What is long term care for the elderly?

THE DANISH EXPERIENCE

Report of a conference
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Almost a year ago, in June 1978, a small multi-disciplinary group consisting of two doctors, a nurse, and a social worker spent a week in Denmark studying the Danish approach to care of the elderly. The visit sprang out of a seminar on the management of chronic illness held at the King's Fund Centre at which one of the participants was Dr. Esther Ammundsen, until recently Director-General of the Directorate of Health in Denmark. Her comments on the differences between the Danish and the British patterns of geriatric care inspired Mr. Graham Cannon, Director of the King's Fund Centre, to sponsor the visit to Denmark by Professor Peter Millard, Professor of Geriatric Medicine at St. George's Hospital, London; Dr. Colin Godber, Consultant Psychogeriatrician, Southampton; Miss Mollie Clark, Divisional Nursing Officer, Southampton; and Mr. Roger Burton, Senior Social Worker, Merton Social Services Department, London.

On Tuesday, 20 March 1979, the first of two conferences was held to examine the Danish experience of long-term care for the elderly, with three distinguished speakers from Denmark: Dr Ammundsen herself to describe general aspects of the subject; Dr. O. Zeuthen Dalgard, Chief Physician at Bispebjerg Hospital, Copenhagen, to discuss geriatrics and long-term medicine; and Mr. Frede Toftgaard Jensen, Director of Social Services at Odense, to talk about community care and social services. The four members of the visiting British group also gave brief impressions of their study tour.

That the conference was heavily oversubscribed demonstrates the eagerness that exists among those caring for the elderly in this country to find out

how other nations look after their old: what medical and social services they offer, what position in society is accorded to the old, how responsibility for their care is shared between the family and the State, and what support an old person may expect as his right once he is unable to support himself. Hearing of home helps available six hours a day seven days a week, of meals on wheels supplied every day and not just three times a week, of a regulation laying down that in local authority nursing homes every resident must have the privacy of a single room with toilet and washing facilities, and that even in the corner of a hospital ward elderly patients are encouraged to have their own possessions around them, must have aroused some envy in the audience.

Speaking first, Dr. Ammundsen said she would try to throw some light on the differences that exist between the Danish and British systems of care. There are many choices for every country to make where fewer families are accepting responsibility for looking after their elderly relatives, throwing an ever-increasing burden on the State. These choices are,

1. who should pay - the family or the public
2. who should establish the necessary management structure - central or local authority
3. which authority should have responsibility for management - the health or the social services? If the responsibility is shared, how should it be divided?

It is in the latter field, Dr. Ammundsen said, that the greatest differences in principle exist. Every country has two separate systems for health and social services, but she had concluded, after participating in innumerable discussions on the need for combination, integration, and co-ordination of these services, that these two systems had to learn to live and work

together, but that complete integration was merely wishful thinking, and would never become reality.

Dr. Ammundsen confined her talk to somatic care in hospitals and residential homes. Hospitals, she said, are the pride and flower of the Danish health service, but they are intended for temporary stay only and have a rapid turn-over of patients in order to justify their enormous expenditure on elaborate equipment and highly skilled personnel. This fact has influenced hospital design: several patients are expected to share one room, and even in the most modern hospital buildings there are only a few single rooms. The social services, on the other hand, which have responsibility for providing care for their institutional clients for the rest of their lives, take a different view. At first their old-age homes were intended for people who could still take care of themselves but who required board and lodging and also, perhaps, company. The inhabitants of these homes often needed nursing care at some stage, so a new type of home was developed known as nursing homes or rest homes. While the original old-age homes were administered and financed by the local municipal and parochial authorities, the newer homes were often privately financed, with some support from local authorities, who were obliged by law to support their chronic sick and elderly.

The design of these homes has been dominated by the principle that everyone has the right to privacy, and that this right should continue to be respected in sickness or in old age. A circular from the Ministry of Housing issued in 1952 stated that all inhabitants of old-age and nursing homes should have their own rooms, and that married couples should have two rooms with a connecting door. A two-bedded room must be the absolute exception.

TABLE 1

Development of old-age homes and nursing homes in Denmark

	old-age homes				nursing homes			
	public	private	in all	beds	public	private	in all	beds
1960	700	100	800	2200	25	330	355	7800
1967	695	55	750	20000	65	380	445	10500
1977		0			950	410	1360	48000
1984	(planned)	0						52000

Showing her first table, Dr. Ammundsen said that the development of old-age and nursing homes during the years following the second world war presented some interesting characteristics (table 1). The main differences between these two types of home lies in the buildings and the personnel. Eighty-five to ninety per cent of the rooms in both are private, where the resident can have his own furniture and other possessions, but the nursing homes are much better equipped with sanitary facilities (all new rooms having their own bathroom, with shower and toilet), and with facilities for physiotherapy and occupational therapy. There are also better service rooms, and access to fresh air by means of a balcony, terrace, or garden. Regarding personnel, the main difference is that the old-age homes have no permanent nursing staff, while it is compulsory for the nursing homes to have permanent nursing personnel. Today about 4,000 registered nurses and 11,000 nursing aides with one to two years' hospital training work in the nursing homes, whose total number of beds is 48,000.

