THE CARE OF THE AGED

REPORT OF AN INTER-DEPARTMENTAL COMMITTEE
INTER-DEPARTMENTAL COMMITTEE
ON THE CARE OF THE AGED

1968

REPORT

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INTRODUCTION

At the beginning of this century the average expectation of life at birth was about 50 years. Now it is about 70 years. In the intervening period the proportion of the population aged 65 years and over has increased from 1 in 15 to 1 in 9. The increase in the number of the aged is most marked among the very old, e.g. in the 15 years from the census of 1951 to that of 1966 the number of those aged 85 years and over increased by 53%—from 13,285 to 20,297—an average increase of over 450 persons per year. Old age is not necessarily a time of ill-health and disability and most of the aged manage to lead independent, or largely independent, lives. There are now, however, more than 300,000 persons aged 65 years and over and the total number is so great that the provision of services for the proportion in need of help still presents the community with an enormous and a growing problem to which there is no ready or simple solution. It is sometimes said that the young people of to-day do not want to look after their aged relatives. Undoubtedly this is true in some cases, but the fact remains that the vast majority of the aged live in the community and that many families make great sacrifices to look after their aged relatives. Even with such sacrifices it is beyond the power of the family, in most cases, to provide for all the needs of the aged—these needs can be met only by a partnership between the family and public and voluntary organisations. The needs vary to a great extent, they can be related to any facet of living, and it requires a multiplicity of measures to meet them. The different measures tend to be complementary and failure to provide one may result in increased pressure on another, e.g. failure to provide financial aid or special housing may result in increased demand for more costly institutional care. Ultimately it may cost less, therefore, to provide some services than to try to do without them. The need for various forms of help may not be so great for the aged who are in the middle and higher income groups as it is for those in the lower income group, but a degree of need still exists. The Committee considers, therefore, that services in the future should cater, to some extent at least, for all classes.

The Committee’s recommendations, regarding the services which should be provided, are based on the belief that it is better, and probably much cheaper, to help the aged to live in the community than to provide for them in hospitals or other institutions. These recommendations are summarised in the following paragraphs—details regarding them and the considerations which led to them are set out in the Report.
RECOMMENDATIONS

Income Maintenance (Chapter 4)

1. In addition to the payments under the general schemes of Social Welfare pensions, benefits and assistance, supplements should be paid to meet the exceptional difficulties experienced by certain poor aged persons in providing the basic needs of housing, heating, lighting and cooking (Paragraph 4.1).

2. Where an aged person is living alone, or is one of a married couple living together, or otherwise has the responsibility as head of a household of providing a home at some cost and is suffering hardship, he should be paid a housing supplement related to his actual outgoings in respect of rent, rates and other expenses (Paragraph 4.2).

3. Aged persons in need should be paid a supplement to meet the costs of heating, lighting and cooking (Paragraph 4.3).

4. The cost of supplementary payments should be borne in full by the Exchequer and, where possible, they should be associated with whatever other form of benefit or pension is in payment by the Department of Social Welfare (Paragraph 4.4).

5. Special arrangements should be made in respect of persons in the age group from 65 to 70 who are not in receipt of any Social Welfare payments (Paragraph 4.5).

6. To meet the need for some flexible form of urgent assistance to cover temporary or exceptional needs the Home Assistance Scheme should be overhauled, particularly in regard to its application in the case of aged persons, so as to provide an adequate service for those who must avail of it (Paragraph 4.6).

Housing (Chapter 5)

7. Housing authorities should include a special survey of the housing needs of elderly persons in every general five-yearly assessment of housing needs which they are obliged to carry out under the Housing Act, 1966 (Paragraph 5.2).

8. Where old people wish to remain in their own homes, these homes, where practicable, should be adapted, repaired or reconstructed to meet their needs (Paragraph 5.4).

9. Where re-housing is necessary new dwellings should be provided as near as possible to the existing homes and neighbours of the old people for whom they are intended (Paragraph 5.5).

10. A specific percentage of all new local authority dwellings should be allocated to aged persons. Initially, the aim should be to allocate a minimum of ten per cent (Paragraph 5.6).

11. Housing authorities should arrange to provide “sheltered housing” (Paragraph 5.7).

12. Voluntary bodies should be encouraged to provide housing for elderly persons with the aid of State and local authority grants (Paragraph 5.8).

13. By use of demountable dwellings and mobile caravan-type homes elderly persons living in dangerously unfit dwellings in rural areas should be rehoused without delay (Paragraph 5.9).
14. Housing authorities should, as a matter of urgency, establish a renting structure realistically related to the limited means of many old people (Paragraph 5.10).

**Other Community Services (Chapter 6)**

15. Health authorities, who have not already done so, should arrange for the provision of a domiciliary nursing service in all areas (Paragraph 6.2).

16. The essential place of general practitioners in the care of the aged in the community should be recognised; their co-operation in preventing unnecessary institutional care should be sought; they should be advised of the possibility of obtaining help from various community services and, where they are paid by health authorities, and the system of payment permits of it, they should be given a higher rate of remuneration in respect of the aged than of younger persons (Paragraph 6.3).

17. Specialist advice should be readily available at the request of the family doctor on an out-patient basis, or in suitable cases on a domiciliary basis. Special clinics should be established for the aged in areas where the demand warrants it (Paragraph 6.4).

18. The special needs of old people should be taken into account in the review of ophthalmic services being undertaken by the Minister for Health (Paragraph 6.5).

19. Dental services should be expanded as soon as possible to cater adequately for the needs of elderly people (Paragraph 6.6).

20. A wide range of medical and surgical appliances should be available on a domiciliary basis and health authorities should review their existing arrangements to ensure that avoidable delays in supply do not occur (Paragraph 6.7).

21. The services of ear, nose and throat specialists should be readily available to the elderly and they should be able to obtain hearing aids without difficulty (Paragraph 6.8).

22. Health authorities should supply, for use in the home, the various aids which are available to prevent accidents and to enable the aged to overcome their disabilities (Paragraph 6.9).

23. Health authorities should arrange for the provision of a physiotherapy service on an out-patient basis in all areas (Paragraph 6.10).

24. Health authorities should arrange for the provision of occupational therapy on a community basis for aged persons who are in need of this service (Paragraph 6.11).

25. Health authorities should provide chiropody services on an out-patient and on a domiciliary basis. Because of the scarcity of adequately trained chiropodists each area should have a nurse trained in pedicure, who could provide a service on an out-patient basis. Public Health Nurses should also receive training in pedicure to provide a service on a domiciliary basis (Paragraph 6.12).

26. Health authorities should arrange for a home help service. Where the service is operated by voluntary bodies, health authorities should contribute towards the cost involved (Paragraph 6.13).
27. Health authorities should employ, or should make arrangements for the employment by voluntary bodies, of sufficient trained social workers to meet the needs of the aged in their areas (Paragraph 6.14).

28. Health authorities should introduce boarding-out schemes as a normal feature of their services for the aged (Paragraph 6.15).

29. Day hospitals should be provided on an experimental basis in Dublin and Cork (Paragraph 6.16).

30. Day centres should be provided in populous areas (Paragraph 6.17).

31. Health authorities should encourage the development of clubs and should give financial support to voluntary bodies which provide them (Paragraph 6.18).

32. Health authorities should encourage the development of laundry services and should offer the use of hospital laundries, or financial assistance, as appropriate, to voluntary bodies which undertake to run this service (Paragraph 6.19).

33. Voluntary bodies should interest themselves in obtaining special concessions for the aged, e.g. reduced prices at cinemas and theatres (Paragraph 6.20).

34. The problem of inadequate nutrition and vitamin deficiencies should be met by education in regard to correct diets and by the provision of meals. Health authorities should give financial support to voluntary organisations providing meals for the aged and, where appropriate, hospital kitchens should be used for the preparation of meals (Paragraph 6.21).

35. The home visiting of the aged should be encouraged in every way (Paragraph 6.22).

36. The provision, by voluntary bodies, of personal services for the aged should be encouraged and the National Council for the Aged (see Paragraph 10.11) should publicise the various forms of personal services which are provided for the aged and which are found to serve a very useful purpose (Paragraph 6.23).

37. Health authorities should encourage and should support, financially, voluntary bodies providing services for the aged (Paragraph 6.24).

Institutional Care (Chapter 7)

38. The concept of County Homes should be abandoned. A system should be developed under which the need of the aged for institutional care would be carefully assessed, steps would be taken to assign patients to the most appropriate form of care and every effort would be made to rehabilitate patients and restore them to the community (Paragraph 7.1).

39. Provision for the aged should be made in four main types of accommodation:—
   (a) general hospitals,
   (b) geriatric assessment units,
   (c) long-stay hospital units, and
   (d) welfare homes (Paragraph 7.1).
40. General hospitals should continue to admit the elderly who are acutely ill, or in need of urgent treatment as a result of an accident or other emergency (Paragraph 7.4).

41. Units, to be known as geriatric assessment units, should be established for the investigation and assessment of elderly patients and for their short-term care and rehabilitation where these are necessary (Paragraph 7.7).

42. Geriatric assessment units should cater for psycho-geriatric patients and should act as the assessment geriatric units recommended by the Commission on Mental Illness (Paragraph 7.11).

43. Elderly patients requiring long-term care in a hospital setting should be accommodated in long-stay hospital units, which should be confined to patients who need continuous nursing care, patients who are bedfast and need nursing care, and patients who are incontinent (Paragraph 7.12).

44. Welfare homes should be established to cater for elderly patients who do not need care in a hospital setting but for whom institutional care is required (Paragraph 7.15).

45. Overall responsibility for the screening of admissions to welfare homes should be assigned to the Chief Medical Officers of health authorities (Paragraph 7.17).

46. A ratio of approximately 40 beds per thousand of the population aged 65 years and over should be set as a reasonable overall target for the provision of beds (Paragraph 7.23).

47. Planning of geriatric assessment units should be on the basis of approximately 4.5 beds per thousand of the population aged 65 years and over—20% to 25% of these beds to be devoted to diagnosis, assessment and intensive treatment and the remainder to rehabilitation (Paragraph 7.24).

48. Planning of long-stay hospital units should be on the basis of approximately 15 beds per thousand of the population aged 65 years and over (Paragraph 7.25).

49. Planning of welfare home beds should be on the basis of approximately 20 beds per thousand of the population aged 65 years and over (Paragraph 7.26).

50. Geriatric assessment units should be located at general hospitals. They should be provided at least in the main teaching hospitals and in the hospitals which it is proposed to develop as "General" and "Regional" hospitals as visualised by the Consultative Council on the General Hospital Services. In addition, other units should be provided on a geographic basis in order to bring services closer to the people for whom they are intended and to facilitate liaison between these units and the community services (Paragraph 7.29).

51. Where possible, long-stay hospital units should be in, or near to, a general hospital and, wherever located, a long-stay unit should be associated with a general hospital (Paragraph 7.30).

52. Welfare homes, subject to organisational and economic factors, should be located reasonably convenient to the persons they are intended to serve (Paragraph 7.31).
Geriatric assessment units should be under the control of specialists in general medicine who are of consultant status. The specialists must be interested in, and have experience in, the care of the aged, including rehabilitation and social care, be in a position to devote the necessary time to the work, including the provision of out-patient and domiciliary services, and have the ability to coordinate their own work with that of other specialists and with the various community services (Paragraph 7.33).

Overall responsibility for long-stay hospital units should rest with the consultants in charge of the geriatric assessment units; they could be assisted in the day-to-day care of patients by local general practitioners (Paragraph 7.34).

Welfare homes should be staffed by family doctors—the patients being given choice of doctor, where it is feasible to do so (Paragraph 7.35).

Arrangements for the payment of capitation fees by health authorities to voluntary general hospitals which treat patients on their behalf should be continued and extended, where necessary, in respect of aged patients (Paragraph 7.36).

The existing arrangements whereby health authorities pay capitation fees to a number of voluntary institutions providing long-stay hospital care for aged patients on their behalf should be extended to all voluntary institutions which provide suitable services and are willing to accept patients sent by health authorities (Paragraph 7.37).

Suitable voluntary homes which are willing to enter into arrangements with health authorities should be recognised as welfare homes and capitation fees should be payable by health authorities in respect of patients sent by them (Paragraph 7.38).

Preventive Measures (Chapter 8)

Specific schemes of prevention should be developed (Paragraph 8.1).

The National Council for the Aged (see Paragraph 10.11) should encourage the development of courses on the problems, both social and economic, of retirement and on the making of plans regarding such matters as finance, health and nutrition, leisure activities and the development of interests after retirement (Paragraph 8.3).

Nurses coming in contact with the aged should receive special training in the recognition of the early signs of physical or mental deterioration, so that they could advise the persons concerned to seek appropriate help (Paragraph 8.4).

A register of elderly persons “at risk” should be maintained by the Public Health Nurse in each district (Paragraph 8.5).

