Contemporary Themes

Falling rate of provision of residential care for the elderly

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Abstract

The rapid increase in the number of very aged people has not been accompanied by appropriate expansion of local authority residential facilities. The rate of provision in 1976 was already acknowledged to be inadequate, but data are now presented to show that since then there has been an effective fall in the rate of provision of some 9000 places—equivalent to, say, 180 old people's homes of 50 places each. The prospects for the future are even gloomier: public spending cuts and local authority priorities suggest a continuing fall in the rate of provision that can be expected to have a profound effect on the National Health Service, on the burden on families, and on the condition in which old people are obliged to remain "in the community" (where support services have likewise failed to keep pace with demographic change).

At the beginning of this century there were not far short of 100 000 old people in Poor Law institutions—6% of the population aged 65 and over. Old age pensions and the 1948 National Assistance Act worked a marvellous change, and many who previously would have had to enter the workhouse to secure a roof over their heads were now able to live on their own or with their families. By 1952 the number of old people in local authority care had been halved, despite the growth in the size of the elderly population.¹ Perhaps it is partly because of the legacy of distaste for the old Poor Law institutions,

coupled with the persistent myth that the homes for the elderly that replaced them are still full of fit elderly people with no real reason for being there, that there has not yet been a public outcry about the inadequate provision of residential care for the elderly today.

The 1948 Act required local authorities to provide "residential accommodation for persons who by reasons of age, infirmity, or any other circumstances are in need of care and attention not otherwise available to them." This accommodation, often termed "part III" after the appropriate section of the Act, was to be provided in small, comfortable homes more akin to hotels than to the old Poor Law institutions. This transformation has largely been achieved, and most of today's homes for the elderly bear little resemblance either to the old institutions or to the sad homes so vividly described 20 years ago by Peter Townsend in *The Last Refuge*.² The residents of part III now are not fit elderly people obliged to accept a place in an institution through poverty or a lack of suitable housing, but very aged and disabled people often needing personal care and almost constant attention. Recent studies such as those in Leicester³ and Manchester⁴ have shown that many part III residents are highly dependent, and often suffer from dementia. The average age of a newly entering resident is now nearly 82.⁵

Demand for part III accommodation: age and dementia?

The numbers of people needing the type of care provided in residential homes have been rapidly growing as a result of the increasing size of the very elderly population. This increase in the number of very old people has naturally also led to an increase in the number of people afflicted with age-related mental and physical disabilities, of which that most likely to generate need for institutional care is dementia. Kay and his colleagues⁶ in the 1960s found that the prevalence of moderate or severe dementia among the whole population aged over 65 was about one in 15, but the prevalence among the over-80s was just over one in five. Since then the over-80 age group has

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grown faster than any other, and so these age-specific dementia rates applied to today's elderly population show a total prevalence rate of one in 10 among the population aged 65 and over.

It is of the nature of dementia—a many-sided deterioration of memory, of personality, and of thinking and coping ability—that sufferers need the same “around-the-clock” surveillance as do small infants; their dependency is essentially the same. They lack everyday skills, judgment, and capacity for self-care, for maintenance of warmth and nutrition, and for protection against common dangers. Like infants, demented people will get one up at night over and over again, will disturb neighbours, and are at perpetual risk of accidents. Not all these needs can be met, and some risks must be taken; but the exponents of the philosophy of “risk-taking” with the elderly would carry greater conviction if they were as ready to apply the same principles to small children, and if it were obvious that they had considered not only the confused old lady's risk of being run over by a passing car but also the predicament of the passing motorist who kills her.

Be that as it may, institutional care exists precisely because it is the most cost-effective way of looking after groups of people with similar disabilities. The size of the group with the multiple disabilities of old age, and the number of old people with dementia, is predictable with an exactitude possible in almost no other field of public policy. The planning ahead of, say, primary school places or new roads depends on largely unpredictable fluctuations in fertility rates or the price of petrol. The elderly of the future are already here; indeed, barring massive migrations or catastrophes, the only direction in which our estimates of their numbers are likely to need revision is upwards. Mortality rates among young people are now so low that any future improvement in life expectancy will probably result only from success in our attack on the killing diseases of late middle age—which will lead to a further aging of the population.

Provision of part III accommodation: DHSS guidelines

The DHSS guideline on the appropriate level of part III provision was set in the early 1970s at 25 places per 1000 population aged 65 and over.⁷ Very few local authorities have approached this level of provision, and it has now in effect been almost abandoned, although still referred to in government publications.⁸ The reference population (over 65s) specified in the guideline is in any case inappropriate, given that the average age of admission to part III is over 80.