In the 1960s the need for old age homes in the traditional pattern was queried. It was considered better for people independent of nursing care to live in pensioners' flats, sheltered housing, or with support from the social services in their own homes. The municipalities were therefore encouraged to build nursing homes, and better State support was made available to approved nursing homes than to old-age homes. By 1973 the old-age homes had officially disappeared, leaving a widespread and comparatively well-equipped system of nursing homes.

This is the great difference between the United Kingdom and Denmark. In Denmark there is a strict policy that hospitals should only be used for temporary treatment and examination. As soon as a condition is considered to be long-term, and the patient in need of continued medical and nursing

care, responsibility for him is transferred to the social services, who - with medical and nursing advice - must decide what should be done for him and, if necessary, admit him to a nursing home. In Denmark, however, as in other countries old people are maintained in their own homes for as long as possible. So the dividing line between health and social services lies at the gates of the hospital; and there are no permanent or long-stay patients in hospitals (except in psychiatric hospitals).

Denmark differs from most countries in this respect, Dr. Ammundsen commented, where long-stay hospitals are often supplemented by private nursing homes and by local-authority old-age homes. She recalled that in the late 1950s and early 1960s there had been such a powerful propaganda campaign for more nursing homes that the Danes were led to believe that everyone would go straight into a nursing home on reaching their 65th birthday! The authorities had been struggling against this misconception ever since, but it had also led to institutions being established by various charitable organisations such as the Red Cross, religious bodies, trade unions as well as by private enterprise amounting to about 230 institutions with a total of 7,000 beds. Two-thirds of these institutions and half the beds were in so-called 'leader-owned' homes, many of which were subsidised by public funds. Recognising that this trend might get out of hand, the Government passed a law in 1964 stating that no new leader-owned nursing homes could be approved for contracts with local authorities, and since then this type of institution has almost disappeared. The self-governing private institutions which have contracts with public authorities and are subject to the same requirements and control as communal institutions now represent one-third of all homes, but they are almost entirely funded out of public revenue.

Dr. Ammundsen went on to explain that in principle everyone who is in need of nursing care can be accepted into a nursing home. The majority pay by surrendering their old-age pension, in return for which they get board and lodging, medical and nursing care, medicine and pocket money. Those with an income additional to their old-age pension pay up to a maximum of sixty per cent of their income after taxation. Their savings or capital, if they have any, are left intact. No one pays the full cost of a place in a nursing home, which is in the region of £15,000 to £16,000 a year.

Some social administrations had tried to develop their own geriatric hospital system by equipping their larger institutions with diagnostic facilities, laboratories, and X-ray departments, but now the health and social service authorities have agreed that there should not be parallel hospital systems dividing the patients by age, so these new geriatric hospitals have been absorbed into the national hospital system - in which, Dr. Ammundsen remarked, patients over 65 consume about half of the total expenditure.

She went on to say that this system of institutional care for the elderly and chronic sick has been built up over a period of twenty years; it is not yet complete, nor is it without its difficulties. One problem stems from the very decentralised system. Local municipalities are very powerful and brook no interference; conditions consequently vary greatly in different localities (table 2).

Dr. Ammundsen said that one of her favourite theories is that it is no use trying to compare or use as a planning unit the over-65 age group, which is commonly done. Between the ages of 65 and 75 the population uses only a small proportion of the public services more than the population as a

TABLE 2

Distribution of nursing-home beds pr 1000 inhabitants

in Denmark 1977

	Fig 1 65 years and over	Fig 2 75 years and over
Copenhagen City	47 (63[x])	122 (164[x])
Frederiksberg City	61	146
Copenhagen County	55	162
Frederiksberg "	91	246
Roskilde "	84	231
West. Zeeland "	76	195
Storstrøm "	85	217
Bornholm "	76	195
Fyn "	61	159
South Jutl. "	61	167
Ribe "	71	190
Ringkøbing "	100	270
Aarhus "	75	203
Viborg "	83	221
North Jutl. "	74	198
Average	69	183

x) included app. 2000 purely psychiatric beds

whole. The real need for services comes from the over-75 group, and still more from those over 80 (figs 1 and 2). Thus 65 and over is an irrelevant group for planning purposes.

Referring again to table 2, she said one problem was insufficient coverage in certain areas, caused partly by the lack of a reporting system. Now, however, the facts and figures from each local authority, and details of their 5-year plans, are published so that comparisons can be made between areas. This should eventually have an equalising effect.

Where there are insufficient nursing homes, patients have to wait for places either in hospital or, preferably, in their own homes, or perhaps in one of the few remaining old-fashioned institutions. In Copenhagen particularly this has led to so-called "waiting departments", which are inadequately staffed and equipped: a situation which Dr. Ammundsen deplores.

It might be asked, she continued, whether the health services had abrogated their responsibility for the old by accepting the principle that every individual has a right to privacy, since this is inconsistent with proper medical treatment and efficient nursing care. But she pointed out that health personnel have a strong influence, and work in close co-operation with the social services and housing ministries in setting standards for the building and equipping of accomodation for the elderly. Specialists in long-term care have a say in the type of care offered to the patient and, where no such specialist exists, this is the duty of one of the chiefs of the hospital medical department.

Every nursing home has a general practitioner in attendance though patients are free to be attended by their own doctor should they prefer. If they become acutely ill they are transferred to hospital. There is no fixed

number of nurses per bed in nursing homes, as the needs of the patients are so varied, so the doctor in charge of the patient's assessment must know the conditions prevailing in the homes in his area before referring the patient to a particular home. The personnel ratio in Denmark varies from 0.25 to 1.25 per bed; the average is 0.75 per bed. The district health officer is responsible for inspecting and controlling the nursing homes.