One of the functions of the National Council for the Aged (see Paragraph 10.11) should be the dissemination of information on how best the aged can preserve their health (Paragraph 8.6).

The National Council for the Aged should collect statistics and information about domestic accidents involving elderly persons and should organise educational and propaganda services for the prevention of accidents (Paragraph 8.7).
Research (Chapter 9)

65. A medico-social investigation of the numbers in institutions and of the reasons why they are admitted and retained should be carried out as soon as possible (Paragraph 9.2).

66. Research should be carried out into the problems, both social and economic, of retirement (Paragraph 9.2).

Organisation and Co-ordination of Services (Chapter 10)

67. Additional social work services, such as the provision of home helps, necessary to help in the solution of the personal and social difficulties of elderly persons, should come under the auspices of the Department of Health (Paragraph 10.3).

68. A permanent Liaison Committee, which would meet as required, should be established to achieve the necessary co-ordination of the activities of the Departments of Health, Local Government and Social Welfare (Paragraph 10.4).

69. It should be the responsibility of the Chief Medical Officer of each area to act as co-ordinating and liaison officer between the different health services, and between the health services and the other public services, such as housing. He should have access to all hospitals and homes catering for the aged. He should act as the link between general medical practitioners and the hospital or home and, by mobilising all the community services available, give them the optimum facilities for treating patients in the community (Paragraph 10.5).

70. Local Social Service Councils should be set up in all areas (Paragraphs 10.6 and 10.7).

71. The area to be served by a Social Service Council should be determined on an ad hoc basis, depending on a number of factors, but the area should not be too small and, where possible, should cover more than one parish (Paragraph 10.8).

72. A Social Service Council should be representative of all the bodies providing services for the aged. It should also have individuals interested in the care of the aged and in a position to help, and some ex-officio members, such as Chief Medical Officers, because of their special responsibilities in this field (Paragraph 10.9).

73. If any voluntary body wishes to remain outside the local Social Service Council its wishes should be respected (Paragraph 10.10).

74. A National Council for the Aged should be established (Paragraph 10.11).

Education and Training (Chapter 11)

75. There should be greater emphasis on the care of the aged in the medical undergraduate curriculum (Paragraph 11.2).

76. Some experience in the care of the aged should be an essential part of the training of all nurses (Paragraph 11.3).

77. The work of enrolled nurses, if the grade is created, should be extended to the care of the elderly in welfare homes (Paragraph 11.4).

78. The National Council for the Aged and the local Social Service Councils should arrange short courses of instruction for home helps (Paragraph 11.5).
79. The National Council for the Aged and the local Social Service Councils should arrange courses of instruction, both by professional workers and by their own skilled and experienced members, for voluntary workers (Paragraph 11.6).

80. The organisation of a positive programme of public education on the needs of the aged should be one of the responsibilities of the National Council for the Aged (Paragraph 11.7).

81. The National Council for the Aged should arrange training courses to which housing authorities could send newly-appointed wardens of old people's dwellings (Paragraph 11.8).

82. The system of awarding fellowships to study abroad to Chief Medical Officers and their assistants should be extended so that all are given an opportunity to make a special study of the problems associated with the care of the aged (Paragraph 11.9).

Legislation (Chapter 12)

83. Health authorities should be given statutory authority to employ home helps or to arrange for their employment by other bodies (Paragraph 12.2).

84. Health authorities should be given statutory authority to provide for the boarding-out of elderly patients (Paragraph 12.3).

85. Health authorities should be given statutory authority to provide, or arrange for the provision of, meals for old people in the community (Paragraph 12.4).

86. In the consideration of future mental health legislation, particular attention should be paid to the question of the extent to which it is necessary to admit elderly persons to mental hospitals (Paragraph 12.5).

87. For short-term hospital care, the same principle in regard to charges should apply to the aged as to all other persons, i.e. services should be provided free, or at reduced cost, depending on means. For long-term hospital care, health authorities should not be debarred from making a charge, but in assessing the charge regard should be had to whether or not the persons concerned have dependants, or need the money to meet legitimate expenses (Paragraph 12.6).

88. In welfare homes, the same principles in regard to charges should apply as are recommended for hospital care (Paragraph 12.7).

89. For services provided in the community, the same principles in regard to charges should apply to the aged as to the rest of the community (Paragraph 12.8).

90. Charges on aged persons in long-stay accommodation or in welfare homes should be so adjusted that they would have some money for personal use. There should be provision for the payment of pocket money to persons between the ages of 65 and 70 who are maintained in institutions and who have no means (Paragraph 12.9).

91. Health authorities should have power to send patients to voluntary homes which would be suitable as welfare homes, similar to their powers to send patients to voluntary hospitals (Paragraph 12.10).
92. Aged persons sent by health authorities to extern hospitals or welfare homes should be subject to the same conditions in regard to charges by health authorities as if they were maintained in health authority institutions (Paragraph 12.11).

93. Health authorities should have power to assist financially, or in any other way, a voluntary body providing a service for the aged which is in general accord with services designated by Regulations for the purpose by the Minister for Health (Paragraph 12.12).

Miscellaneous (Chapter 13)

94. The task of co-ordinating information concerning all services available for the aged should be the responsibility of the Minister for Health (Paragraph 13.1).
REPORT

PRELIMINARY

Appointment of Committee

I. The Committee was appointed in October, 1965, by the Minister for Health, in consultation with the Ministers for Local Government and Social Welfare. Its function was to examine and to report on the general problem of the care of the aged and to make recommendations regarding the improvement and extension of services.

Procedure

II. The Committee issued a public advertisement inviting persons desiring to give evidence, or to make any submissions, to communicate with the Secretary. It also wrote to a number of organisations and individuals, with a particular interest in the care of the aged, inquiring whether they wished to submit any evidence or views to the Committee. Written evidence was submitted by 18 organisations and individuals and oral evidence was given by another 19 organisations and individuals. Lists of these are at Appendix A (Page 125) and Appendix B (Page 125) respectively. The Committee, as a group, visited four County Homes (the Sacred Heart Home, Carlow, St. Mary's Hospital, Clastleblayney, St. Colman's Hospital, Rathdrum, and the County Home section of St. Camillus's Hospital, Limerick, and one district mental hospital (St. Dymphna's Hospital, Carlow). Individual members visited many other County Homes. During the group visits, discussions were held with officials of the local health authorities. In Limerick, discussions were also held with representatives of voluntary bodies providing services for the aged. Special visits were made to Kilkenny and Waterford to hold discussions with local officials and representatives of voluntary bodies. The Committee also visited Scotland where they saw hospital units, welfare homes and sheltered housing schemes in Aberdeen, Dundee, Edinburgh and Glasgow. They had discussions with representatives of the Scottish Home and Health Department, Scottish Development Department and Ministry of Social Security, and with representatives of the Regional Hospital Boards and local authorities in the centres visited. The Chairman participated in a Study Group on Social Welfare Programmes for the Elderly, organised in Stockholm by the Government of Sweden in co-operation with the United Nations, within the framework of the European Social Development Programme.

Acknowledgements

III. The Committee wishes to express its appreciation of the help given by all the bodies and individuals who gave evidence, or made written submissions. All views submitted and representations made were carefully considered and they were of great assistance to the Committee in its work. The Committee also wishes to express its appreciation of the help and co-operation afforded by the various bodies and individuals whom it met in the course of its visits. Everything possible was done to make the
visits as pleasant and as beneficial as possible. In addition to benefiting from the inspection of the services available, the members had most fruitful discussions with the many persons with whom they came in contact. The Committee is particularly indebted to Mr. G. A. M. McIntosh of the Scottish Home and Health Department who made the very excellent arrangements for the visit to Scotland, and to the many people in the different places who helped to make the visit a most helpful and informative one.

**Arrangement of Report**

IV. Part I of the report gives a brief outline of the historical development of services for the aged. Part II records recent developments and gives an outline of the services at present available. Part III contains the Committee's recommendations as to the improvement and extension of services. A summary of the recommendations is given in pages xii to xxiii.

The term Ireland, as used throughout the Report, other than in the historical section, excludes the counties of Antrim, Armagh, Derry, Down, Fermanagh and Tyrone, which are referred to as Northern Ireland.
PART 1 — HISTORICAL

Chapter I

First Provisions

1.1 Public provision for the care of the aged in this country dates from the 18th century. Specific provision was not made for aged persons but they, in common with others, were given some help because they were poor, or sick, or infirm, or unable to support themselves. Houses of industry, or workhouses, which catered for the destitute, were authorised by law as early as 1703 in Dublin and 1735 in Cork. There were numerous other Acts dealing with the poor, including the aged, but the main basis of the Poor Law, as it was called and as it existed prior to the year 1921, was the Poor Relief (Ireland) Act, 1838, which was modelled in all its main provisions on the English Poor Law Amendment Act, 1834. The 1838 Act authorised the English Poor Law Commissioners to constitute Boards of Guardians in Ireland, to join together townlands to form Unions and to cause to be erected in each such Union a workhouse in which it was lawful to relieve such destitute poor persons as by reason of old age, infirmity, or defect might be unable to support themselves. The original Act was permissive.

The Workhouse

1.2 The workhouse was the central feature of the Poor Law relief and until 1847 it was the sole means of relief. Its avowed purpose was to discourage applications for relief so thoroughly that only those who were genuinely destitute would apply. Buildings were of the cheapest description, compatible with durability, and all mere decoration was studiously excluded. The following description of a typical workhouse is taken from the report of the Poor Relief Commission of 1927 (paragraphs 34 and 35):—

"The majority of the buildings were commenced in the years 1839 to 1840 and finished within three or four years. They were built much on the same plan. The walls were unplastered and the rooms unceiled. In their construction and fitting-up a rigid economy was observed. One side of the house was allotted to males and the other to females. The classification on each side was roughly as follows:—

(1) the admission, ward which in later years became the casuals' or night lodgers' ward,
(2) the able-bodied,
(3) the infirm,
(4) the school and children ward,
(5) the infirmary,
(6) the lunatic ward."
In addition, there was on the female side a nursery and maternity ward. In some of the larger workhouses there were wards known as the male and female separation wards. The standard of comfort in the body of the house was, in many instances, very poor and the closet and bathing accommodation bad. It will be readily understood that an institution sheltering 12 or 14 different classes of all ages and of the most diverse character was difficult of management and that the association of all classes did not of itself conduce to their comfort or improvement. The workhouse infirmaries were largely occupied and properly so, having regard to their origin, by the bedridden and feeble who, though not acutely ill, nevertheless required nursing care. This militated against their use as general hospitals for the treatment of acute cases. As a rule, the infirmaries were kept up to a much higher standard than the rest of the house, but in many places they lacked proper water supply, sanitary and bathing accommodation and operation theatres.”

**Out-door Relief**

1.3 The Poor Relief (Ireland) Act, 1847, provided for the appointment of Irish Poor Law Commissioners to take over the functions of the English Commissioners and placed a statutory obligation on the Guardians of every Union to make—

“provision for the due relief of all such destitute poor persons as are permanently disabled from labour by reason of old age, infirmity or bodily or mental defect, and of such destitute poor persons as being disabled from labour by reason of severe sickness or serious accident are thereby deprived of the means of earning a subsistence for themselves and their families whom they are liable by law to maintain.”

The Act authorised the Guardians—

“to relieve such poor persons being destitute as aforesaid either in the workhouse or out of the workhouse as to them shall appear fitting and expedient in each individual case.”

Apart from removing the permissive features of the 1838 Act, the 1847 Act was important as it was the first authority for giving what came to be known as “out-door relief”.

**Medical Treatment**

1.4 The Poor Relief (Ireland) Act, 1851, frequently referred to as the Medical Charities Act, conferred on the sick poor the right of free medical advice, treatment and medicine. It provided for the division of each Union into dispensary districts, the appointment of medical officers and the supply of necessary medicines and appliances.

**Extension of Powers of Guardians**

1.5 The Poor Relief (Ireland) Act, 1862, provided for the admission to workhouses, subject to a charge, of poor persons requiring medical or surgical aid. It also author-
ised the Guardians to send any inmates of workhouses, who required special treatment, to any hospital or infirmary, which was willing to receive them, and to pay the cost of treatment and conveyance.

**County Infirmaries and Fever Hospitals**

1.6 In addition to the provisions made under the Poor Law, there were hospitals set up with parliamentary sanction and administered apart from the Poor Law. They were known as County Infirmaries and County Fever Hospitals. An Act of 1765 authorised the establishment of County Infirmaries as "receptacles for poor who are infirm or diseased". The Hospitals (Ireland) Act, 1818, authorised the establishment of County Fever or Infectious Hospitals. Under these Acts and subsequent Acts the Infirmaries and County Fever Hospitals were financed partly by private donations and partly by subscriptions from the Grand Juries and subsequently County Councils. They were governed by Local Committees. They were usually looked upon as providing for a better class than the workhouse infirmaries.