Rates of residence standardised for age and sex

To determine whether the provision of part III places has kept pace with the growth in the number of very old and disabled people it is necessary to examine rates of provision standardised for age and sex differences. We have done this for the years since 1976, and the results are shown in the table. The 1976 sex-specific residence rates for those aged 65-74, 75-84, and 85 and over have been applied to the number of old people in each age group (as estimated by the Office of Population Censuses and Surveys) in subsequent years to calculate the number of part III places that would be needed for the rate of provision to remain constant. Comparison of the expected number of supported residents and the observed number in each year allows calculation of a residence ratio standardised for age and sex. It may be seen from this that the rate of provision fell by nearly 5% between 1976 and 1980 alone. Provisional estimates, kindly provided by the DHSS (subject to revision), of the number of local authority supported residents in 1981 show not only a further fall in the rate of provision but also an absolute fall in the number of residents. If provision of part III places in 1981 had been made at the same rate as in 1976 there would have been just under 126 500 supported residents in England rather than under 117 500, so in real terms provision

has decreased by over 9000 places in six years. (At the same time the number of part III places used for short-stay admissions has increased. Holiday, rehabilitation, and “assessment” admissions are an excellent idea, but this provision is needed in addition to long-stay provision rather than by reducing the number of long-stay places available.)

Local authority supported part III residents, numbers observed and numbers expected from 1976, and age and sex specific residence rates, England 1976-81

Year	Observed	Expected	Standardised residence ratio
1976	115 111	115 111.0	100.0
1977	116 564	116 683.2	99.9
1978	117 878	119 153.9	98.9
1979	117 136	121 227.3	96.6
1980	118 813	124 105.4	95.7
1981	117 483	126 496.2	92.9

Sources: DHSS, PSS LA statistics RA1, RA2, and RA3 returns (some figures provisional).⁹ OPCS, population estimates and population projections.

Planned provision of part III places and public expenditure: the past five years

1976 was chosen as the base year not because the level of provision then was considered adequate (it fell short of the DHSS guideline by 43 000 places) but because it was in that year that the then government issued its consultative document *Priorities in Health and Social Services for the period 1976 to 1980*.⁹ This included recommendations on the provision of part III places that even then took into account restrictions on public expenditure. It was recognised that an extra 2500 places a year would be needed simply to keep up with growth in the size of the population aged over 75 (if the over-85s had been separately considered this figure would have been even higher). As a result of financial restrictions, it was proposed that only an additional 2000 part III places would be provided each year. Yet even this short-term target, which already accepted a fall in provision, has not been met. Even more worrying is that local authorities have been unable to achieve the very slight expansion in the number of part III places that they planned in 1977 and 1978. In both these years local authorities were required to submit local authority planning statements^{10 11} to the DHSS showing their intentions for the subsequent three years. In both sets of LAPS returns the planned expansion fell some way below the growth in part III necessary to maintain existing rates of provision, and also below the interim target suggested by the DHSS; but even those very modest plans have not been achieved. Figure 1 shows for 1976-81 the discrepancy between the actual level of provision of part III places and the provision planned by local and central government. The gap between the observed number of supported residents and the number there would have been had the 1976 rate of provision been maintained is even wider.

The next five years: no plans and more cuts?

We have shown that in the past six years there has been a relative fall of 7% in the rate of provision of part III places. Local authorities have been unable to fulfil modest plans for expansion which would, even if achieved, have only partially met the increased pressure on resources caused by the aging of the population. This in itself is serious enough, but the prospects for the immediate and long-term future are even more alarming.

For most of the period since 1976 local authorities have been asked to cut back on planned growth. During the period 1975-6 to 1978-9 personal social services expenditure grew at an annual rate of 3.3% (although expenditure on part III grew at only 2.2% a year⁵). The position now is that local authorities are

FIG 1—Residents supported by local authorities in part III accommodation: numbers observed, planned, and expected, England 1976-81.

being asked not merely to restrict planned growth but actually to cut back on current levels of expenditure until at least 1983-4.¹² This is already showing its effect on the provision of part III places. In 1980-1 the opening of at least eight establishments for the elderly was delayed or abandoned for financial reasons.¹³ (Not all of these were residential homes for the elderly; the information available does not distinguish between different types of establishment.) Although this number of establishments is small, it indicates the seriousness of the situation, for failure to use capital plant on which debt charges are payable is a grossly uneconomical way of economising and a measure of desperation. More vulnerable to cuts is expenditure on supporting residents in private and voluntary homes. The DHSS noted in their recent report on community care⁵ that voluntary provision of residential accommodation seemed to have fallen. The figures available suggest that the rate of support by local authorities for residents in private and voluntary homes has fallen by more than the rate of provision in local authorities' own part III homes. (It is impossible to be more precise because the DHSS collects information on supported residents both from local authorities and from private and voluntary homes and the information provided from the two sources does not always tally.)