Referring briefly to psychiatric hospitals, Dr. Ammundsen said that until recently these had been financed and administered exclusively by the State, and had followed the usual pattern of very large hospitals often situated in the countryside. Now responsibility for psychiatric care has been decentralised and passed to local authorities, so that the psychiatric hospital system can be fully integrated with the acute somatic hospitals. Patients are accepted for both short and long-term stay, though where their condition is permanent they may be transferred to a smaller special home.

With the growing pressure on nursing homes, due to the increase in the elderly population, other solutions to care are being sought in the form of sheltered housing, collective housing, day homes, day centres etc. Of these sheltered housing is most popular, and it is planned to increase the number of apartments available from 3,700 to 8,400 over the next five years. The personnel required number about 20 to 25 per 100 apartments. They are often built in proximity to a nursing home or other institution; so far they are mainly to be found in Copenhagen and other large cities, but they will become widespread in the future.

TABLE 3

Social welfare expenditure 1975/76

for population aged 65 and more

13% of total population

BNP 1975 227000 million d.k.

Consumption 1975 170000 million d.k.

Old age pension	9700
Primary health service 1/4 of total 4100	1000
Secundary health service 1/2 of total 8900	4500
Nursing homes	3800
Homehelp, other welfare services	1100
Rent subsidies, pensioners dwellings	400
total	20500

9% of BNP

9% of BNP 12% of consumption

Dr. Ammundsen ended her talk by showing table 3, which gives details of the cost of the Danish system of long-term care of the elderly.

During question time she was asked what size the nursing homes had to be in order to be cost effective. She replied not bigger than 50 to 60 beds, though they had been forced to provide some larger ones, particularly in Copenhagen. She was also asked what care facilities were given to the elderly confused; she said that if a confused patient is admitted to a "normal" nursing home, and cannot be managed, he is transferred to a psychiatric home; but unfortunately there are too few psychiatric nursing homes outside Copenhagen.

The second speaker Dr. O. Zeuthen Dalgaard, began by giving some demographic data. Denmark is a small country, he said, inhabited by 5.1 million people, most of whom live in urban areas; approximately one-third live in the metropolitan area of Copenhagen. Fourteen per cent of the population (0.7 million people) are aged 65 and over. The high rate of increase in this age group is slowing down, but the peak will be reached in 1990, when it is estimated there will be 0.8 million people aged 65 and over, representing 15.2 per cent of the total population. The number of people aged 75 and over is expected to increase from 0.29 million in 1980 to 0.36 million in 2000, and the number of those 85 and over will rise even more rapidly: from 54,000 in 1980 to 89,000 in 2000, when they will represent 1.7 per cent of the population (table 4).

During the 1960s, Dr. Dalgaard said, more than 200,000 married women had gone to work in industry, and these women found it difficult to care for their elderly relatives

TABLE 4

DENMARK

Population increase in Period of 70 years

	Age 80 - 84	Age 85 - 89	Age 90 and more
1980	87400	40100	13800
1990	108600	53800	21600
2000	106800	61800	27400
2030	144900	70800	26600
2050	135000	73900	32200
2050 and (over 1980 change)	154	184	233

Since 1950 Dr. Torben Geill, Medical Director of the Old People's Town in Copenhagen, had tried to copy the British pattern of geriatric care, but he had failed largely because general practitioners had claimed they were already geriatricians! He had succeeded in building up a geriatric department. Dr. Dalgaard had taken over his post in 1966, and by 1969 there were five geriatric departments in old people's homes under the social administration in Denmark's largest cities, and five geriatric departments in hospitals under the health administration. But the National Health Board would not agree to the establishment of two hospital systems. Ln 1969 the Board set up a working group to study the possibility of establishing special long-stay units in somatic hospitals. (Hospitals normally provide acute care, assessment services, and rehabilitation to all patients, including the elderly, for an average stay of not more than three months. The responsibility for custodial care falls to the social services). The group recommended that there should be long-term treatment units in regional and large general hospitals; the estimated need was 0.8 beds per 1,000 of population.

In 1972 the Minister of the Interior established the specialty of long-term medical care; it is based on the British specialty of internal medicine, with special training in geriatrics. In Denmark the specialty is defined by an average of three months' hospital care, not by the patient's age or disability. A long-term care unit functions parallel with intermediate and intensive care units. It assists, and receives assistance from, the other specialist consultants; it diagnoses and treats; it reactivates and rehabilitates medical patients - often elderly ones; it assesses and discharges patients to their homes or to an institution; and it provides a day hospital service.

In Denmark, Dr. Dalgaard continued, there is a single source system. The family doctor provides only primary care, no secondary health care. He is a co-ordinator of all social and health-care services to the patient at home. He has to pay home visits to the house-bound, refer patients to specialized diagnostic and therapeutic services, assess the need for home nursing and collaborate with the social services over the home assistance service. No home visits are made by hospital geriatricians.