**Voluntary Hospitals**

1.7 In addition to the workhouses and public hospitals various voluntary hospitals were erected during the 18th and 19th centuries, mainly in Dublin. They were charitable institutions and catered, among others, for the aged who were sick.

**Local Government Board for Ireland**

1.8 The Irish Local Government Board Act, 1872, established the Local Government Board for Ireland. It took over the functions of the Irish Poor Law Commissioners and acted as the central authority for the public hospitals and for other aspects of the health services.

**Vice-Regal and Royal Commissions**

1.9 Towards the end of the 19th century public opinion demanded a modification of the existing system of poor relief. The Vice-Regal Commission on Poor Law Reform, which reported in 1906, found 159 workhouses in operation. It recommended a re-distribution of patients so as to secure the largest possible measure of specialisation. It reported that the arrangements existing in most workhouses were quite unsuitable for the treatment of surgical or even medical cases according to any modern standards. It recommended that the infirm or aged should be removed from the workhouses to a County Institution to be known as the County Alms House. A Royal Commission on the Poor Laws which reported in 1909 was in general agreement with the findings and recommendations of the Vice-Regal Commission. It stressed that effective classification could not be attained as long as all classes of inmates were housed within the walls of a single institution and it affirmed that it was a cardinal principle of all proposals that there should be classification by institutions and not merely in institutions. No effective steps were taken to implement the recommendations of the Vice-Regal or of the Royal Commission.
Old Age Pensions

1.10 Prior to 1909, the aged poor whose relatives or friends were unable to support them, and for whom outdoor relief was inadequate, had no option but to seek the shelter of the workhouse which was regarded by most as the very last resort. The establishment of some form of old age pension for aged workers had for many years prior to 1909 been the subject of some consideration and indeed agitation. In 1864 the Government Annuities Act provided a scheme whereby persons could purchase, through the Post Office, small annuities to provide for their old age but this scheme was not a success, due mainly to the fact that the persons for whom it was designed were not in a position to pay the necessary subscriptions. The pressure for a proper pension scheme on a State-wide basis continued and was increased following the introduction of old age pension schemes in Germany and Denmark in 1891, in New Zealand in 1898, in New South Wales and Victoria in 1901 and in France in 1905. Eventually in 1908 the Old Age Pensions Act was passed which provided for a scheme for non-contributory old age pensions at the age 70 subject to a means test. This was the first scheme in Britain or Ireland to cover the whole population and to be financed wholly out of voted monies. From it has developed the whole structure of the Social Welfare Income Maintenance Services as they are known in this country and which cover, at present, non-contributory pensions not only for the aged but also for widows, orphans and the blind, together with the contributory schemes of pensions and benefits for the aged, widows, orphans, the sick, the disabled and the unemployed.

Housing

1.11 The housing of old persons is not shown in the historical records of Irish public authorities as a separate or special problem. As part of the community, the aged poor shared the grossly overcrowded and insanitary conditions in the major urban centres of which there are records going back to the 16th century. In the “Report of Inquiry into the Housing of the Working Classes of the City of Dublin 1939/43” these conditions are illustrated by quoting the results of some surveys made over the years. In 1798 a count was made in a street in a slum area of Dublin which gave an average of 28.7 persons per house. A census in 1841 showed 23,000 families in Dublin living in single rooms and in one area there was an average whole population occupancy rate of 11.6 persons per house. In 1913, 25,822 families lived in 5,188 tenement houses and 20,108 were in occupation of one room only. In 1938, 28,679 families lived in 37,848 rooms in 6,307 tenement houses. In rural areas old persons bore their share of the burden of banishments to remote areas, mud-walled cabins, famine, rack rents, evictions and emigration which were the lot of the poor. Their only escape was to the workhouse—a fate regarded by many of them as worse than death. In later years, old people shared in the progressive improvement of housing conditions in both urban and rural areas. Because of the more pressing demands for housing for large families it is only recently, however, that the housing of the aged has been recognised as a distinct and separate problem.
Chapter 2

Changes Since 1922

2.1 Since the establishment of the State in 1922 there have been far-reaching changes in the administration and scope of the health and social services. In so far as the aged are concerned the present position is set out, in broad outline, in paragraphs 2.2 to 2.50 under the following headings:

(a) Administration,
(b) County Homes,
(c) Hospitals and Voluntary Homes,
(d) Domiciliary and Out-patient Health Services,
(e) Housing,
(f) Social Welfare Services, and
(g) Voluntary Organisations.

(a) Administration

Central Administration

2.2 Under the Ministers and Secretaries Act, 1924, the Department of Local Government and Public Health, with its own Minister, became the central authority and took over the administration of the law previously administered by the Local Government Board for Ireland. Old age pensions, however, came to be administered partly by the Office of the Revenue Commissioners. In 1947 separate Departments of Local Government, Health and Social Welfare were established. In so far as the aged are concerned, the Department of Local Government now deals with housing, water supplies, sewage disposal and other sanitary services; the Department of Health deals with all other aspects of the health services; and the Department of Social Welfare deals with the income maintenance services, public assistance and other forms of social services.

Local Administration

2.3 On the advent of self-government, Boards of Guardians were abolished and were replaced by Boards of Assistance, or Boards of Health and Public Assistance. Several changes in local administration were made subsequently—the details are not relevant to this report. Broadly, the present position is that local health authorities (in some cases, joint boards consisting of representatives of two or more authorities), deal with the health services, subject to the general direction and supervision of the Minister for Health. Local authorities (County Councils, Corporations and Urban District Councils) deal with housing and sanitary services and also with public assistance.
The County Management Act, 1940, extended the management system, which had already been introduced for the Corporations of Dublin, Cork, Limerick and Waterford, to all areas. Under this system a Manager is responsible for the day-to-day executive functions of the local bodies.

(b) County Homes

Origin

2.4 During the War of Independence, the British authorities had maintained the Local Government Board for Ireland as the central authority, but a Department of Local Government was set up by Dáil Éireann and was recognised by a number of local councils. For a while, therefore, there were two central authorities. As indicated earlier, the Department of Local Government and Public Health became the central authority in 1924. County schemes were formulated by County Councils in 1921 and were formally legalised by the Local Government (Temporary Provisions) Act, 1923. County Schemes provided for the rationalisation of the workhouse system and the substitution of specialised hospitals and homes for the former general mixed workhouses. Many workhouses were closed and, in most areas, only one was retained to serve as a County Home. There was a general impression, or implied intention, that County Homes should be reserved for the aged and infirm poor and chronic invalids. Insufficient provision was made for classes such as unmarried mothers, children and mental defectives so that, in practice, County Homes still retained many of the characteristics of the mixed workhouse. Health authorities, with the approval of the Minister for Health (see paragraph 7.37), give assistance to bodies providing accommodation for aged persons, but the main provision for the aged, whether sick or infirm or in need only of shelter and maintenance, is made in County Homes. A full list of institutions designated as County Homes and hospitals which have County Home sections is at Appendix C. It will be noted that there are seven institutions with accommodation of the County Home type in Dublin, seven in Cork, three in Louth, two each in Galway, Kerry, Limerick, Waterford and Wexford, and one each in Carlow, Cavan, Clare, Donegal, Kildare, Kilkenny, Laois, Leitrim, Longford, Mayo, Meath, Monaghan, Offaly, Roscommon, Sligo, Tipperary (N.R.), Tipperary (S.R.), Westmeath and Wicklow.

Commission on Poor Relief

2.5 A Commission was appointed by the Minister for Local Government and Public Health in 1925 to enquire into the laws and administration relating to the relief of the sick and destitute poor. One of its functions was “to enquire into the adequacy and the suitability of schemes which have been formulated under the Local Government (Temporary Provisions) Act, 1923, and make recommendations”. The Commission submitted its report in 1927. It stated that in nearly all the County Homes were to be found lunatics, idiots, imbeciles and, except in those counties where other special provision is made for them, expectant and unmarried mothers and children. It considered that the County Homes were not fit and proper places for the reception of the various classes which were to be found in them. It recommended that the original intention to reserve the County Home for the aged and infirm poor and chronic invalids should be revived, that the Homes should be
brought up to a satisfactory standard and that separate specialised accommodation should be provided for unmarried mothers, children and mental defectives. In general, these recommendations were not carried out.

Inter-Departmental Committee (1949)

2.6 In 1949 an Inter-Departmental Committee consisting of representatives of the Departments of Health, Social Welfare, Local Government and Finance was set up by decision of the Government to examine the question of the reconstruction and replacement of the County Homes and to submit a report to the Minister for Health. It found that the County Homes were still being used for the chronic sick, the aged, mental defectives, the blind, deaf mutes, casuals, unmarried mothers and children. Buildings generally were found to be lacking in comfort and amenities. Sanitary and bathing facilities were insufficient and, in most cases, there were inadequate cooking and heating facilities. The 1949 Committee recommended that County Homes suitably reconstructed, should be reserved for the aged and chronic sick and that unmarried mothers, mental defectives, epileptics, blind and deaf mutes and casuals should be provided with alternative accommodation. The 1949 Committee adverted to the trend in other countries towards the provision of accommodation for old people in homes entirely distinct from hospitals. It felt, however, that as a matter of practical policy the housing of the aged and the chronic sick in a single institution had much to commend it. It considered that the busy atmosphere of a fairly large home had the desirable effect of preserving the mental and physical alertness of the patients—an effect often missing in the smaller and more quiet homes. It also considered that the borderline between the aged and chronic sick is sometimes narrow and that there is less upset to a patient in transfer from one portion of an institution to another than in transfer from one institution to another. It recommended that only one type of home should be provided.

White Paper of 1951

2.7 A White Paper, which was issued in 1951, indicated that the Government had accepted the recommendations of the 1949 Inter-Departmental Committee. It was stated that, while in general it was not intended that there should be a multiplicity of homes and hospitals for the accommodation of the aged and chronic sick in any area, sympathetic consideration would be given to proposals for a limited number of subsidiary institutions, provided by adaptation of existing local authority buildings or country houses, in a few of the very large counties where hardship would result from removing old people too great a distance from their friends. To assist in the reconstruction of County Homes the Government undertook to make State grants available to local authorities by way of contribution to loan charges on monies borrowed for the purpose of carrying out approved works. The grant was at the rate of 50% of approved loan charges.

Work on County Homes

2.8 Up to the end of 1966 improvement schemes were undertaken at Athy, Castlebar, Castleblayney, Clonakilty, Ennis, Longford, Mountmellick, Stranorlar and Trim. Many of these schemes have been completed and the remainder will be completed
in 1969. Some existing buildings are being reconstructed but in most of the centres new accommodation is being provided. The total number of beds involved is 2,195 (plus accommodation for 265 staff) and the estimated cost is £3,340,000. Since 1966 further schemes have been undertaken or have been put to tender covering work at Carrick-on-Shannon, Killarney, Roscommon, Regina Coeli Hostel, Dublin, and Usher's Island Hostel, Dublin. These will provide 668 new beds and the estimated expenditure will be £900,000. Schemes are at present in course of planning for the provision of further new accommodation at Athy, Boyle, Ennis, Kilrush and Longford. These will give a total of 712 beds at an estimated cost of £1,200,000. Further information regarding the work being done is given in paragraph 7.39.

Categories of Patients

2.9 Changes have occurred in the categories of patients in County Homes, but these homes still continue to deal with many persons in addition to the aged and chronic sick. The following table shows the numbers in different categories in County Homes on 31st March, 1950 and on 31st March, 1966:

<table>
<thead>
<tr>
<th>Category</th>
<th>31/3/1950</th>
<th>31/3/1966</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under 65 years</td>
<td>65 years and over</td>
</tr>
<tr>
<td>Chronic sick</td>
<td>806</td>
<td>2,404</td>
</tr>
<tr>
<td>Aged other than chronic sick</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other adults</td>
<td>1,717</td>
<td>2,095</td>
</tr>
<tr>
<td>Mentally handicapped</td>
<td>383</td>
<td>212</td>
</tr>
<tr>
<td>Casuals*</td>
<td>84</td>
<td>139</td>
</tr>
<tr>
<td>Children</td>
<td>829</td>
<td>53</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>3,819</td>
<td>4,766</td>
</tr>
</tbody>
</table>

*Mainly homeless persons who remain for a few nights only.

Staffing and Treatment

2.10 Most County Homes are staffed at general practitioner level. Nurses and other para-medical staff are employed, but the numbers are limited. At Appendix D is a statement showing in respect of each County Home the numbers of doctors, nurses, social workers, physiotherapists, occupational therapists and chiropodists employed.

Admissions

2.11 Admissions to County Homes are governed by the Institutional Assistance Regulations, 1954, which provide that a person may be admitted:

(i) on an order given by the Manager of the health authority;
(ii) on an order given by a member of the health authority, or by a person authorised by the health authority to issue directions for the giving of general medical services;

(iii) on an order of the officer in charge of a hospital maintained by a health authority where the person is transferred from such hospital to the County Home;

(iv) under an agreement with another health authority;

(v) on the direction of the medical officer of the County Home or, in his absence, without such direction, in a case of urgent necessity.

