Abstracts

Sociology and Social Policy — John Bond

A. K. Bjelland, 'Aging and identity management in a Norwegian elderly home'. *Human Relations*, **38** (1985), 151–165.

Since Goffman[1] first coined the term *total institution* social scientists, in particular anthropologists and sociologists, have expended considerable effort in gathering data in order to test the appropriateness of Goffman's ideal type. A variety of studies, perhaps exemplified by Townsend's[2] classic British study of residential homes in England and Wales, have shown that the charactistics of the total institution do exist in many institutions with elderly residents, but noteworthy is the fact that not all these institutions exhibit such characteristics.

Bjelland's paper offers a different focus. Her aim was to describe the way in which residents living in one Norwegian elderly home try to make sense of their lives through continued efforts to establish a positive self-image and personal identity, in face of both their own and their co-residents' declining health and independence. The study was undertaken using methods of participant observation.

Goffman[3] described a set of general modes of adaptations applicable to homes for the elderly. Bjelland shows how residents, faced with specific challenges, developed several strategies of adaptation which were based largely on gender and dependency or health status. She shows how different adaptation patterns are made relevant for the residents' interpretation of behaviour, and further categorisations of each other. It is through these categories or typifications, to use Shutz's term[4], that residents interpret and justify their own and others' behaviour.

Six categories of residents are identified: 'housewives', 'ladies', 'men-folk', 'gentlemen', 'bedridden' and 'seniles'.

Housewives. These women are the most active residents, engaging in all activities and maintaining their own private space immaculately. They are often considered by staff as 'ideal residents' since they are always grateful and rarely complain. 'Housewives' are generally found in the main public areas of the home.

Ladies. These women are more dependent on staff and engage less in

social activities, staying in their own rooms and the secondary public areas like corridors and hallways.

Men-folk. The adaptation of these men represents the polar opposite of the 'housewives'. They refuse to co-operate with staff, are discontented and complain regularly. They tend to remain in the secondary public areas and avoid having contact with the 'housewives'. They do, however, attempt to remain independent.

Gentlemen. These men are actively engaged in activities in the home, appear grateful and rarely complain, but unlike the 'housewives' receive assistance from staff.

Bedridden. Residents so defined are not necessarily bedridden, but rather they stay in their own rooms and do not have a regular seat in the main public areas. The 'bedridden' are pitied, but avoided, by other residents because of the implication of encroaching death to themselves.

Seniles. These residents display an adaptation pattern that deviates from those of all other residents. They are found in all areas of the home and their deviant behaviour produces an ambivalent reaction from other residents, ranging from complete avoidance and negative sanctioning to a more acceptable attitude.

The residents' adaptation patterns and their evaluations of their own behaviour and of others represent ways of coping as an inmate of a 'total institution'. Entry to an old peoples home generally implies a reduction in autonomy and independence. The dilemmas which arise from being an 'inmate' and the patterns of action and conflict that are generated are, to a great extent, due to the residents' identity as men or women, except where residents become typified as 'bedridden' or 'senile'.

COMMENT

Participant observation in one setting does not allow us to generalise to other settings. Rather it allows us to translate the observations into other environments in order to provide an appropriate theoretical framework. However, the categories identified by the present study are comparable to those which we might observe in other similar settings in a variety of countries, although staff and residents in these other settings might well provide slightly different adjectives with which to describe the categories.

B. G. Hanson, 'Negotiation of self and setting to advantage: an interactionist consideration of nursing home data'. *Sociology of Health and Illness*, 7 (1985), 21–35.

Another type of institution which often exhibits charactistics of the total institution is the nursing home. In many ways nursing homes differ very little from the home for the elderly described in the previous paper. Rather than focusing on categories of residents defined by residents and staff this paper is concerned with the dynamics of the process of negotiation in a nursing home. Again a single setting is described (a Toronto nursing home), and again participant observation was the method used.

In addition to providing policy-makers and professionals with an understanding of the way negotiation proceeds within this kind of institution, this paper provides sociologists with elaboration and extension of sociological theory by introducing the idea of *primary* and *secondary advantage*. These two sensitising concepts bring together two further ideas of Goffman: that of *impression management*[5] and *frame analysis*.[6]

Primary advantage refers to the change or modification to the primary framework present at the setting. The process of gaining primary advantage involves convincing other actors in the setting that a new definition of the frame should be given predominance. Impression management is one process which might be used by ego to convince other actors. Thus within the nursing home which exhibits characteristics of the total institution, staff may automatically do things for residents even though they are capable of doing some things for themselves, albeit in a limited fashion. The resident who is able to convince staff of his ability will bring about a change of frame so that actors reframe the nature of the interaction between staff and residents. For example, if a resident wishes to put his own sugar in his tea and brings about a change of frame so that staff accept that he puts his own sugar in his tea he will have achieved a primary advantage.