Secondary health care (hospital care) is free for all Danish citizens. In 1969 the administration of all general hospital services in each country was transferred by law to the county councils. All but one of Denmark's fourteen counties have populations of approximately 200,000. Each country is required to maintain or develop one medical centre of sufficient capacity for the needs of its population and the county hospital must include the specialty of long-term medical care. It will take time, particularly as it will involve a massive building programme and the closing of many small hospitals. The first phase of this reorganisation has consisted of a functional co-ordination of existing services. All future expansion of services will have to follow a comprehensive plan for each county that must be approved by the Minister of the Interior and the National Health Board.

The bed and staff capacity of hospitals in Denmark are shown in tables 5 and 6. Dr. Dalgaard pointed out that vast differences occur in different counties. In the capital region of Denmark there is an average of 5.9 beds per 1,000 inhabitants, varying from 8.6 in the municipality of Copenhagen to 4.2 in the county of Copenhagen. There are 6.6 somatic hospital beds, and 8.5 somatic plus psychiatric beds in the whole of Denmark. Expenditure on hospital care in 1978 was about 11,000 million kroner,

TABLE 5

Denmark January 1978

Bed capacity in hospitals

Half of the bed days are consumed by person aged 65 and more.

6.6 somatic hospital beds per 1000 inhabitants

8.5 somatic plus psychiatric hospital beds per 1000 inhabitants

0.2 long term medical beds per 1000 inhabitants

1.3 recommended norm long term medical beds

1.1 deficit long term medical beds

The provision of long term medical care beds in hospitals is only 1000 beds, so we are far behind from the recommended norm. Since the energy crisis 1973 we have had to fight for more beds, because we are obliged to convince the general physicians in internal medicine that long term medicine ought to take over some of their beds.

A norm of 1.3 beds per 1000 population gives 6500 beds so only 15% of the population gain admittance to this service.

TABLE 6

Hospital care in Denmark January 1978

Number of beds and staffing

	beds	number of full time staff per bed
Hospitals with 3 clinical departments and more.		
more than 800 beds	11251	2.5
less than 800 beds	13744	2.2
Hospitals with 2 clinical departments	4415	1.8
mixed	1675	1.6
specialized somatic	2361	1.5
somatic hospitals in all	33446	2.2
psychiatric hospitals	10151	1.1
all in total	43497	1.9

The 1000 long term medical beds are scattered over the different types of large and small somatic hospitals.

approximately half of which was consumed by those aged 65 and over. An estimated fourteen per cent of the population are hospitalised as in-patients one or more times a year, but the figure jumps to twenty-five per cent for those aged 70 and over. The average length of stay is eleven days for patients below 70, but thirty days for those aged 70 and over. In the municipality of Copenhagen more than sixty per cent of deaths occur in hospital and fifteen per cent in nursing homes. Out-patient services are limited to patients requiring hospital facilities for diagnosis and treatment.

The recommended norm of 1.3 beds per 1,000 population for long-term care in hospital provides for 6,500 beds, but the actual number of beds (1,000) is far below this norm. Since the energy crisis in 1973, Dr. Dalgaard said he had been fighting for more long-term beds, and trying to convince general physicians in internal medicine that some of their hospital beds should be converted to long-term beds. Only fifteen per cent of the population gain admission to the long-term service. The beds are scattered over different types of hospital. He also pointed out that there are no university chairs in geriatrics in Denmark.

In 1976 the Minister of the Interior sent a letter to county councils recommending that the turn-over of patients should be adapted to care resources. The turn-over of patients in long-term medical units is sixteen times faster than the turn-over in nursing homes. So Denmark has an almost perfect health-care system with no duplication of health and social services.

Dr. Dalgaard went on to explain that by law the municipalities must set up geriatric assessment committees with joint social and medical expertise.

TABLE 7

Imminent or established social breakdown of the elderly caused by inability to cope independently in own home caused by disabilities

assessment made by long term department after referral from general practitioner and district nursing services.

difficulty in walking	1/3
vertigo, falls or fainting	1/3
mental disturbances dementia (confusion) psychoses neuroses (fear)	1/4
decreased vision	1/5
Cardiopulmonary troubles (dyspnoea, angina pectoris)	1/5
urinary incontinence	1/8
decreased function of upper extremities	1/10

Assessment for institutional care made by long term medical departments in Denmark

Wants from patients and or relatives homevisitor Request from general practitioner	The patients pass the hospital as out-patients or in-patients	1/3 - 1/2 need and are assessed for institutional care approximately 1/2 are discharged to their own homes

Long-term medical care departments are strongly represented on these committees, but where no such department exists the general physician is a member.

No elderly person should be accepted for institutional care without having been screened both medically and socially by a long-term care department, either in out-patients or after in-patient admission. But the law is not yet respected in all municipalities; local authorities should seek advice from the assessment committee, but some of them assess patients and accept them for nursing home, day home or sheltered housing without seeking the committee's advice.

An analysis of 196 consecutive referrals from GPs and district nurses, made by Dr. R. Krakauer (of Dr. Dalgaard's department) and published in The Lancet (September 16, 1978) revealed what disabilities caused inability to cope independently at home and consequent social breakdown (table 7).

The high quality of nursing homes and especially of sheltered housing has increased the demand, and put heavy pressure on the assessment panels, but only one-third to one-half are found to need institutional care; at least one-half of patients are discharged to their own homes. Criteria for assessing patients have been set up based on experience from long-term medical departments in Copenhagen, Odense and elsewhere (table 8).