Where a person has been admitted otherwise than in accordance with (i) above, the Manager must later consider whether or not it is proper for the person to be kept in the County Home.

(c) Hospitals and Voluntary Homes

Local Authority Hospitals

2.12 In addition to County Homes, health authorities maintain a number of district hospitals, county hospitals, regional hospitals and mental hospitals. These hospitals do not cater for the aged, as such, but in all of them are to be found a number of the aged who are sick or in need of some specialist treatment, or for whom alternative accommodation is not available. Estimates regarding the numbers of aged persons in these hospitals are contained in paragraph 7.22. The total number involved is approximately 6,700.

Voluntary Hospitals and Homes

2.13 A number of elderly patients are maintained in voluntary and private general hospitals, private nursing homes and similar centres. Between 1963 and 1966 a survey was made of 14 Dublin general hospitals, as a joint study between the Departments of Social Medicine and Social Studies in Trinity College and the Department of Social and Preventive Medicine in University College, Dublin.* The survey showed that 28.1% of the patients were aged 65 years and over. As the 14 hospitals were not identified the Committee assumed that a similar position obtained in all the voluntary and private general hospitals in Dublin. Returns were obtained from the voluntary and private hospitals in the remainder of the country, and from nursing homes catering for patients suffering from acute conditions. Returns were also obtained from voluntary homes and institutions catering for the aged, or for persons suffering from chronic ailments, and from convalescent homes. A list of those from which returns were sought is at Appendix E. All homes of this type are not registered and it is possible that there are some small ones, in addition to those on the list, of whose existence the Committee was not aware. The Committee estimated that there are approximately 5,400 aged persons in general hospitals, homes and other institutions. Particulars are given in paragraph 7.22.

(d) Numbers In Institutions

Total Number of Aged Persons in Institutions

2.14 The figures available to the Committee do not give the exact number of persons aged 65 years and over who are in institutions, but from the information available the Committee estimates that the number is approximately 20,000. This represents about 7 beds per thousand of the total population, or 62 beds per thousand of those aged 65 years and over. Views regarding the existing number and the number of institutional places which should be provided are contained in paragraphs 7.22 and 7.23.

(e) Domiciliary and Out-Patient Health Services

Medical Services

2.15 Health authorities provide for persons in the lower income group a general medical service (a general practitioner, medical and surgical service, medicine, ophthalmic, dental and aural treatment and medical, surgical and dental appliances). Health authorities also provide for persons in the lower and middle income groups specialist out-patient clinic services and they arrange with general hospitals to provide similar specialist clinics. Details are not available regarding the number of aged persons dealt with at such clinics.

Nursing Services

2.16 Health authorities may provide a nurse or nurses to give advice or assistance on matters relating to health and to assist sick persons. They may also arrange for the provision of the services of a nurse or nurses by voluntary bodies. On 31st March, 1968, 392 nurses were employed directly by health authorities on district nursing duties and arrangements had been made with voluntary bodies for the services of 105 nurses.

Appliances

2.17 In addition to the medical and surgical appliances referred to in paragraph 2.15, health authorities may supply or lend, in cases of need, items such as bed-pans, rubber sheets, bed-rests, foam mattresses and hoists. Arrangements to supply articles of this nature have been made by 26 authorities (there are in all 27 authorities).

Physiotherapy and Chiropody

2.18 Health authorities may provide or make arrangements for the provision of physiotherapy and chiropody on an out-patient basis. Arrangements of this nature have been made by eleven authorities in regard to physiotherapy and by three authorities in regard to chiropody.

Ophthalmic Services

2.19 Health authorities provide ophthalmic services for persons in the lower income group. Part-time ophthalmologists are employed to carry out eye examinations, to
provide treatment for ailments and diseases and to prescribe spectacles. The spectacles are supplied by opticians who are under contract to the health authorities. Apart from these services, persons insured under the Social Welfare Acts are entitled to optical benefits (see paragraph 2.39).

Dental Services
2.20 Dental services are provided by health authorities for persons in the lower income group. The services are provided mainly by whole-time dentists employed by health authorities. In some areas, the services provided by whole-time staff are supplemented by the part-time employment of private practitioners. In addition to the services provided by health authorities, dental benefits are available to persons insured under the Social Welfare Acts (see paragraph 2.39).

Aural Services
2.21 Health authorities employ ear, nose and throat specialists to examine patients referred to them and to treat ear diseases. They also have an arrangement with the National Rehabilitation Board to provide hearing aids when these are prescribed by specialists. These services are at present confined to persons in the lower income group for whom they are provided free of charge. Persons insured under the Social Welfare Acts are entitled to assistance towards the cost of providing or repairing hearing aids (see paragraph 2.39).

Assistance to Voluntary Bodies
2.22 A number of voluntary bodies provide domiciliary services (see paragraph 2.50). Health authorities may provide assistance for any body which provides, or proposes to provide, a service "similar or ancillary to a service which the health authority may provide". All activities of voluntary organisations are not covered by this provision. In the five years ended 31st March, 1968, capital grants amounting to £69,200, and in the year ended 31st March, 1968, maintenance grants amounting to £22,900, were paid by health authorities to voluntary organisations providing services for the aged.

(f) Housing

General
2.23 Elderly persons were not distinguished as a separate class in housing legislation until 1953. Local authorities, in implementing their housing programmes, were required to have regard to certain basic priorities, mainly the elimination of unfit dwellings, and policy in relation to such matters as the payment of State subsidy and the allocation of tenancies was orientated towards the achievement of these ends. For example, slum clearance housing in urban areas qualified for State subsidy at the rate of two-thirds of the annual loan charges, compared with one-third in "ordinary" cases, and Regulations made by the Minister for Local Government prescribed a high preference, in the letting of houses, for families who had been living in dwellings which were deemed to be unfit for human habitation. The housing
needs of elderly persons were met by housing authorities within their general powers under the Housing Acts and they were dealt with usually in association with general slum clearance operations. While housing authorities were encouraged by the Minister for Local Government to provide a diversity of accommodation in their schemes to meet the needs of small family units or single persons, the housing of elderly persons was not isolated for attention as a particular problem in its own right until 1953.

Reservation of Houses for Particular Classes

2.24 In 1948 the concept of providing houses reserved for a particular class of persons was first introduced into housing legislation (Housing Amendment Act, 1948). The power to provide these dwellings was given to urban authorities only. Special grants of up to £250 a house were payable in respect of the houses in lieu of a contribution to annual loan charges. Initially, newlyweds were the only class of persons singled out for this purpose but in 1953 it was provided in Regulations made by the Minister for Local Government (Housing [Management and Letting] Regulations, 1953) that lettings of reserved houses could be made also to elderly persons. In practice, however, while a total of almost 800 reserved houses were provided by housing authorities, nearly all of them were for newlyweds and the rehousing of elderly persons has, therefore, continued to be carried out mainly in conjunction with the general operations of housing authorities.

Grants for Essential Repairs

2.25 The special problem of the elderly living in unfit conditions in remote areas where there will almost certainly be no demand for the tenancy of a dwelling after the lifetime of the present occupiers has also received attention. Provision for a special type of grant to cater for this type of case was made in the Housing (Loans and Grants) Act, 1962, and re-enacted in the Housing Act, 1966. Under these provisions the essential repairs necessary to prolong the life of the dwelling may be carried out either by the occupant or by the housing authority. The Minister may make a grant of up to £80 in respect of the work and the local authority may contribute the full cost of the balance either in cash, materials or labour.

Grants for Dower Houses and Additional Rooms

2.26 Section 17 of the Housing Act, 1966, provides for the making of a State grant not exceeding £175 for the provision of a new dower house, i.e. a small second house on a farm. In this case also, the local authority may make a supplementary grant not exceeding the State grant. State grants up to £140 per house are also available for the provision of an extra room or rooms to accommodate, in the main, an elderly person transferring his holding to a member of his family or to the Land Commission. In this case also the local authority may make a supplementary grant not exceeding the State grant. The two provisions outlined above are intended to encourage the provision of suitable separate housing accommodation for elderly persons, and should help to give them the degree of privacy and independence they desire, while at the same time they are enabled to hand over the family house to the members of their families.
Grant-aided Housing for Elderly Persons

2.27 To encourage philanthropic and charitable bodies to make a contribution to the particular problem of the housing of the aged a special scheme of grants was provided for in the Housing (Loans and Grants) Act, 1962. Under this scheme, which was more generous than the normal provisions open to all classes, each living unit provided would qualify for a maximum State grant of £300 and local authorities were empowered to give supplementary grants not exceeding the State grant.

This scheme proved popular with religious communities and bodies like the Society of St. Vincent de Paul, Iveagh Trust, Soroptimist Association and St. Anne’s Co-Operative Guild Ltd., Limerick. Progress was hastened by co-operation, and a considerable amount of oral consultation, between the various bodies and the Department.

Subsidy for Dwellings for Elderly Persons

2.28 The Housing Act, 1966, contains a number of provisions which have a direct bearing on the problem of elderly persons’ housing. Probably the most important is that which applies the higher rate of subsidy (two-thirds of annual loan charges) to all dwellings provided by housing authorities for elderly persons regardless of whether or not the re-housing is associated with a statutory housing operation of the authority such as slum clearance or the demolition of unfit or dangerous dwellings. This provision should add considerably to the number of local authority dwellings reserved for the exclusive use of the elderly.

Priorities in Allocation of Tenancies

2.29 A scale of priorities for the allocation of tenancies is no longer prescribed statutorily but is settled locally by each authority within broad lines laid down by statute. Thus a housing authority with an acute need for dwellings for the aged in its area could give re-housing of the aged a special priority.

Standards for Dwellings provided by Local Authorities and Charitable Organisations

2.30 For the guidance of philanthropic bodies in this field, the Minister for Local Government has prepared an explanatory memorandum outlining desirable standards of design and accommodation. At appendix F is an extract from that memorandum, showing the standards suggested for accommodation for the aged. A note is also included in Appendix F regarding the general standards recommended for local authority dwellings for elderly persons.

Recent Developments

2.31 The Minister for Local Government, by Circular Letter of 9th November, 1966, called for a comprehensive approach by housing authorities to the care of the aged; he asked for a special survey by housing authorities, to be carried out in close liaison with health and public assistance authorities, to ascertain and classify the specific housing requirements of different categories of the aged for specific provision in
their house building programmes for the aged. The Committee understands that there has been encouraging response from many housing authorities to the Minister's call for a vigorous and imaginative approach to the provision of adequate and suitable housing accommodation for the aged.

Rural Areas

2.32 In some counties the worst housing conditions of elderly persons exist in rather remote rural areas where there will be no continuing need for dwellings after the lifetime of the present occupants of the unfit houses. To meet the needs of cases which cannot be covered by the provisions referred to in paragraph 2.25 the Minister for Local Government has had a special prototype demountable dwelling erected near Newbridge with the ready co-operation of Kildare County Council. Details of this dwelling have been conveyed to all rural housing authorities. The construction is based on a timber frame with asbestos-polystyrene sandwich infill panels. The prototype, which is suitable for use by an old person or by an elderly couple, comprises some 267 sq. ft. and cost about £600. It should be possible to reproduce it in quantity at a lower cost. The Kildare dwelling is only one of a number of possible solutions. A number of housing authorities and some commercial interests have evolved or are evolving their own types and designs and they are being given every encouragement by the Minister. Some authorities prefer the caravan-type mobile home which has the added advantages of compactness, built-in furniture and full mobility.

(g) Social Welfare Services

General

2.33 The Department of Social Welfare is responsible for the administration of certain income maintenance services which include not only schemes where the need to maintain income is directly related to the attainment of old age, i.e. the old age pension scheme, but also schemes to cover the loss of or the reduction in earning power arising from other causes, e.g. unemployment, prolonged illness, which may be the result of or be aggravated by or be more pronounced in old age. These services fall into two main categories—those provided under the social insurance scheme and those provided under the social assistance scheme. An outline of these schemes as they affect aged persons is given in the following paragraphs and statistical information in relation to old age pensions is given in Appendix G. The rates of pension and benefit given in the following paragraphs include the increases announced by the Minister for Finance in his budget statement on 23rd April, 1968, provided for in the Social Welfare (Miscellaneous Provisions) Act, 1968, and operative from August, 1968, in the case of the social assistance scheme and from January, 1969, in the case of the social insurance scheme.