Secondary advantages are outcomes, rewards or sanctions that are a function of the prevailing definition. Thus being allowed to put his sugar in his tea is the logical outcome of achieving a primary advantage.

Having defined these sensitising concepts Hanson goes on to show that they are not only of sociological significance. In particular she shows how untrained staff can achieve primary and secondary advantage. Consider the resident who is currently characterised as restless. If he is found wandering the home at night the nurse or auxiliary nurse has the option of whether to report or not. How she reports will depend

on what she wishes to happen. If she continues to define the resident's state as restlessness then no action will follow. However, if she describes the behaviour as disturbed then medical staff might review the resident and reclassify him as disturbed. This change in resident category will be negotiated, but if the change is accepted the nurse will be seen to have achieved primary advantage, since the frame will now be different.

In this paper Hanson goes on to consider the importance of this process for professional staff. When considering the dynamics of any health care setting it is crucial that one be aware of what these actions mean in the context of the setting. We should all be sensitive to the fact that there may be motives attached to the information upon which decisions are made. For example, nurses who negotiate with doctors for p.r.n. drugs for residents (sometimes referred to as standing orders) will be altering their position *vis-à-vis* the treatment of residents.

COMMENT

Erudite extensions of sociological theory will always be welcomed by other sociologists. The difficulty, which is not new to sociology, is one of convincing health professionals in particular, or fellow citizens in general, that what we describe in sociological theory is not merely trivial or 'common-sense'. Frame analysis and the concepts of primary and secondary advantages are not easily understood by our fellow citizens because of the apparent trivialness of what is being said. With hindsight much of sociology is obvious. We will therefore need new sociological insights in order to effect change in policy and practice.

R. Bland and R. E. Bland, '"Contract" and admission to old people's homes'. *British Journal of Social Work*, **15** (1985), 133–144.

This paper discusses the idea of 'residents' in old people's homes receiving 'contracts' as a positive and inexpensive policy change which may help prevent the existence of homes exhibiting characteristics of the total institution. In general the authors promote the idea of a contract, but they do consider a number of circumstances under which a contract appears to be inappropriate. These they discuss under four headings: gemeinschaft relationships; trust and full knowledge; unequal power; and one party not competent.

A classic in sociology is Tönnies' (1887) discussion of two general types of social relationship: *Gemeinschaft* and *Gesellschaft*.[7] Contracts are gesellschaft in nature since they are usually found when parties are

essentially separate in their interests but come together for a specific, often limited purpose. Old people's homes not exhibiting the characteristics of a total institution–those offering a true *home* in which there is a fusion of the interests and purposes of various individuals living and working there–are gemeinschaft in nature. In such a case any suggestion of a contract would be out of place and considered offensive. Of course, we need to clarify whether the relationships in the home are truly gemeinschaft or whether staff just perceive them as such. The perception would clearly be unrealistic, since staff and residents occupy different social worlds and gemeinschaft relationships imply commonality of social worlds.

In institutions where residents and staff have a detailed understanding of the rights of residents (and the rights of staff) and each trusts each other, contracts are not required. Even though most potential residents are likely to trust staff, their understanding of what life in a home would be like is often limited. In such familiar circumstances some kind of contract would clearly give potential residents greater understanding.

An important characteristic of the total institution is the way that staff and inmates have unequal power, and this is most clearly exemplified in the case of the prison. Equally we can see that in most institutions caring for older people staff exert power over residents. 'Contracts' might be inappropriate in such situations, since those with power are in a situation to impose the 'full trust and knowledge' model on the weaker party. However, this argument is somewhat circular in that the agreement of a contract might help redress any imbalance in power.

The most obvious circumstance under which a contract would be inappropriate is when residents are not competent to conclude one. Again, however, there is a problem of who decides who is competent. Health professionals, for example, using the model of the doctor–patient relationship, may have a different perception of competence than say social workers or the residents or their families. However, even where incompetence is agreed it does not preclude the possibility of the 'contract' being established between the home and the residents' families.