Three-quarters of the residents in nursing homes are women and one-quarter men (table 9). One-half use wheelchairs, very few are chronic bedridden, two-thirds are aged 80 and over, average age being 86; only two per cent are couples. One-quarter are admitted to hospital each year (fractured hip etc.) and a little less than one-quarter are discharged. The death rate among residents is one-fifth and there is an equivalent number of admissions.

TABLE 8

LONG TERM MEDICAL DEPARTMENTS

Criteria for assessing patients to institutional care or care in own home.

1	social and medical care		
	custodial care		
	nursing home	sheltered housing	own home
Need for personhelp to transport with walking aids or wheelchair	X		
without personhelp		X	X
vertigo, falls and faintings often or constant	X	X	
mental disturbances*) severe dementia psychosis	X		
severe neurosis (fear) need for personhelp	X	(X)	

*) Joint assessment with Geriatric psychiatrist

LONG TERM MEDICAL DEPARTMENTS

Criteria for assessing patients to institutional care or care in own home.

	social and medical care		
	custodial care		
	nursing home	sheltered housing	own home
severe cardiopulmonary troubles	X	X	
constant incontinence need for personhelp	X	(X)	
decreased function of upper extremities personhelp to feed	X		
personhelp to dressing to be put to bed to personal toilette		(X)	X

TABLE 9

Characteristics of residents in nursing homes.

Women	3/4
Men	1/4
using wheelchairs	1/2
chronic bedridden	very few
80 years and more	2/3
average age	86
couples	2 &
Hospital admissions - Surgical and medical	
per year	1/4
discharge little less than	1/4

death rate 1/5 of residents plus residents moving in per year

The policy of the Danish Society of Long-Term Medical Care is that all patients really in need of the facilities of high-technology acute medicine should have access to this service (table 10).

Expansion over the five years 1977-1982 is being focussed on sheltered housing, day homes and centres in order to conserve resources. Staff salaries are by far the largest element of cost, Dr. Dalgaard said. The staff/patient ratio in nursing homes is 0.73/77 to one, but in sheltered homes is only 0.18. He quoted from one of Horace's Odes: "Those who want much are always much in need." He ended by describing the queue problem as a question of supply and demand (table 11). If demand is bigger than supply the queue will increase to infinite proportions. Normal queue discipline is "first come, first served" but perhaps other rules will have to be devised. The most needy patient is the one needing admission on to the acute hospital, but this type of patient has a higher mortality and therefore consumes fewer "bed days". On the other hand, he requires more nursing care. "Since we are short of resources, we need some new inventions", Dr. Dalgaard commented.

During question time, he was asked how many elderly people in Denmark die in their own homes. He replied that in Copenhagen sixty-two per cent of those over 65 die in acute hospitals, twenty per cent die in nursing homes, and the remaining eighteen per cent die at home; this pattern is uniform over the whole country. He was also asked how a GP got a patient into hospital; he answered that if a patient suffered a fracture which could not be treated in the nursing home where he was resident, he would be sent to hospital and his bed kept open for him, as he would be returned to the home very quickly. No hospital can refuse to admit a patient but patients can be discharged as early as the day after admission.

TABLE 10

Long Term Physicians Wants for Future Trends.

Model of admission to hospital for elderly patients

with organspecific disease	to	organspecialized department
with acute disease needing large medical resources	to	general medicine department
with social breakdown disability multipathology	to	long term medical department
eventually acute disease needing small medical resources		

TABLE 11

The Queue Problem

Supply and Demand

$$S = \frac{R}{rv \cdot B} \qquad S \geq 1$$

Queue $\longrightarrow$ infinite

Servicefactor	S
Requests	R
Reciproke value of bed days in hospital or nursing home	rv
Hospital or nursing home beds	B
Queue discipline	first come first served
Rules of assessment	most need first served

Asked if there is any ancillary rehabilitation service and whether hospital staff also work in the community, Dr. Dalgaard said that there is a rehabilitation ward in hospitals but no domiciliary service provided from that ward. The hospital's responsibility stops when the patient is discharged; he then comes under his family doctor. There is a very good nursing home system but there is a sharp division between the hospital and the community-based services. When a patient is sent home the hospital doctors recommend that he have certain services; often their advice is followed, but they have no responsibility for ensuring these services are in fact provided.

The third speaker, Mr. Teftgaard Jensen, who is Director of Social Services for Odense, looked at problems of long-term care of the elderly from the viewpoint of a social administrator in a municipality with responsibility for both social and health departments. Odense, the third largest city in Denmark, has 170,000 inhabitants and the social services department has a staff of about 6,000.

In 1976 a very ambitious law, called the "bistandaloven" or public assistance act, was passed imposing on local authorities the responsibility for ensuring the well-being and security of all inhabitants who cannot take care of themselves. Four years ago the Danish Government had asked social service departments to prepare and submit five-year plans for social welfare every year. By itself, Mr. Jensen said, this did not make them provide a better service but it made them look at needs regularly and think them through.

In Denmark they are moving away from a system of "earmarked repayments" from the State to a system of block grants to force local authorities to set their own priorities and stop the municipalities from "sucking on their soda straw" - one end of which is in Treasury funds! Fifty per cent of funds are "earmarked repayments" and seventeen per cent are block grants.