(i) Social Insurance

Insured Persons

2.34 Social insurance under the Social Welfare Acts is compulsory for all employees (other than self-employed persons) aged 16 to 70 years subject to certain exceptions
which include persons whose employment is in a non-manual capacity at a rate of remuneration in excess of £1,200 a year. Most persons compulsorily insured are insured for all benefits but persons in certain employments such as permanent and pensionable employment in the Civil Service, in the Defence Forces as commissioned officers, as teachers or under a local or other public authority, are insured only for the purposes of widows' and orphans' pensions. Persons ceasing to be compulsorily insured may continue their insurance for pension purposes by becoming voluntary contributors. The total insured population represents some two-thirds of the population gainfully employed and some one-quarter of the total population. The contributions paid by contributors and their employers meet about two-thirds of the cost of the schemes and the Exchequer pays the balance. The benefits which insured persons who are aged and their dependants may obtain are not subject to any means test and are set out in paragraphs 2.35 to 2.39.

**Old Age (Contributory) Pension**

2.35 This pension is payable at age 70 to a person whose insurance under the Social Welfare Acts satisfies certain prescribed conditions. The insurance must have commenced before he reached the age of 60, he must have had not less than 156 employment contributions paid (a minimum of three years' insurable employment) and he must have had an average of not less than 48 contributions paid or credited for each year of insurance up to age 70. A person need not have retired from gainful employment in order to qualify for pension. A pensioner can obtain an increase of pension in respect of his wife (or in the case of a woman for her husband if he is physically or mentally incapable of self-support) and his children, if any, under the age of 16 years. The maximum weekly rates of pension are 72/6d. for the pensioner alone and 132/6d. for a married couple, unless both husband and wife qualify separately for 72/6d. each. Lower rates of pension are payable where the insurance conditions are not fully satisfied. Increases of pension are payable in respect of qualified children under 16 years of age, 15/6d. for each of the first two children and 10/6d. for each additional child. From January, 1969, an incapacitated pensioner may be paid an increase of 45/- a week for a daughter who has been insurably employed but leaves employment to look after him or her. The payment is limited to cases where the pensioner is so incapacitated as to require full time care and attention and there is no other adult living with him or her capable of providing that care and attention. Similar payments subject to the same conditions may be made to incapacitated widows aged 70 and over who are receiving widows' (contributory) pension (paragraph 2.36) and to persons receiving non-contributory old age pension (paragraph 2.40).

**Widows' (Contributory) Pension**

2.36 This pension is payable to a widow who at the date of her husband's death satisfies the insurance conditions for pension on the basis of her late husband's insurance or on her own. These conditions are briefly that he or she had not less than 156 employment contributions paid (a minimum of three years' insurable employment) and had a yearly average of not less than 39 contributions paid or credited in the last three or five years before the date of the husband's death or attainment
of the age of 70 or an average of not less than 48 contributions paid or credited for each year of insurance up to that date. There is no age limitation for pension. However, a widow who qualifies for old age (contributory) pension on attaining the age of 70 cannot receive that pension and widows' (contributory) pension at the same time, only the pension more favourable to her being payable. The weekly rates of widow's (contributory) pension are 65/-d. for widow's who have no qualified children and 67/6d. for widows with qualified children together with increases of 15/6d. for each of the first two qualified children and 10/6d. for each qualified child in excess of two. Reduced rates of pension are payable where the insurance conditions are not fully satisfied. The additional payment of 45/-d. a week mentioned in paragraph 2.35 above may also be paid to an incapacitated pensioner aged 70 and over.

Unemployment Benefit

2.37. This benefit is payable for a maximum period of 312 days to unemployed persons aged less than 70 years who are available for and capable of work, and whose social insurance satisfies prescribed conditions. However, persons who are aged 65 years or more and who have had not less than 156 employment contributions paid in respect of them may continue to draw unemployment benefit up to the age of 70 as long as they are unemployed. The rates of unemployment benefit are 65/-d. a week for the insured person with an increase of 52/6d. a week for an adult dependant, increases for children being payable on the same basis as for widows' (contributory) pension. Reduced rates of benefit are payable where the insurance conditions are not fully satisfied.

Disability Benefit

2.38. This benefit is payable to insured persons under the age of 70 years who are certified as incapable of work by reason of illness and whose insurance satisfies the prescribed conditions. Provided the person has 156 employment contributions paid, payment of benefit may continue up to age 70 as long as the incapacity lasts and the necessary evidence is supplied. The rates of disability benefit are the same as of unemployment benefit.

Treatment Benefits

2.39. The following benefits are also available to insured persons regardless of age:

Dental Benefit:

The full cost of all forms of conservative treatment, dentistry, extractions, fillings, etc. and one-third of the cost of prosthetic dentistry, (including provision of dentures, repairs, additions, alterations and remodelling) according to a scale of fees fixed by the Minister from time to time.

Optical Benefit:

The cost of examination, advice and, if necessary, prescription by an ophthalmic surgeon, a medical practitioner or an ophthalmic optician and a sum not exceeding 23/6d. towards the provision of optical appliances or the repair thereof.
Medical and Surgical Appliances:

Two-thirds of the cost of providing or repairing hearing aids or contact-lenses where the price does not exceed £3, or where it exceeds £3, such portion of the cost as may be determined.

(ii) Social Assistance

Old Age (and Blind) Non-Contributory Pensions

2.40 This pension scheme is financed directly by the State and is governed by the provisions of the Old Age Pensions Acts. The pension is paid, subject to a means test, to persons who have attained the age of 70 years and who do not qualify for old age (contributory) pension. The maximum weekly pension, 65/-d., is paid to persons whose means, assessed in accordance with the provisions of the Old Age Pensions Acts, are nil. For those who have assessable means the weekly pension rate is reduced and the minimum pension is payable where the assessed means do not exceed £195-15-0d. per year. The basic rate of pension is also increased, with suitable adjustment of the means scale, where there are qualified children, at the rate of 12/6d. per week for each of the first two children and 7/6d. per week for each qualified child in excess of two. The additional payment of 45/-d. a week mentioned in paragraph 2.35 above may also be paid to an incapacitated pensioner.

The Old Age Pensions Acts also provide that a person who is so blind as to be unable to do any work for which eyesight is essential, or to be unable to follow his or her ordinary occupation, may receive a pension, from the minimum age of 21 years, at the same rates as and subject to a means test similar to that applied to old age pensions.

Particulars of the rules for the assessment of a pensioner’s means, showing in particular the items disregarded, are given in Appendix H.

Widows’ (Non-Contributory) Pension

2.41 This pension is paid, subject to a means test, to widows under 70 years of age who do not qualify for widows’ (contributory) pension and the means are assessed as shown in Appendix H. The maximum weekly pension, 63/6d., is paid to those whose assessed means are nil. As in the case of old age non-contributory pension, the rate of pension is reduced as means increase, the minimum pension being payable in cases where assessed means do not exceed £182-15-0d. a year. Again, as in the case of old age non-contributory pensions, this means limit is extended where there are qualified children and allowances for children are paid at the same rates as in that pension.

Unemployment Assistance

2.42 Unemployment assistance is payable up to age 70, subject to the fulfilment of certain conditions, to unemployed persons who are available for employment but who are not eligible for unemployment benefit. Payment of assistance is subject to a means test and can continue as long as the unemployment lasts. The maximum weekly rates of unemployment assistance are, for a person with no dependants,
51/6d. increased by 46/-d. for an adult dependant in urban areas (45/6d. and 44/-d. respectively elsewhere), with 12/6d. for each of the first two qualified children and 7/6d. for each qualified child in excess of two.

(iii) Other Services

General
2.43 There are also certain other services under the general control of the Department of Social Welfare, some of which are administered by local authorities or other bodies, under which the aged also benefit or which are specifically for the aged. These are the blind welfare scheme, the cheap fuel scheme, and home assistance, which apply regardless of age and the schemes of free travel, free electricity allowances and free radio and television licences which apply to pensioners over 70 years of age.

Blind Welfare
2.44 In respect of each blind inmate of approved homes and hostels for the blind annual capitation grants of £65 and £125 are paid by the Department and the local authorities, respectively. The local authorities also pay allowances (which are additional to blind pension) to necessitous blind persons living at home or in lodgings. The scales of allowance vary with the different authorities; the highest rates being payable in the Dublin and Cork County Boroughs, as follows:

<table>
<thead>
<tr>
<th></th>
<th>Dublin</th>
<th>Cork</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single blind person</td>
<td>31s. 0d.</td>
<td>35s. 0d.</td>
</tr>
<tr>
<td>Married man with dependent wife</td>
<td>55s. 6d.</td>
<td>60s. 0d.</td>
</tr>
</tbody>
</table>

Outside Dublin and Cork County Boroughs the rates vary widely, the average being 7/6d. for a single person and 15/-d. for a married man with a dependent wife.

Cheap Fuel
2.45 The cheap fuel scheme applies to 17 cities and towns in non-turf areas (mainly in the eastern and southern seaboards). Under the scheme persons in receipt of non-contributory old age, blind and widows' pensions are entitled to 1 cwt. of fuel (turf or timber) per week on payment of 6d. Certain other categories get the fuel on payment of higher rates of contribution, e.g. recipients of unemployment assistance —1/-d., families with low incomes—2/-d. Home assistance recipients get the fuel allowance free of charge. The scheme is administered by the local authorities who are recouped by the Department of Social Welfare the net cost of fuel supplied, other than fuel provided for home assistance recipients.

Home Assistance
2.46 Home assistance is payable by public assistance authorities. The Public Assistance Act, 1939, which is the statutory basis for the service, does not prescribe specific rates of assistance. It provides that a poor person who is unable to provide by his own industry or other lawful means the necessities of life for himself or any
persons whom he is liable to maintain shall be eligible for assistance and that it shall be the duty of the Public Assistance Authority to give such assistance as shall appear to them to be necessary or proper in each particular case. While administration of public assistance is subject to the general direction and control of the Minister for Social Welfare, section 5(2) of the Act prohibits the Minister from directing the giving of assistance to any individual person.

**Free Travel Facilities**

2.47 Free travel facilities are available to old age pensioners, both contributory and non-contributory, blind pensioners, widow (contributory) pensioners aged 70 and over, the adult dependants aged 70 and over of old age (contributory) pensioners and persons aged 70 and over resident here who are receiving retirement pension from Britain or Northern Ireland. The facilities are available on road and rail services of Córas Iompair Éireann and on the road services of the County Donegal Railways (Joint Committee) and the Londonderry and Lough Swilly Railway Company.

**Free Electricity Allowance**

2.48 This allowance consists of up to 100 units of electricity, free of charge, in each two-monthly period, plus relief from the two-monthly fixed charge on the E.S.B.'s domestic consumer tariff. To be eligible, a person must be a registered consumer of electricity and be receiving non-contributory old age pension or blind pension or old age (contributory) pension or, being aged 70 or over, widows' (contributory) pension and, in addition, must be residing alone or with one or other of the following classes of persons only—

- a wife, an invalid husband or other invalid person who ordinarily resides with the pensioner, other old age or blind pensioners, a child or children under the age of sixteen for whose maintenance the pensioner is ordinarily responsible, a child or children over the age of sixteen who is full-time school-going, a person receiving retirement pension from Britain or Northern Ireland or a person aged 16 or over, who is required to live with the pensioner in order to give him constant care and attention because the pensioner is an invalid or so infirm due to age as to require such attention.

**Free Radio and Television Licences**

2.49 From 1st July, 1968, licences for radio and television and for radio only are provided free of charge for persons receiving non-contributory pension under the Old Age Pensions Acts or (contributory) pension or, being aged 70 or over, widows' (contributory) pension. The conditions for receipt are that the pensioner must be living alone or with one or other of the classes of persons set out in paragraph 2.48 above only.

(h) Voluntary Organisations

**Work of Voluntary Organisations**

2.50 In addition to providing hospitals and homes a number of voluntary organisations, including religious bodies, provide non-institutional services for the aged. Some
have been set up specifically for this purpose, others do it as part of their more general work of a charitable or philanthropic nature; some deal only with limited services, e.g. the supply of meals, others provide a variety of services; some operate on a national basis, others operate only in certain areas; some operate on their own, some in conjunction with other bodies; the work of some is fairly well-known but the work of others is practically unknown to the public at large. It would be impossible within the limits of this report to give a full picture of the range and variety of the work of every organisation but included in their activities are the following:

- Domiciliary visiting;
- Visiting of patients in institutions and the provision of comforts;
- The provision of transport for attendance at religious services, shopping, dispensary etc.;
- Nursing;
- Chiropody;
- Physiotherapy;
- Hairdressing;
- Financial help;
- Giving of advice;
- Help in correspondence;
- Assistance in obtaining help from Public Authorities;
- Meals;
- Home helps;
- Laundry service;
- Supply of fuel;
- Supply of furniture, bedding and clothing;
- Supply of television and radio sets;
- Supply and installation of cookers and heaters;
- Housing;
- Repair, decoration and cleaning of houses;
- Help in gardening;
- Organisation of social functions, film shows etc.;
- Holidays;
- Day trips;
- Provision and operation of information centres, social centres and clubs;
- Library service;
- Birthday and Christmas friend schemes.

