, coupled with financial constraints and changing philosophies of care has, over the last 10 years, brought the concept of 'community care' to the forefront of health and welfare service provision.[1-3] As a result health authorities are exhorted to develop a more comprehensive range of services to enable 'priority' groups such as the frail elderly to live in the community. At the same time, however, cutbacks in public expenditure have forced health authorities to make choices and decisions as to where their priorities lie. If the planning of services is to become more responsive to the needs of the client the way in which policies are translated into actual services must be considered. Although the overall guidelines and economic boundaries are determined by government and then interpreted at district and local level, it is the service providers such as general practitioners who ultimately choose the priorities and who play a crucial role in deciding who gets which service.

This paper is based on a large-scale survey of the elderly living in the Trafford area of Greater Manchester which was commissioned by the health authority to provide a data base from which services could be planned. The aims of the study were to determine the functional abilities and support networks of those aged 65 years and over living in Trafford; their use of nursing and nursing-related services and the relationship between their functional ability and their use of services.

This paper focuses on those variables which relate to the division between statutory and lay care.

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Method

A structured interview schedule was developed which drew on the work of Carstairs[4] and Hunt[5] and focused on the elderly person's perception of their functional abilities in activities of everyday living. In addition a life satisfaction index[6] and mental status test[7] were included along with indicators of the respondent's social and environmental conditions.

A random sample of people aged 65 years and over was drawn from the case lists of all those general practitioners who had patients residing in Trafford and was then stratified according to age, sex and geographical location in order to reflect the total elderly population.

Interviews were carried out by a field work team in the home of each respondent over a one-month period. Each interview took between 45–90 minutes, and individuals with a score of 6 or less on the mental status measure were excluded from the study because their responses may have been unreliable. Proxy interviews were sought where a relative, close friend or cohabitant was available.

Results

The sample interviewed comprised 1406 over-65-year-olds (3.8% of the total elderly population of Trafford).

Despite the close association between advancing age and disability, the majority of the sample were not functionally impaired; 93% ($n=1304$) of respondents believed their health to be fair or good and the numbers of those unable to perform a range of activities of daily living was small (Table 1). More elderly people had problems with mobility outside of the home and getting into and out of the bath than with mobility inside the house, getting dressed or light housework. Problems with incontinence varied according to the specific nature of the problem and the time of day. Stress incontinence presented the biggest problem (13%, $n=178$), with daytime incontinence (9%, $n=122$) and night incontinence (3%, $n=44$) experienced by fewer numbers.

Contact with all statutory services, with the exception of the general practitioner, was minimal; only 7% of the sample ($n=96$) had been visited by the district nurse and less than 1% ($n=9$) had been visited by the health visitor in the month preceding the study. However 29% ($n=402$) had received chiropody and 14% ($n=199$) home help services. The most frequent source of contact with the health service was with the general practitioner; in the previous three months 58% ($n=813$) of respondents had been to see their doctor.

The greatest overlap of domiciliary services was between the home help and chiropody services (9% of the sample received both services, $n=121$), the district nursing and chiropody services (4% received both, $n=52$) and the district nursing and home help service (3% received both, $n=43$). When three services are considered the overlap is further diminished with only 2% of the sample ($n=34$) receiving district nursing, chiropody, and home help services.

When assistance with each activity of daily living was analysed the statutory services were found to be only minimally involved in helping the elderly with their day-to-day activities (Table 1). Only 10 elderly people received help from the statutory services with mobility outside, one person had help with mobility inside and one had help with getting dressed. More help was provided for getting into and out of the bath (14 people), and light housework (37 people). Spouses, daughters and daughters-

Table 1. Ability to perform certain tasks and sources of help for the 1406 elderly respondents. Number of respondents shown with percentage in parentheses.