The authors having established some situations where contracts might be considered as inappropriate go on to describe six functions or advantages of contracts. First, the contract would provide residents with some kind of security of tenure–at the least provide them with the circumstances under which they would be discharged. The second function of the contract would be to inform the residents about the way in which the home is managed. Thirdly, the contract symbolises a new

beginning in a place of new activity and experience. Fourthly, the contract would force staff to think about what they do, by placing them in the position of having to explain the pattern of life in the home. Fifthly, the contract would not be a standard form but a document negotiated by both sides. This would help staff to see residents as individuals and encourage residents to behave as such. Finally, the presence of a contract would help to symbolise the equality of the two sides.

COMMENT

There are probably a variety of practical and legal difficulties associated with the introduction of contracts within institutional settings. However, most of these difficulties could be overcome if there were a will to move in that direction. The notion of contracts would obviously assist in making residents more autonomous and is therefore something I hope we would all encourage. Of course, it should not only be limited to residential homes; private nursing homes and hospitals would be appropriate institutions to look at next.

L. Challis, 'Controlling for care: private voluntary homes registration and inspection – a forgotten area of social work'. *British Journal of Social Work*, **15** (1985), 46–56.

The relevance of a 'contract' may not be only for public residential homes. In Britain there exists a growing private and voluntary sector encouraged both by policy rhetoric and supplementary benefit (social security) payments. A 'contract' would be equally relevant for residents entering homes operated by voluntary agencies or for commercial purposes. Challis is concerned in this article with a complementary theme, namely the registration and inspection of homes, with a particular emphasis on the role of social workers.

In Britain residential homes are registered and inspected by the local social service authority and nursing homes are registered and inspected by the local health authority. Statutory instruments set out the details of requirements to be met before each home can be registered. Reflecting the fact that there is considerable overlap in the kinds of clients using the two types of facilities is that the two types of registration have much in common: both insist upon thorough fire precautions, certain environmental health standards, specify the number of bathrooms, lavatories and hand basins required and also specify the mini-

mum acceptable room size or bed spaces. The main difference between the two rests on the assumption that people in nursing homes will spend more time in bed, will need qualified nursing care and will be physically more ill than people in residential homes. Consequently the requirements for nursing homes stipulate larger bedrooms with communal areas being optional, SRN nursing cover at all times, minimum staff–patient ratios and more frequent inspections than in residential homes.

Implicit in these requirements were two objectives: first to prevent the exploitation of the weak and vulnerable, and secondly to ensure that specified minimum standards were achieved and maintained. However, Challis identifies the absence from the statutory instruments of an explicit statement of objectives. Current statutory instruments are based on earlier legislation drawn up during the twenties and thirties, and these earlier documents also lacked a statement of explicit objectives. A further concern recorded by Challis is the small number of staff devoted to inspection of homes. With the sudden expansion in the private sector there has been little or no expansion in the numbers of staff involved in inspection. These staff also are often of low status and have little effective communication with other staff involved in the registration and inspection of facilities for other client groups.

Challis also reports data from a study of people in private and voluntary care which showed that staff concerned with the registration of residential homes had limited knowledge about the kinds of state benefits available to residents, or grants and rates reductions for proprietors of these homes. Of more concern was that registration staff did not know what the charges for care were, nor did they know about the costs of providing care. Without this information it is difficult to see how local social service authorties are able to know whether financial exploitation of clients occurs.

Challis concludes that financial exploitation of the elderly could only be avoided if the statutory instruments set explicit objectives. First, to make consumers aware that there is a choice about which home to enter; secondly, to make consumers aware of what the cost–charge differential is in any particular home; thirdly, to bring charges in line with costs or assist dissatisfied consumers to change their home. To achieve these objectives Challis indicated that regulating staff require more information about the costs and charges made for care and the client's knowledge of this information. In addition they would need power to control charges and make alternative placements for dissatisfied consumers.

A supplementary issue discussed by Challis is quality of care. She

emphasises that financial exploitation does not necessarily imply poor care. Judgements on the quality of care will depend on who makes the judgement. Different clients will have and expect different care, and judgements may well differ from professionals involved in the inspection of premises. If one objective of registration and inspection were to go beyond minimum standards of physical amenities into the area of quality of care more would need to be known about individuals' circumstances and needs.

In order to do this Challis argues for two intermediate steps. First, that each private and voluntary home should have a social worker experienced in the residential and social care of older people as a designated liaison officer. Secondly, that a complaints procedure should be devised, and each resident and the families of residents should be informed of the procedure. To these steps we might also add the establishment of 'contracts'. These three steps may have some effect on the number of private and voluntary homes exhibiting charactistics of the total institution.