At Appendix I (page 136) is a list of organisations of whose activities the Committee was made aware. In addition to the organisations listed it is probable that there were many others of whose work no information was available to the Committee. The Committee found most heartwarming the dedication and zeal of the organisations with which it came in contact.

In addition to the work of organised groups a great amount of help is provided, on a voluntary basis, by kindly and charitable individuals and families.
PART III — VIEWS AND RECOMMENDATIONS OF THE COMMITTEE

Chapter 3

INTRODUCTORY

General

3.1 There has been, in recent decades, a very great increase in the number of aged persons. Fortunately, a large proportion do not need public social support, except, possibly, financial support, but the numbers who require a considerable amount of help are still so great that the provision of the services they need is an enormous problem to which there is no ready or simple solution—it is only by a multiplicity of measures that the numerous and varied needs of the aged can be met. These measures tend to be complementary and failure to provide one may result in increased pressure on another, e.g. failure to provide community care, or special housing, may result in increased need for costly institutional beds. Failure to provide treatment services in institutions may lead to greater length of stay and fewer discharges with the result that more beds are needed. The provision of some services may be, therefore, not so much a question of choice as of necessity. In this country many services have been provided for the aged, but a comprehensive and integrated form of care has not been developed. Services are inadequate in many respects, but the number of beds in institutions is exceptionally high (see paragraph 7.22). The increased and increasing numbers of aged persons and the greater public appreciation of the right of the aged to share in the improved standards of living make it essential to review the existing services and to see in what respects they need to be improved and extended. In this task it is essential to remember that all the aged are not in need of help and that most of those who do need help require it because they have individual needs—not merely because they are old. It is also essential to remember that public and family care should be regarded as complementary—not as alternatives—and that the public authority should endeavour to help the family, not to take over from it.

Meaning of “Aged”

3.2 There is no definite age at which a person can be said to be “aged” and in need of help. In some the faculties decline rather early, while in others health and vigour continue almost undiminished until late in life. For statistical purposes it is usual to fix arbitrarily an age, usually somewhere between 60 and 70 years, at which people are regarded as entering the category of the aged... The Committee has taken the age of 65 years as it is the usual age of retirement in this country. It realises, however, that some persons under this age, possibly well under it, can be regarded as “aged” and in need of the same form of help as much older persons, while many over the age of 65 years are not in need of help of any kind. In addition, the need for different services may arise at different ages, e.g. the need for special housing may arise before the age of 65 years while the need for institutional care may not
arise until the 70s or 80s. The term "geriatric" is frequently used in regard to the aged but it is used with different meanings. Some use it as synonymous with chronologically aged, others use it only in regard to those who are biologically aged; some use it in regard to all types of care (including social care) required by the aged, others use it only in regard to diseases and disorders associated with old age; most, but not all, exclude from the term conditions requiring treatment of an acute nature such as surgery. To obviate ambiguity the Committee uses the term only where the meaning attached to it is clear.

**Numbers of Aged Persons**

3.3. In 1901 the average expectation of life at birth in this country was 49·3 years for men and 49·6 years for women. It is now 68·13 years for men and 71·86 years for women.

The following table shows the growth, over the period 1936-1966, in the number and proportion of old people in our population:

<table>
<thead>
<tr>
<th>Year</th>
<th>Aged 65 years and over</th>
<th>Aged 75 years and over</th>
<th>Aged 80 years and over</th>
<th>Aged 85 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of total population</td>
<td>Number</td>
<td>% of total population</td>
</tr>
<tr>
<td>1936</td>
<td>286,684</td>
<td>9.66</td>
<td>87,743</td>
<td>2.96</td>
</tr>
<tr>
<td>1946</td>
<td>314,322</td>
<td>10.64</td>
<td>99,881</td>
<td>3.38</td>
</tr>
<tr>
<td>1951</td>
<td>316,391</td>
<td>10.69</td>
<td>108,727</td>
<td>3.67</td>
</tr>
<tr>
<td>1961</td>
<td>315,063</td>
<td>11.18</td>
<td>118,785</td>
<td>4.21</td>
</tr>
<tr>
<td>1966</td>
<td>323,007</td>
<td>11.20</td>
<td>118,682</td>
<td>4.12</td>
</tr>
</tbody>
</table>

Between 1936 and 1966 the number of persons aged 65 years and over rose by 36,323, an increase of 12·7%. Even more significant is the increase in the numbers in the upper age groups. As people advance in years their dependence grows greater and few of those over the age of 75 years will be completely independent and the older they become the more their dependency will increase. In thirty years the number of those aged 75 years and over increased by 35·3%, of those 80 years and over by 60·8%, and of those 85 years and over by 76·4%. In the fifteen years from 1951 to 1966 the increases were 9·1%, 26·5% and 52·8% respectively. The following table shows the numbers of aged persons which it is anticipated will be in the country in 1971 and 1981:

<table>
<thead>
<tr>
<th>Year</th>
<th>Aged 65 years and over</th>
<th>Aged 75 years and over</th>
<th>Aged 80 years and over</th>
<th>Aged 85 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>1971</td>
<td>327,258</td>
<td>122,489</td>
<td>55,897</td>
<td>*18,644</td>
</tr>
<tr>
<td>1981</td>
<td>363,437</td>
<td>135,896</td>
<td>65,728</td>
<td>21,004</td>
</tr>
</tbody>
</table>
Number of Males and Females

3.4 The following table shows the numbers of males and females in the different age groups according to the 1966 Census of Population:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 years and over</td>
<td>149,949</td>
<td>173,058</td>
</tr>
<tr>
<td>75 &quot; &quot; &quot; &quot;</td>
<td>52,660</td>
<td>66,022</td>
</tr>
<tr>
<td>80 &quot; &quot; &quot; &quot;</td>
<td>23,916</td>
<td>31,965</td>
</tr>
<tr>
<td>85 &quot; &quot; &quot; &quot;</td>
<td>8,092</td>
<td>12,205</td>
</tr>
</tbody>
</table>

Comparison with Other Countries

3.5 A decline in the birth rate, a substantial decrease in the general death rate in the younger age groups, improved medical care and better social conditions have all combined to produce, in most countries, a considerable increase in the proportion of the population who are of advanced years. In this country the age structure of the population has been affected by the emigration of large numbers of young people. The following table shows the proportion of total population who are aged 65 years and over in different countries:

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage of total population who are aged 65 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>13.2</td>
</tr>
<tr>
<td>Sweden</td>
<td>12.7</td>
</tr>
<tr>
<td>France</td>
<td>12.6</td>
</tr>
<tr>
<td>Belgium</td>
<td>12.5</td>
</tr>
<tr>
<td>England and Wales</td>
<td>12.3</td>
</tr>
<tr>
<td>Norway</td>
<td>11.8</td>
</tr>
<tr>
<td>West Germany</td>
<td>11.7</td>
</tr>
<tr>
<td>Scotland</td>
<td>11.3</td>
</tr>
<tr>
<td>Ireland</td>
<td>11.2</td>
</tr>
<tr>
<td>Denmark</td>
<td>11.2</td>
</tr>
<tr>
<td>Switzerland</td>
<td>10.7</td>
</tr>
<tr>
<td>Italy</td>
<td>9.7</td>
</tr>
<tr>
<td>Netherlands</td>
<td>9.6</td>
</tr>
<tr>
<td>United States of America</td>
<td>9.4</td>
</tr>
<tr>
<td>Greece</td>
<td>9.0</td>
</tr>
<tr>
<td>Spain</td>
<td>8.3</td>
</tr>
</tbody>
</table>

The proportion of persons aged 65 years and over does not, however, give the complete picture. The birth rate in this country is high with the result that the proportion of children and young persons is also high. The following table shows

*Based on figures taken from the Demographic Yearbook 1966, United Nations.
the proportion of total population in different countries in the working age groups, say, 20 to 64 years:—

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage of total population who are aged 20 to 64 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>48.6</td>
</tr>
<tr>
<td>United States of America</td>
<td>51.0</td>
</tr>
<tr>
<td>Netherlands</td>
<td>52.5</td>
</tr>
<tr>
<td>France</td>
<td>54.1</td>
</tr>
<tr>
<td>Scotland</td>
<td>54.6</td>
</tr>
<tr>
<td>Norway</td>
<td>54.8</td>
</tr>
<tr>
<td>Denmark</td>
<td>55.9</td>
</tr>
<tr>
<td>Belgium</td>
<td>56.4</td>
</tr>
<tr>
<td>Spain</td>
<td>56.4</td>
</tr>
<tr>
<td>Austria</td>
<td>56.6</td>
</tr>
<tr>
<td>Greece</td>
<td>56.9</td>
</tr>
<tr>
<td>England and Wales</td>
<td>57.0</td>
</tr>
<tr>
<td>Italy</td>
<td>58.1</td>
</tr>
<tr>
<td>Switzerland</td>
<td>58.2</td>
</tr>
<tr>
<td>Sweden</td>
<td>58.3</td>
</tr>
<tr>
<td>West Germany</td>
<td>59.9</td>
</tr>
</tbody>
</table>

It will be seen that Ireland has the lowest percentage of population in the working age groups. The balance between those in productive employment and the dependent members of the community is, therefore, very unfavourable.

**GENERAL CONSIDERATIONS**

**Classes to be Catered For**

3.6 In the past, services for the aged, other than those provided from their own resources or with the help of relatives and friends, were confined almost entirely to the destitute. The increase in the nature and extent of Social Welfare pensions and benefits, and the provision of other social services, such as subsidised housing, have greatly reduced the number of those who are destitute. It must be assumed that this trend will continue. Some services, e.g. hospital and specialist services, are now provided free or at reduced cost for more than the poor; similarly, grants for new or reconstructed dwellings are not restricted to the poor and contributory pensions are payable without any means test. The need for various forms of help may not be so great for the aged who are in the middle and higher income groups as it is for those in the lower income group, but a degree of need still exists. The Committee considers, therefore, that services in the future should cater, to some extent at least, for all classes.

*Based on figures taken from the Demographic Year Book 1966, United Nations.*
Standard of Institutional Care
3.7 As already stated institutional care was originally designed to cater for those of
the destitute who had to accept it. There has been considerable improvement in
the standard of amenities and facilities, particularly where new or reconstructed
buildings have been provided, but there are still many buildings where the position
is very unsatisfactory. As the standard of living improves, old people are entitled to
a share in that improvement. In addition, the recruitment of staff will be adversely
affected if the standard of institutional accommodation is low. The Committee con­siders, therefore, that the general standard of institutional care provided must be
raised progressively.

Standard of Services in Other Countries
3.8 The standard of services, both domiciliary and institutional, and of amenities
provided for the aged has improved greatly in many countries in recent years. The
Committee considers that this country must aim to provide similarly improved
standards. The Government has expressed its desire to become a member of the
European Economic Community. One of the aims of the Treaty of Rome is to
promote close collaboration between member countries in the social field.

The Aim of Services
3.9 It is generally accepted that it is better, and probably much cheaper, to help
the aged to live in the community than to provide for them in hospitals or other
institutions. The Committee considers that the aim of services provided for the aged
should be:—

(a) to enable the aged who can do so to continue to live in their own homes;
(b) to enable the aged who cannot live in their own homes to live in other
similar accommodation;
(c) to provide substitutes for normal homes for those who cannot be dealt with
as at (a) or (b);
(d) to provide hospital services for those who cannot be dealt with as at (a), (b),
or (c).

To achieve these aims housing services, schemes of financial assistance and other
social welfare services, and health services must be closely integrated with one an­
other as they are all essential parts of a comprehensive service for the aged.

Need for Planning
3.10 A host of bodies, public and private are involved in the provision of services
for the aged and their activities must be carefully planned and co-ordinated so that,
as far as possible, a complete and integrated service is provided for all and waste
and duplication avoided. While planning is essential, it must be flexible; the ex­
tent to which particular measures are necessary, desirable, or feasible, will vary from
place to place and from time to time. In later paragraphs the Committee suggests
a pattern of services which should be developed in the immediate future. While a
basic pattern is visualised for the country as a whole, it may have to be modified to meet the needs of particular areas and it will have to be kept under continual review as new approaches to the problem of the aged are developed. The Committee considers it desirable, as far as possible, to provide for the aged within the general scheme of health and social services for the country, rather than to set the aged as a group apart from all others in need of help.