Municipalities have true home rule; they are able to administer freely, without State involvement, provided they work within the framework of the law. There is consequently considerable variation between the different municipalities. Services are improving, particularly in the areas of child and old-age welfare but there are still not enough facilities for the elderly and there is continued pressure from hospitals to relieve the pressure on expensive hospital beds.

Mr. Jensen reiterated that in Denmark, as in Great Britain, the aim is to maintain old people in their own homes as long as possible, but this is easier said than done, and needs a firm yet understanding approach as the ideas of the old person, his relatives and the practitioners are not always the same. A number of factors have to be taken into consideration:

1. humane factors - ie where the patient suffers from severe dementia
2. where he requires continued nursing care
3. when it becomes too expensive to maintain him in his own home.

In Odense it has been proved that of the eight per cent of people over 65 requiring care in special homes a small proportion could have remained at home with support from the social services, but that it was more costly to do this than to provide a place in a care home. This eight per cent of older people do not need regimented hospital care; they need home-like conditions - that is, proper communal facilities, and their own room with bath and toilet.

Mr. Jensen then described the resources at the command of a social welfare administration to improve the quality of life for the elderly and to maintain them at home for as long as possible. First, the Danish old-age pension represents a reasonable income, but if for some reason it proves inadequate a supplementary pension is payable. A pensioner without extra allowances pays a maximum of fifteen per cent of his rent (including flats and private houses), relatives looking after old people are also paid an allowance.

Second, there is a vigorous effort by private and voluntary workers to "put life into later years" by organising clubs, library facilities, chiropody, cinema and theatre visits, sight-seeing trips and home visits. This campaign is heavily subsidised by public funds.

Third, the home care system provides home helps for up to six hours a day, seven days a week, free of charge to old-age pensioners. No one has to pay for more than six hours a week. The home helpers have a compulsory four-week training course. Their knowledge of the daily lives of the aged proves very useful to social service departments. The home nursing service is available on a doctor's prescription, but most home care is supplied by the home helpers who pay regular visits during the evenings and at night if necessary. There is a "tucking in" service for instance. Other facilities include adaptations in the home for disabled people; electronic supervision, both active and passive, which makes contact with the rescue service; a wide range of equipment, from special eating utensils to electric wheelchairs and special beds.

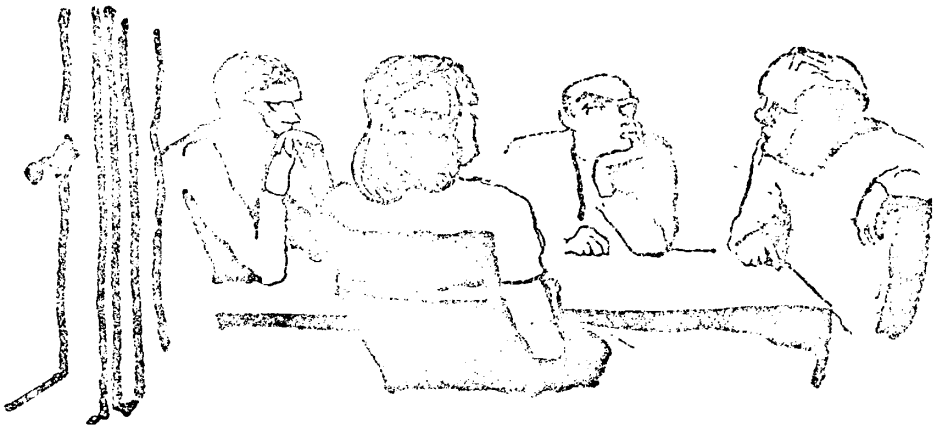
Fourth, as "external care" there are day homes and day centres according to need: for instance, there are beds in care homes for old people when their families are away on holiday or in other special circumstances.

Mr. Jensen said it was important to point out that these services could be supplied individually or in combination. For example, the home helper gets you up in the morning and cleans your house; you are collected by the transport system from your home and taken to the day centre where you spend the whole day; the home helper provides a tucking-in service at night; your flat is equipped for all your needs and there is a telephone as essential contact with the services.

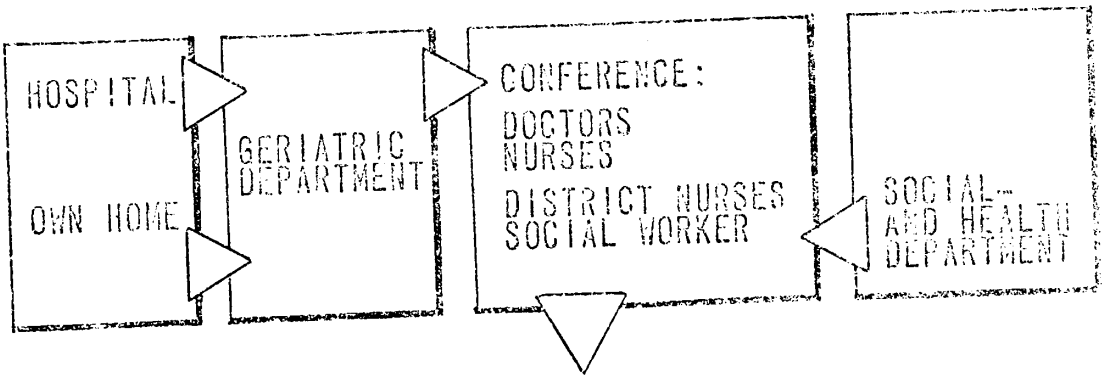
With increased knowledge of the living conditions of the elderly, Mr. Jensen continued, it was clear that their needs are often greater than they initially say. There is a saying that old people are the "area of insatiate needs", and for this reason it is important always to estimate the needs before deciding on the remedial measures to be provided. It is important for all staff to remember that both the hospital and the social services cost money which comes from the same purse.