Ironically, in the most recent White Paper, *Growing Older*,¹⁴ the government emphasises the importance of the private and voluntary sector in providing residential care for the elderly.

In the same document it is conceded that the provision of residential care falls below needs in many parts of the country. The DHSS report on community care acknowledged that, "there may be a tendency to underestimate the core of elderly people who in the long term require residential or hospital care."⁵ In *Care in Action*, the DHSS handbook of policies and priorities, health and local authorities were urged to "maintain an adequate provision for the minority of elderly people requiring long-term care in hospital or residential homes."¹⁵ Unfortunately, none of these documents indicate where local authorities are to find the money to fulfil their obligations to the elderly needing residential care.

Even if local authorities are able to protect expenditure on residential care and maintain the same number of places during the period of cuts planned until 1984 this will represent a further reduction in the relative rate of provision, for the numbers of very elderly will continue to increase. This assumption may be over-optimistic, for although the elderly are deemed a priority

group in *Care in Action*,¹⁵ services for nearly all the other traditionally protected groups are also accorded priority status. Furthermore, as indicated above, during the period of restricted growth in expenditure of 1975 to 1978 residential services for the elderly were particularly hard hit, suggesting that local authorities do not necessarily regard this as a priority sector.

Surprisingly, what provision of part III places local authorities plan to make in the next few years is unknown. Since 1978, local authorities have no longer been required to report their intentions in this regard to the Secretary of State. This means that the only systematic information available on the provision of part III places by individual authorities is retrospective. It also means that the government cannot know in detail either what is planned, or what effect its local government expenditure cuts are having on these plans. It is one thing to accept that cuts have their cost; it is quite another not to be counting that cost.

The next 20 years

It is not only the present and the immediate future that causes concern. By the end of the century the number of very elderly people will have increased still further, and over 32 500 additional part III places will be needed in England *simply to ensure provision at the same rate as in 1976*. Figure 2 shows the number of places required in 1981-2001 as determined by the 1976 rate of provision and the size of the elderly population as projected by OPCS. The number of places needed to meet the

FIG 2—Residents supported by local authorities in part III accommodation: projected numbers according to 1976 age and sex specific rates and DHSS guidelines, England 1981-2001.

DHSS guideline of 25 per 1000 population over 65 is also shown. The DHSS guideline relates to places rather than supported residents and so the numbers have been adjusted downwards, on the assumption of an occupancy rate of 95%, in order to make them compatible with other figures based on rates of residence.

The number of places required according to this DHSS guideline remains fairly constant to the end of the century because of the levelling off of the number of people aged over 65. If this guideline were adjusted to take account of the aging

of the elderly population it would continue to rise, just as the number of places needed according to 1976 age and sex specific residence rates continues to rise. The effect of adjusting the DHSS guideline to take account of changes in age structure has been illustrated in fig 2.

Conclusion

One of the self-inflicted wounds of our Welfare State is the disarticulation of health services and social services from each other. Much has been done to bridge this divide, but the fact remains that social services departments plan and operate, and are financed, largely independently of the health service; yet the health service (the largest client group of which are the elderly) depends on the provision of complementary social services. No better example of how this may still be forgotten even by central government is in two separate but significantly related references. One, a recent government report on the care of the elderly hospital patient,¹⁶ discusses what can be achieved by a geriatric service with a given number of beds. The second, in the simultaneously published report on community care⁵ already referred to, is the statement that, "the number of residential places . . . will fall considerably short of what is desirable." But one cannot legitimately speculate on sufficiency of beds without considering complementary provision. No geriatric service can cope if the total local "pool" of places falls too low as a result of deficiencies in the residential sector. Of course, there is plenty of scope for debate as to the best balance of care between the NHS and local authorities; but this is a separate issue that does not affect the combined total of places needed.

The age-related rate of provision of part III has already fallen and seems certain to fall further unless urgent action is taken. Community care cannot provide a real alternative to residential care for those who need around-the-clock support and live alone, but in any case DHSS returns show that since 1978 the provision of home helps¹⁷ and meals-on-wheels¹⁸ has also failed to keep pace with the aging of the population. Unless central government provides more money to increase the provision of part III in line with the growth in the number of the very aged, the only result can be further pressure, not only on already overstretched beds in departments of geriatrics (which in some parts of the country, such as Devon, cost over five times as much a year as part III places⁵) but also on the beds of almost all other specialties. Too few residential places mean a heavy increase in the number of very aged, disabled, or demented people who place

their families under cruel stress, or, if they have no families, suffer neglect "in the community."

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