Range of Services to be Provided

3.11 The aged are not a homogeneous group. Their needs vary to a great extent and are related to every facet of living. The provision of all the services which they may require is an enormous problem which has not been solved in any country and which is probably incapable of being fully solved. The aim, however, should be to ensure that the aged receive a fair share of available resources and that as comprehensive services as possible should be provided for them. It is impossible to specify every way in which help can be provided but the Committee considered the matter under the following heads:

- Income Maintenance
- Housing
- Other Community Services
- Institutional Care
- Preventive Measures
- Research
- Organisation and Co-ordination of Services
- Education and Training

... Chapter 4
... Chapter 5
... Chapter 6
... Chapter 7
... Chapter 8
... Chapter 9
... Chapter 10
... Chapter 11
Chapter 4

INCOME MAINTENANCE

General

4.1 Accepting that the primary aim should be, as set out in paragraph 3.9, to enable the aged to continue to live in their own homes, the payments available to aged persons under the income maintenance services of the Department of Social Welfare should, with whatever other means are available to them, enable them to do so in reasonable comfort unless there are some grave physical or social circumstances which necessitate admission to a hospital or institution. That these payments do not in many cases so provide is evident from the fact that old age pensions, for example, are being supplemented by home assistance in a considerable number of cases—some 3,500 at present—although home assistance should be a short-term payment to tide a person over temporary need rather than a way of life. It is likely that the need for such supplement also arises in numerous other cases as there is evidence that many people in straitened circumstances refrain from applying for home assistance because it bears the stigma of poor relief. In addition others drift into County Homes who, with a little financial help or domiciliary care or physical assistance, could continue to live in the community. In these circumstances, the Committee feels it is essential that something should be done to improve the income maintenance services for the needy aged. To increase general rates of pensions and assistance sufficiently to provide adequately for the persons with little, if any, means would, however, be very costly. An overall increase of 5/- a week in non-contributory old age pensions alone would cost in the neighbourhood of £1½ million a year but such an increase would not be sufficient to meet the position of many of those whose needs are greatest. It would be a more effective use of available resources and be of considerable assistance in reducing the numbers of the aged seeking admission to institutions if priority in the allocation of available funds were given to those most in need. The Committee recommends, therefore, that in addition to the payments under the general schemes of pensions, benefits and assistance, supplements should be paid to meet the exceptional difficulties experienced by certain poor aged persons in providing the basic needs of housing, heating, lighting and cooking.

Housing Supplement

4.2 The question of the provision of housing and matters relating to the repair, improvement and maintenance of housing by local authorities is dealt with in Chapter 5. It is the policy of the Minister for Local Government that housing accommodation should be provided by housing authorities for persons in need of re-housing, irrespective of their rent paying capacity and that, by the operation of differential rent schemes, the rents charged to such categories as old age pensioners should be
nominal. Unfortunately it may take some time before the policy becomes fully effective in all areas; in addition, it does not cover the position of those who are not in local authority dwellings. The Committee recommends, therefore, that where an aged person is living alone, or is one of a married couple living together, or otherwise has the responsibility as head of a household of providing a home at some cost and is suffering hardship, he should be provided with assistance to meet his housing commitments. Most of those concerned will already be in receipt of some form of pension or benefit and the assistance could take the form of a housing supplement associated with the pension or benefit. In other cases special arrangements should be made (see paragraph 4.5). The supplement should be paid whether the persons concerned are in local authority or private housing. It should be a weekly amount based on the annual outgoings in respect of rent, rates or other expenses involved, such as mortgage interest, insurance etc., subject to overriding limits which would take into account whether or not the person was living alone. In order to ensure that aged persons in local authority housing would get the full value of the housing supplement the Committee recommends that in calculating the total family income for the differential rent scheme the housing supplement should be ignored.

**Supplement for Lighting, Heating and Cooking**

4.3 There are already in existence a cheap fuel scheme (paragraph 2.45) and a scheme of free electricity allowances (paragraph 2.48). The cheap fuel scheme is limited to certain areas and the free electricity scheme is of little value except where heating and cooking are done by means of electricity. The Committee considers that, where practicable, in the interests of their self-respect, old people should be enabled to pay their own expenses rather than have these expenses paid for them. The Committee accordingly recommends that the existing schemes should be terminated and superseded by a general scheme of assistance towards the cost of lighting, heating and cooking. In most cases the assistance should be by a supplement similar to the housing supplement already suggested. It should be a weekly amount related to annual costs. The Committee recommends that persons living in sheltered housing conditions, or homes or establishments for aged persons, and who have to pay something towards the cost of heating, lighting and cooking should be eligible for these supplements.

**Administration**

4.4 As it is the intention that the supplements dealt with in the preceding paragraphs should be national in coverage and have a common basis of assessment of rates of payment, the Committee recommends that the cost should be borne in full by the Exchequer out of general taxation. The Committee is also strongly of the opinion that the payment should, if it is administratively possible, be associated with whatever form of benefit or pension is in payment by the Department of Social Welfare. It is appreciated that this may cause some difficulties but the Committee feels that the interests of the recipients would be best served by having one aggregate weekly payment made to the individual rather than a number of smaller payments from different sources. The cases in which these supplements would be payable would be determined on applications made by the persons concerned. This would
require that full publicity should be given to the scheme at its inception and subse­quently. Cases where persons were entitled to supplements but unaware of their existence would, of course, become apparent to Social Welfare Officers during the course of investigations of means for pension purposes and to Home Assistance Officers during the course of their normal duties. Cases might also come to light where other officials or voluntary bodies come across them in the course of their normal activities. In these cases, applications should be completed. Where additional or special information is required, the applications could be referred to the local district nurse or social worker, if one is employed, to report on the social aspects or the degree of need. Suitable machinery for deciding cases would be a matter for the Department of Social Welfare. In regard to the question of need, however, the Committee suggests that a more generous attitude be taken than the rather stringent approach used for home assistance purposes. In particular, where a person has qualified for a non-contributory pension at one of the higher rates, indicating that he has little or no assessable means, it should be accepted that a *prima facie* case exists for supplements provided the person can satisfy whatever other conditions are relevant.

**Assistance for Persons Outside Scope of Supplement Schemes**

4.5 The proposals for supplements to benefits, pensions and assistance in the preceding paragraphs are related to the existing schemes where a qualifying age of 70 years applies to both contributory and non-contributory old age pensions and are intended to cover also persons between the ages of 65 and 70 who are blind pensioners, widow pensioners, or recipients of disability benefit, unemployment benefit and unemployment assistance. To provide for those needy persons in the age group from 65 to 70, who would fall outside the scope of these arrangements, the Committee recommends that, while the present qualifying age of 70 for old age pension obtains, special arrangements should be made to enable supplementary assistance to be paid to them on the lines of the supplements proposed for recipients of social welfare payments, the cost being borne by the Exchequer.

**General Aid**

4.6 No matter how comprehensive social services and income maintenance services may be they cannot cover every eventuality and occasional cases of individual hardship will inevitably arise. There will thus always be a need for some flexible form of urgent assistance to cover temporary or exceptional needs, or to tide people over until help from other sources can be arranged. The home assistance scheme was designed to meet that need, by assistance either in cash or kind. Home assistance, however, does not meet these requirements satisfactorily—among the reasons for this failure being the low payments made and its continued unfortunate association with poor relief. The latter factor leads many aged persons to refrain from seeking it although in need of help. The Committee recommends that the Home Assistance scheme should be overhauled, particularly in relation to its application in the case of aged persons, so as to provide an adequate service for those who must avail of it.
Chapter 5

HOUSING

Importance of Suitable Housing

5.1 The Committee has been impressed by the importance, in the care of old people generally, of the provision of suitable accommodation to meet their special needs. From discussions with various voluntary organisations and visits to different parts of this country and to Scotland, it is satisfied that the provision, in good time, of suitable housing accommodation specially adapted to the needs of the aged is one of the most important factors in enabling them to continue to live in the community.

Assessment of Needs

5.2 The Committee recognises that for adequate action to be taken the extent of the problem must in the first place be firmly established. A comprehensive assessment of housing needs, with special reference to ascertaining the existing position in regard to the housing needs of the aged has been completed by housing authorities generally and the position revealed in regard to the housing of the aged is set out in Appendix J. The Committee recommends that housing authorities should include a special survey of the housing needs of elderly persons in every general five-yearly assessment of housing needs which they are obliged to carry out under the Housing Act, 1966.

Approach to Housing the Aged

5.3 Elderly persons generally prefer to be left in their own homes. They are frequently most reluctant to move from their present houses, which are often held at very small rents or are owned by the occupants. New dwellings, however comfortable they may be, entail a drastic and generally unwelcome change in environment at a time when such a change is least acceptable and is most liable to lead to an initial breakdown of confidence which may trigger off a general mental and physical deterioration. Great care is therefore, needed to ensure that full weight is given to what the individual old person wants in arriving at a decision in regard to the type of housing accommodation to be provided.

Reconstruction and Repair of Existing Dwellings

5.4 The Committee, therefore, recommends that where old people wish to remain in their own homes and their existing accommodation can be adapted or repaired or reconstructed (with the aid of State and local authority grants) to meet their needs adequately for their lifetime, this should be done. Interim programmes designed to carry out essential repairs and improvements to existing accommodation
should also be implemented without delay in areas where, although new dwellings are necessary, it may not be practicable to proceed immediately with specific building programmes to provide new housing for the aged.

Provision of New Dwellings—Integration with Community

5.5 Where the provision of new dwellings is necessary, and rehousing on the spot is impracticable, the new dwellings should be provided as near as possible to the present abodes and existing neighbours of old people. Generally, large concentrations of old persons' dwellings in any one place should be avoided. Continued integration with the general community should be aimed at, with neighbours encouraged to help in looking after the old person's welfare, in conjunction with public health and welfare services. The feasibility of providing some normal family-type dwellings with independently designed annexes for old persons should be considered. These would enable tenants (either of the old person's own family, or tenants specially picked by the local authority for the purpose) to give special attention to the needs of the old persons. An alarm bell could be fixed to alert the tenant to any emergency needs of the old person.

Allocation of Percentage of New Dwellings to the Aged

5.6 The Committee feels that the inevitable increase in the number of old persons, particularly in the older categories, will tend to exacerbate the housing problem in relation to the aged as years go on and for this reason it would urge that an element of risk should be accepted by providing too much, rather than too little, accommodation in the early years. The Committee is aware of particular problems which arise in regard to the provision of the small type of accommodation especially required for old persons and accepts that the pressure of the demands of families in need of re-housing may tend to push aside the claims of old persons. To avoid this, the Committee recommends that housing authorities should reserve specifically for elderly persons a percentage of all dwellings provided. This percentage should be established in each area by reference to demographic factors related to the present population structure, a forecast of the growth in the number of aged persons, and the existing ascertained needs of the aged. Initially, a minimum of ten per cent should be the aim.

Sheltered Housing

5.7 Where it is not feasible to meet the housing needs of the elderly in their own or similar homes, the Committee recommends that "sheltered housing" should be considered as a first choice. The term "sheltered housing" is applied to housing accommodation which gives each person a separate and independent dwelling or flatlet with some common facilities such as dining and recreation rooms, storage space and facilities for laundry. Such housing is particularly useful for elderly persons who need a little supervision and help and may have some difficulty in ordinary homes, but it can suitably be used for any elderly persons. The Committee recommends that housing authorities should make provision for sheltered housing but that there should be no compulsion on the residents to use the communal facilities. Compulsory use of the dining facilities for at least one meal a day may be considered desirable but
even this limited degree of compulsion, though well intended, may tend to intro-
duce an institutional aspect into sheltered housing and this should be avoided. Every flatlet should be connected by an alarm system, located within easy reach of the bed, and connected to the central quarters of a warden, or other person with appropriate experience. Sheltered housing has been found most acceptable to old persons and has been particularly successful in maintaining their dignity, independence, and mental and physical well-being, especially where the compulsory use of recreational and dining facilities is avoided. Where a particular need arises for institutionalised type of housing accommodation providing independent bedroom accommodation only, with all other facilities shared, it should be designed and operated rather as a welfare home, properly staffed, than as housing accommodation.

Role of Voluntary Organisations

5.8 Many voluntary organisations provide housing for the aged, or assist in its provision. Others help considerably in bringing cases of need to the attention of housing authorities. The Committee feels that the important contribution which voluntary organisations are making to the housing needs of the aged should receive maximum encouragement. The Committee recommends:

(i) All voluntary bodies should be made aware of the State and local authority assistance available for the housing of elderly persons and a special pamphlet should be prepared by the Department of Local Government for this purpose and made freely available to all voluntary bodies. The pamphlet should contain some information about financing the capital cost, and the cost and extent of the problems involved in the subsequent management, letting and maintenance of the accommodation.

(ii) Plans of small houses acceptable for grant purposes, designed to meet the special needs of aged persons, should be made available free or at nominal cost.

(iii) A vigorous campaign should be undertaken by voluntary bodies to stimulate sponsorship by business firms of housing for elderly persons. This has already been done successfully in the admirable housing projects sponsored by the St. Anne's Co-operative Guild Ltd. in Limerick.

(iv) An officer of the housing authority should be designated in each area to act as liaison officer to the local Social Service Councils, the establishment of which is recommended in paragraph 10.6, so that voluntary organisations may be kept informed of action by the housing authorities in their areas in regard to the housing of the aged.