"Visitation" is an important word in Danish social welfare administration. It is difficult to translate from the Danish but roughly it means assessment and disposition of care planning and it is a key concept. Table 12 shows the system for decision-making for patients who have been in a hospital long-term care ward. There has to be co-operation between the staff of the long-term medical care department, the social workers, the home nurses and the home helpers in reaching a decision on how to meet the individual's care needs. The demand for co-operation must come from the top, Mr. Jensen emphasised; political and administrative leaders must be the first to break down any barriers. Today most people maintain that they co-operate well but it is still necessary to formalise contacts in order to ensure on-going co-operation. In old-age care it is important not to make decisions only on paper. People with personal knowledge of the patient must be involved. It is also important to have some

TABLE 12



"Visitation": Assessment and disposition of care planning



1. Demand for cooperation
2. Formalized contacts
3. Personal knowledge of the patient
4. Qualified knowledge of own duty
5. Knowledge of the co-worker's duty
6. Authority

understanding of one's colleagues work. Finally, each participant in these planning conferences must have true authority, that is, he must have the power to take decisions without afterwards encountering difficulties.

To end, Mr. Jensen showed a chart* giving details of the demands made on the services provided by the social welfare administration by the different age groups. This illustrated his worries about the future, as demands are increasing so rapidly. In Denmark there is not only an increasing demand for services, but also for improved quality of those services. It is difficult to fill places in the older institutions as relatives fight hard to get places for their old people in the newer and better homes for which there are now waiting lists. The aged sometimes have to wait in other institutions for months or even years before getting permanent accommodation.

Although he was worried about the future, Mr. Jensen said that he could still be happy because at least in the good times Denmark had been able to develop their services to the elderly to a very high level.

During question time he was asked about the Danish meals-on-wheels service. It was started ten years ago he replied, not because old people could not afford to cater for themselves - their pensions are so high that they can easily keep themselves - but because the medical long-term care departments considered it important that elderly people maintained at home should be properly nourished and have special diets if necessary. To get meals-on-wheels you have to be referred by the geriatric department, you cannot just ask for them. They are available seven days a week, at a token price of about half the actual cost.

* See Appendix

The afternoon session was devoted to short talks by the four members of the British team and to questions and general discussion.
Professor Millard said he had been most impressed by seeing old people in sheltered housing, in nursing homes and even in hospital wards with their own possessions around them. This made a poor comparison with Britain, where this was only possible in sheltered housing or residential homes.

Roger Burton spoke highly of the Danish meals-on-wheels service being available seven days a week and of their home help service - both considerable improvements on our own. He added that in day centres the patient could order a meal to take home with him in the evening and that if public transport is not available he can take a taxi which will be paid for by the local authority. He also pointed out that Danish home helps have a basic training programme of 240 hours, while ours only have 12 hours training. The Danish home help is a much more skilled person.

Referring to attitudes towards the elderly, Mr. Burton said that the most encouraging remark he had heard in Denmark was: "We believe that old people have contributed towards the society that we have today and they should now have their reward". This is in marked contrast to the British attitude which places the elderly at the bottom of the list of priorities. Too often social workers regard children and young people as more important than the old because they have their lives in front of them, while there is little point in spending time and effort on the old whose lives are almost over. This is in direct contradiction of the British Association of Social Workers' code of ethics. Mr. Burton said that his visit to Denmark had been like a breath of fresh air and he hoped we, in this country, could get some of their vitality and freshness

into our approach to the old.

Miss Mollie Clark pointed out one asset this country has: the network of domiciliary tradesmen - milkmen, postmen, paperboys - which if cultivated by professional staff can become part of an unofficial alert system about old people who live alone. She too was full of praise for what the Danes have achieved for their old people and had been impressed by the adjustable-height sinks he had seen in sheltered housing; in the same building all residents had a house phone and could also have an ordinary telephone if they wished as wiring was provided.

Miss Clark explained that the nursing homes in Denmark are staffed by nurses called "nursing home assistants", together with nursing assistants and usually a registered nurse in charge. The registered nurse and nursing assistant grades are equivalent to those in this country but there is no equivalent here for the nursing home assistant. They have a two-year training designed to prepare them to work in the home environment. They did not train in hospital but in the context of the patient's home where, within the limits of his disability, he can still control his own affairs and retreat from institutional life to his own private accommodation. The status of these nursing home assistants is similar to that of our own community nurses. It had been salutary to see patients being nursed where privacy, dignity and identity were constantly being reinforced. She strongly advocated trial schemes on the Danish model.

Dr. Colin Godber also urged that we should imitate the Danes, particularly in their sheltered housing and nursing homes and the degree of privacy given to residents. He had been impressed by the broad responsibility of the Social Services Departments in Denmark, which afforded much more opportunity for switching resources within their remit: i.e. in the

balance between sheltered housing and other institutional care according to need.

The elimination of the boundary between social service department and housing department is a distinct advantage; many residents in nursing homes had formerly lived in sheltered accommodation but this had created no difficulty in their being referred to the nursing home: a situation rare in Britain. A further advantage was that Danish social service departments could offer much more comprehensive staff training courses. The nursing home assistant, for instance, is a species we should look at closely.