	Performs task with difficulty[a] (% of total sample)	Unable to perform task[a] (% of total sample)	Receives help with task (% of total sample)	Source of help: Spouse	Daughter/ daughter-in-law	Friends	Statutory services	Other	Overlap between lay and statutory services
Getting about outside on level surface	326 *(23)*	106 *(8)*	151 *(11)*	52	53	29	10	7	5
Getting about inside on level surface	130 *(9)*	12 *(1)*	37 *(3)*	18	13	–	1	5	1
Getting dressed	90 *(6)*	20 *(1)*	39 *(3)*	23	12	–	1	3	–
Getting into and out of bath	403 *(29)*	140 *(10)*	125 *(9)*	44	37	2	14	28	4
Light housework	118 *(8)*	89 *(6)*	171 *(12)*	88	37	3	37	6	10

[a] Some subjects had difficulty with more than one task.

in-law, however, were responsible for the majority of help with activities of daily living (Table 1). Problems such as incontinence, despite posing a large burden on any family, were also dealt with predominantly within the family. Six per cent ($n=80$) of the elderly people had help with extra washing for incontinence difficulties but statutory services, in the form of home helps, assisted in only four of these cases. In nearly half the cases where help was received with extra washing this was provided by spouses ($n=16$) and by daughters/daughters-in-law ($n=16$), but the individual dealt with washing themselves in the majority of cases ($n=42$).

Although there was no statistically significant difference in selected functional abilities between those who lived alone and those who lived with others, the district nursing and home help services were more likely to be provided to those who lived alone. In the case of home helps this was statistically significant ($P<0.05$, chi-square test). Services such as meals-on-wheels, luncheon clubs and day centres were utilized in only a small number of cases; no more than 9% ($n=133$) of the sample visited a day centre and only 3% ($n=39$) received or used either of the meal facilities. It was also rare to find informal support supplemented by statutory services (Table 1).

In some cases there was no help available to individuals who perceived themselves to be unable to perform an activity unaided. Twenty-nine elderly people who said they were unable to get into or out of the bath (2% of the sample) had no one to help them. Similarly, particular services were not received by those who would have benefited from them, for example, only half of those who stated that they experienced problems of incontinence actually received an incontinence aid.

When those not receiving a specific service were asked if they thought that they required it 20% of the sample said they needed chiropody ($n=272$) while only 4% needed the home help service ($n=62$).

Discussion

The findings of this study suggest that in reality community care for the elderly means care by lay carers. Assistance with all tasks ranging from intensely personal care, for example bathing and dressing, to the practical household tasks, such as cooking and cleaning, was more consistently and extensively provided to the elderly by spouses and daughters/daughters-in-law than by the statutory services.

The finding that few lay carers receive support and assistance from the statutory services is not in itself new.[8-12] However, the reasons for this are not clear. It may be that the very essence of the lay carer–dependant relationship defines the amount and type of contact with, or approach made to, the statutory services. Alternatively it may be that the services are rationed by those who provide them according to universal but unspoken criteria. This concept of rationing is reinforced by the presence within the data of a number of other social criteria which appear to play a more important role in service delivery than the actual functional abilities of the elderly person. It was found that elderly people who lived alone were more likely to receive a service than those living with others. This would be a logical basis for the allocation of resources if elderly people at home alone are actually at greater risk than those who live with others. However, this overlooks the well-established networks of support from friends and neighbours that the elderly who have always lived alone may have developed over time.[13]

It is not clear from this research whether the general practitioner filters out those individuals who have a network of support or whether the community nursing service uses its own criteria to assess the situation before deciding whether or not to visit or whether to withdraw their service as soon as it becomes known that a carer is 'available'.

As the study showed, most of the informal care was carried out by women. It may be that where there is a female relative present elderly dependants are assumed not to need hospital or domiciliary care. While it may be true in some cases that women are more willing and able to undertake a heavier burden of care than men, it is likely that many women feel obligated to provide this care and it should not therefore be used as a guiding principle for the allocation of nursing and social services resources in the community.

Amid this paucity of statutory support it seems misguided to be concerned, as policy makers are, with the issues of collaboration and cooperation. There is no evidence from this research to suggest that the problems of caring for the elderly originate in the multiplicity of services that 'tread their way up the garden path'. Rather the problem lies with the professional attitudes which determine, within the broader economic constraints, the precise nature of the service delivered.

Whatever the process of providing services for the elderly, it is apparent that at this practice level rational planning is replaced by rationing. It is unlikely that carers will find their burden eased unless there is a change in professional attitudes. The value of carers needs to be acknowledged in future policy decisions but this must be done in a way which avoids further entrenching their role by institutionalizing and reinforcing the social and familial obligation to care at whatever cost.

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