K. Wright, 'Long-term care for the elderly: public versus private'. *Public Money*, **5** (1985), 52–54.

Much of the current rhetoric surrounding the debate of whether to provide long-term care for the elderly within the public or the private sector focuses on cost. In Britain private nursing care is provided to 'private' patients using their own resources to buy nursing in an institution, by 'public' patients supported by social security payments and by 'public' patients being placed by the health authority in contract beds. Since 1983 the Government has encouraged increased collaboration between health authorities and the private sector by the use of contract beds.

This short paper examines some of the effects on NHS costs of a health authority contracting out beds to private nursing homes. It is based on a study undertaken in an area where this system has been adopted for some time. Of 402 beds available to consultant geriatricians 16% are contract beds in private nursing homes. This paper examines the comparative cost of long-stay hospital beds and contract beds.

Wright calculated the costs involved in caring for patients in these two settings and found that the health authority made a saving of £62 per patient week – up to a third – on each contract bed used. His paper focuses on three possible explanations for this price difference.

The cost of hospital care includes costs which do not fall on the

nursing homes. Drugs and dressings are provided by the hospital, but by the family practitioner committee in the case of nursing homes. However, if the capital costs of geriatric hospitals are taken into account and the cost of drugs and dressings subtracted, the price difference between hospital and home rises from £62 to £81 per patient week.

A second explanation of the price difference suggests that patients in hospital are more dependent. Using the modified version of the Crichton Royal Behavioural Rating Scale. Wright measured dependency among different categories of patients. Whereas 'private' residents in nursing homes were markedly less dependent than hospital patients, there was no marked difference between 'contract' residents and hospital patients, although the hospital had the heavier workload. This was reflected in manpower levels in both sectors. However, by making allowence for the different dependency levels of patients and residents Wright reduced the price difference to about £50 per patient week.

A third explanation, about which considerable controversy is likely to be aroused, is that the quality of care in hospital was higher than that in nursing homes. Nursing homes were not supported by remedial staff and facilities. Wright has been able to estimate an allowance for this, but much more difficult is to estimate the cost of different styles of nursing. In general terms, however, Wright as an unbiased non-professional observer was able to suggest that the quality of care in the different settings was not that variable. He therefore concluded that 'contract beds offered the health authority an efficient alternative to the expansion of hospital care for a large group of patients. The question remained, however, whether the existing cost difference would stand the test of time' (p. 53). Wright qualifies this conclusion by making the following observations.

(1). Nursing homes find it difficult to accept certain categories of patient.

(2). Although homes are required to provide adequate physical standards, and as Challis has described are subject to inspection, it is difficult for a health authority to define and ensure standards of nursing care.

(3). Nursing homes do not have the resources to provide occupational therapy or physiotherapy.

(4) Nursing homes accept patients on the understanding that if and when they are no longer able to provide the appropriate care, the consultant will find a hospital bed for the patients concerned.

COMMENT

This small study is a useful contribution to the debate over private or public care. Cost is without doubt an important aspect of providing services for older people. Unfortunately it is not the only aspect, otherwise decisions would be relatively easy to make. The difficulty of reaching sound conclusions about the viability of private care does not rest on financial considerations alone. Quality of care remains a central issue, both for people in institutions and people living at home. Cheaper options in both the private and public sectors might be politically attractive, but cheaper options probably mean an increase in the number of institutions exhibiting characteristics of the total institution – something we have all been trying to get away from for the last thirty years.

NOTES

1 Goffman, E. 'Asylums', In *Essays on the Social Situation of Mental Patients and Other Inmates*. Anchor Books, New York, 1961.
2 Townsend, P. *The Last Refuge. A Survey of Residential Institutions and Homes for the Aged in England and Wales*. Routledge & Kegan Paul, London, 1962.
3 *Ibid.*
4 Schutz, A. *The Phenomenology of the Social World*. Heinemann, London, 1972.
5 Goffman, E. *The Presentation of Self in Everyday Life*. Doubleday, New York, 1959.
6 Goffman, E. *Frame Analysis*. Harper Colophon, New York, 1974.
7 Tönnies, F. *Community and Association*. Harper & Row, New York, 1957 (orig. 1887).

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Primary Health Care — David Wilkin

G. Ford and R. Taylor. 'The elderly as underconsulters: a critical reappraisal'. *Journal of the Royal College of General Practitioners*, **35** (1985), 244–247.

In this review article Ford and Taylor challenge the widespread belief that underconsultation is a problem among the elderly. They review the accumulated evidence from many studies conducted during the 1960s and 1970s. Most of the early studies conclude, on the basis of evidence of reported morbidity, that underconsultation is a serious problem. However, the authors draw upon evidence from more recent work, including their own longitudinal study of ageing, to show that