Dr. Godber had also been impressed by the transport system. The non-urgent ambulance service is contracted out to taxi firms so that old people do not suffer if an emergency makes heavy demands on the ambulance service. He thought, however, that geriatricians have more scope in this country.

The following further points emerged during the panel discussion:

There are no pre-retirement courses in Denmark and no other similar organised activities. Nor do tradesmen call at people's homes, so that someone living alone may see no one for days, weeks or even months on end.

There is no general practitioner specialty in Denmark but a GP training is in preparation. GPs are encouraged to study while they are in service but no pressure is put on them by the State to do so.

There is resistance by registered nurses towards the nursing home assistants. There is also a shortage of trained nurses, mainly because

demand has greatly increased but also because there is a shortage of both teachers and training places. There is no shortage of home helpers but their quality is not always high enough. They are paid less than a registered nurse: £7,000 a year compared with £8,000 a year.

Old people in Denmark participate in all decisions regarding their welfare. They cannot, for instance, be admitted to a nursing home unless they have signed an application form.

Many geriatric patients in Denmark suffer from some degree of dementis. If their dementis is extreme they can be transferred to a psychiatric nursing home, but this is rare.

A Danish GP's list is smaller than that of his British equivalent: about 1,800 patients, although it is planned to drop this limit to 1,500. (In Britain it is 2,300 on average, 3,500 maximum.) There are two systems of payment: per capita and per capita plus a token fee. There is no rule for GPs to visit all patients over 80 regularly, though many do.

On discharge from hospital, it is the responsibility of the "leading" doctor and nurse to advise the social services what the patient's needs are but there is no further follow-up service from the hospital. Only a few social workers are employed in hospitals.

The key worker in setting up home support in Denmark is the home nurse who visits the home and acts as liasion between GP and local authority. Referrals for social support must go before the assessment committee who make the final decision.

Asked finally whether their splendid support for the elderly tended to encourage relatives to relinquish their responsibilities for their old folk, Dr. Ammundsen said that it was now too late to turn back, though this might be true. As long as women wanted and needed to work outside the home, the obligation to care for the elderly would be thrown on to the State. An evolution that had gone on for at least fifty to a hundred years could not now be changed.

Pat Young

April 1979

APPENDIX

Goals: As long as possible in own home

but:
1. humane considerations
2. care or nursing considerations
3. economic considerations

Experience:

8% unavoidable institutionalization

care under homelike conditions

		Pr. 1000	65 years. +	
Care home	heavy care		40	67
	light care		13	
Sheltered flat			14	
24-hour service			1	
Daycarecenter			37	
Homehelp			160	
District nurse			140	

MEASURES.

1. ECONOMIC:

National old-age pension
Rental subsidy
Special economic help
Economic support to the family
Medicine

2. "WELFARE":

Clubs
Library service
Chiropodist-service
Cinema
Theatre
Sight-seeing
Voluntary visiting service

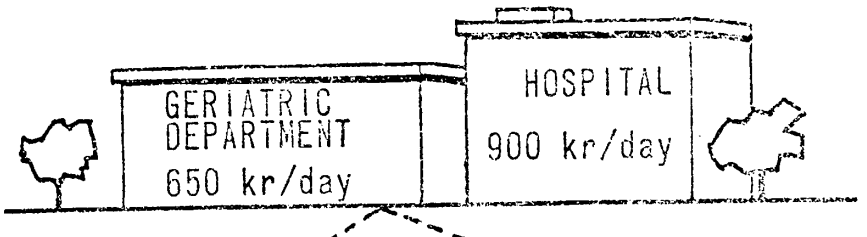
3. HOME CARE:

Homehelp
District Nursing Services
24-hour help
Evening home help
Meals on wheels
Housing Alteration
Electronic care
Laundry service
Telephone
Equipment for handicapped persons

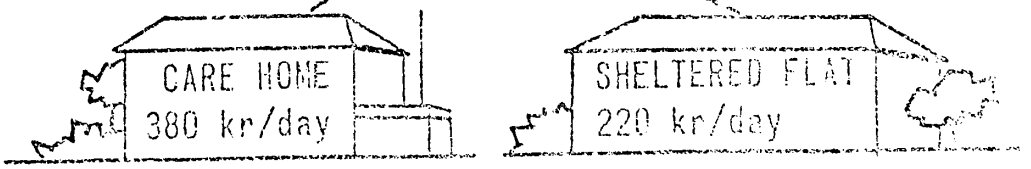
4. EXTERNAL CARE:

Day care in care home
Day care center
Relief-help in care home

5.



6.



Age	65-69	7o-74	75-79	8o-84	85-89	9o +	Ave-rage
"Heavy" care home	o,6%	1,5%	3,9%	8,6%	16,9%	39,3%	4,28%
Light care home	o,3%	o,7%	1,4%	3,2%	6,8%	9,8%	1,6%
Sheltered flat	o,4%	1,2%	2,3%	5,2%	11,4%	16,3%	2,6%
District nurses-service	5,o%	8,9%	13,9%	26,6%	27,1%	42,o%	2o,58%
Homehelp	5,4%	1o,o%	19,2%	32,6%	31,4%	29,4%	15,6%