Unfit Dwellings in Rural Areas

5.9 As indicated in paragraph 2.32, some of the worst housing conditions of elderly people exist in the more remote rural areas. Many of these probably could be kept out of institutions, perhaps permanently, by providing them with reasonable housing accommodation and some community care. With the development of the demountable and mobile “caravan” type dwellings, housing authorities are now in a position
to deal with this problem. The Committee recommends that immediate action should be taken by housing authorities to rehouse any elderly people in rural areas who are living in dangerously unfit dwellings which cannot be repaired.

Rents

5.10 The Committee considers that, with subsidy at the rate of two-thirds of loan charges arising from capital expenditure now being granted in all cases for re-housing of elderly persons, the way is open for housing authorities to press ahead with building programmes to meet the needs of the aged in all areas where an established demand exists and to let houses to old persons at rents which they can afford. It regards it as urgently necessary that all housing authorities should establish renting structures which in the case of old persons will have regard to the fact that their means are generally very limited. It has been recommended in paragraph 4.2 that any supplement to pension or benefit should be ignored by the housing authority in calculating the total family income for the purpose of determining the rent to be paid by elderly persons.

General Housing Standards for Elderly Persons

5.11 The Committee wishes to emphasise the importance of introducing and maintaining very high standards of amenity and comfort, particularly insulation, in special housing for the aged. Factors which should receive special consideration are:

Heat:

Uniformity of heat should be provided to avoid chilling of legs and feet. In general temperatures should be 2°–3° higher than those normally acceptable. The type of fuel used should call for the least physical effort on the part of the old person.

Light:

A high standard of light without glare should be aimed at to compensate for failing eyesight. Switches should be handy and located so that the way ahead is lighted.

Noise:

Sites should be placed away from noisy conditions. Special attention should be paid to sound insulation in buildings.

Fire:

Fire hazard is a special problem in the case of old persons because of their failing eyesight, poor hearing and slow physical movement. Special care should therefore be taken in the location of exits and in the forms of heating; non-inflammable materials should be used to the greatest extent possible.

General:

Dwellings should be at ground level wherever possible or lifts should be provided. Rooms should be on one level with non-slip floors. Doorways should be wide enough to take a wheelchair and there should be no thresholds. Hand rails should be provided in corridors and particularly on both sides of stairs. Layout should be designed to avoid fatigue in housekeeping. Storage spaces should be at arm level. Bathrooms should have non-slip floors; special hand grips should be provided at baths, W.C.s etc. Windows should be designed to give the occupants a good view of what is going on outside.
Chapter 6

OTHER COMMUNITY SERVICES

General

6.1 A wide range of services is required, in addition to income maintenance and housing, to enable as many old people as possible to remain in the community. The cost of providing community services may be high but it may be more economic in the long run than to wait until institutional care becomes a necessity. The main services which the Committee considers should or can be provided are set out in this chapter but it wishes to emphasise that there is an endless variety of ways in which help for the aged can be provided and it does not regard as exhaustive the types of services specified. Some services should be provided by health authorities, others by voluntary organisations and others as the result of a joint effort by health authorities and voluntary organisations. Suggestions as to the role voluntary bodies should fill in the provision of community services are contained in paragraph 6.25, but the position may vary from time to time and place to place. In all cases the roles of voluntary organisations and public authorities should be regarded as complementary and the aim should be to achieve that by co-operation and joint effort the needs of the aged and their families are met to the fullest extent possible.

Domiciliary Nursing

6.2 Health authorities may provide nurses to give advice or assistance on matters relating to health and to assist sick persons, and may also arrange for the provision of the services of nurses by voluntary bodies. The total number of nurses providing domiciliary nursing services on 31st March, 1968, was 497, but the amount of time spent by them on the care of the aged is relatively small. By Circular letter 48/65 of 22nd September, 1965, (copy at Appendix K) the Minister for Health indicated to health authorities that they should review their district nursing services for the aged. In addition to the duties suggested in the Circular, the Committee recommends that stress should be laid on the educational role of the nurse. She should endeavour to educate relatives and the public regarding the care of the aged and regarding the adoption of a more tolerant attitude towards them. She should also endeavour to educate the aged how to look after themselves, to be as useful as possible in the home, to engage in useful work or employment wherever possible and to avoid as far as they can the adoption of an intolerant or aggressive attitude towards other people. Nurses trained in audiometry testing should administer tests to old people when there is any question of deafness or considerable loss of hearing.

The Committee recommends that as the domiciliary nursing service is a vital part of the services for the aged, health authorities, who have not already done so, should provide, or arrange for the provision of, a domiciliary nursing service in all areas.
Medical Care

6.3 Health authorities are obliged to provide a general practitioner medical service for persons in the lower income group. The White Paper on the Health Services which was issued in January, 1966, indicated that recipients of non-contributory old age pensions, blind pensions and widows' pensions would be included among the classes eligible for the general medical services, so that a considerable proportion of the aged will be entitled to general medical care free of charge. Those outside the lower income group will have to pay for the services of the family doctor but medicines may be supplied free or at reduced cost in certain circumstances. Family doctors are in a key position and their approach will determine, to a considerable degree, the extent to which domiciliary care of the aged will be feasible. The aged, as a class, will be in need of considerably more medical care than other sections of the community. There may be a tendency among some doctors to send elderly patients to hospital to overcome the problem of providing them with continual or continuous medical care. The task of the family doctor in treating them at home will be made considerably easier if a range of services for the aged is developed. On the assumption that a range of services will be developed the co-operation of all doctors should be sought so that only those in need of hospital care are sent to hospital. The Minister has already stated (Circular No. 48/65) that family doctors should be invited to utilise the services of nurses for domiciliary nursing and visiting; that they should be advised of the possibility of home helps, financial assistance and help in housing; and that they should also be informed of the possibility of obtaining appliances etc. such as are mentioned in paragraph 2.17. Other services, as detailed in paragraphs 6.4 to 6.23, should also be readily available to the family doctor, in appropriate cases. The Committee recommends that the essential place of general practitioners in the care of the aged in the community should be recognised and that—

(a) their co-operation in preventing unnecessary institutional care should be sought,

(b) they should be kept informed of the possibility of obtaining help from various other community services, and

(c) where they are paid by health authorities and the system of payment permits of it, they should be given a higher rate of remuneration in respect of the aged than of younger persons.

The Committee considers that extra remuneration is justified in view of the greater need of the elderly for medical care.

Specialist Advice

6.4 Health authorities have an obligation to arrange for specialist services for the lower and middle income groups. The Committee recommends that specialist advice should be readily available for the aged, on an out-patient basis, or in suitable cases on a domiciliary basis, and that special clinics for the aged should be established in areas where the demand warrants it. The time necessary to deal with an elderly patient is often much greater than that necessary to deal with other patients and the tempo
of an ordinary clinic is often not suitable for the elderly patient. The special clinic for the aged has the added advantage that it affords an opportunity to start medico-social assessment as well as clinical assessment. In paragraph 7.9 the Committee recommends that, where possible, there should be a domiciliary consultation before a person is admitted to a geriatric assessment unit. In other cases it may not be feasible to bring an elderly person to a clinic or out-patient department and a domiciliary consultation may be desirable. The specialist should in all such consultations be accompanied by the family doctor. In addition to the services of the specialist dealing directly with the care of the aged, it may be necessary to arrange for specialist advice from other persons such as psychiatrists, ophthalmic surgeons and oto-rhino-laryngologists. There should be close cooperation between specialists, providing services either on a hospital or out-patient basis, and the family doctor, Chief Medical Officers and others dealing with community services so that proper follow-up services may be provided.

**Ophthalmic Services**

6.5 Good ophthalmic services are most important for elderly people. Impairment of eyesight through neglect of eye defects or diseases or the use of unsuitable spectacles can affect very adversely their ability to look after themselves. The existing arrangements for the provision of ophthalmic services, described in paragraph 2.19, are not regarded by the Minister for Health as wholly satisfactory and it was indicated in the White Paper on the Health Services that he proposes to have discussions with representatives of the ophthalmologists and of the opticians as to how they might be improved. From the point of view of elderly persons it is important that each health authority area should have clinics in operation in a sufficient number of centres to ensure that hardship is not caused through excessive travelling. Transport to clinics should be provided where necessary. The avoidance of excessive travelling also applies in relation to the supply of spectacles. The arrangements in operation in most areas whereby a single optician is under contract to a health authority to supply spectacles to the whole area can cause difficulties, e.g. representations were made to the Committee that in the Dublin Health Authority area elderly people living outside the city find it extremely difficult to attend at the premises of contractors which are located in the city centre. The Committee recommends that the special needs of old people should be taken into account in the review of ophthalmic services being undertaken by the Minister for Health.

**Dental Services**

6.6 It is indicated in the White Paper on the Health Services that the Minister for Health proposes, as a first step, to expand the dental staffs of health authorities and the facilities at their clinics so that a fully effective service can be given to the classes at present eligible for it. The scope of the service would next be extended to make it available at charges to the middle income group generally. As indicated in paragraph 2.20, health authorities provide dental services for persons in the lower income group. The services provided for adults at present are not, however, adequate. Because of a shortage of personnel and the high incidence of dental caries it has been necessary to apply a system of priorities. First priority is given to children. Persons
requiring treatment for medical reasons are next in the order of priority. The operation of the priority system results in long delays in the provision of dental treatment and dentures for persons, including elderly persons, not in the classes entitled to priority. An adequate dental service is important to the welfare of elderly people. In particular, the lack of dentures, or the use of unsuitable dentures, make it difficult for old people to eat a number of foods necessary to the balanced diet required for health. The Committee recommends that dental services should be expanded as soon as possible to cater adequately for the needs of elderly people.

**Medicines and Medical and Surgical Appliances**

6.7 Health authorities are obliged to make available, without charge, medicines and medical and surgical appliances to persons in the lower income group. Medicines are normally supplied through the dispensaries. Some voluntary organisations have represented to the Committee that the necessity for aged persons to attend dispensaries to obtain drugs and medicines creates hardship for them in that they frequently have to wait for long periods in draughty or badly ventilated conditions with unsuitable and uncomfortable seating. It has been suggested to the Committee that special facilities, separate from the dispensary system, should be provided for the aged. The Committee considers that there is substance in the complaints made, but the matter should be met by the changes proposed in the White Paper on the Health Services and their Further Development. Under these proposals drugs and medicines for persons eligible for the general medical service will be supplied through retail chemists.

The Minister has already urged health authorities (Circular 48/65) to supply or lend such items as bedpans, bed rests, rubber sheets, foam mattresses and hoists to aged persons to enable them to remain in their homes rather than enter a hospital or county home. Among the items which the Committee considers should be made freely available in cases of need are:

<table>
<thead>
<tr>
<th>Bed blocks</th>
<th>Mattresses</th>
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<tbody>
<tr>
<td>Bedpans</td>
<td>Mattress covers</td>
</tr>
<tr>
<td>Bed cradles</td>
<td>Pillows</td>
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<tr>
<td>Bed rests</td>
<td>Rubber sheets</td>
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<tr>
<td>Blankets</td>
<td>Sandbags</td>
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<tr>
<td>Commodes</td>
<td>Sheets</td>
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<tr>
<td>Crutches</td>
<td>Special beds</td>
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<tr>
<td>Feeding Cups</td>
<td>Urinals</td>
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<tr>
<td>Fracture boards</td>
<td>Walking aids</td>
</tr>
<tr>
<td>Hoists</td>
<td>Walking sticks</td>
</tr>
<tr>
<td>Incontinence pads</td>
<td>Wheelchairs</td>
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This list is not intended to be comprehensive and may be added to as required.

The Committee has received complaints about delay by health authorities in supplying appliances of this nature. Arrangements for the distribution of these items should be such that they can be supplied quickly when needed. The Committee recommends that all health authorities should review their existing arrangements to
ensure that avoidable delays do not occur and that each health authority should place responsibility for the control of stocks and issue of items on a designated officer.

Aural Services

6.8 As indicated in paragraph 2.21, free aural services are confined to persons in the lower income group. The White Paper on the Health Services contains, however, a proposal to extend aural services to the middle income group, hearing aids to be provided at charges of up to £5.

Defective hearing can have a very severe effect on the lives of old people as it results in social isolation and is often a factor in the onset of senile mental degeneration. Old people who are hard of hearing tend to restrict their already limited social contacts because they feel at a loss in company. Deafness in later life should not be accepted as natural to old age. Old people who develop difficulty in hearing should be encouraged to seek medical advice to see whether remedial treatment is possible or a hearing aid would be of help. The Committee recommends that old people should have readily available to them, through their general practitioners, the services of ear, nose and throat specialis, and that arrangements should be made to enable them to obtain suitable hearing aids without difficulty.

Aids in the Home

6.9 There are numerous aids which can be supplied to the aged to help them to overcome their disabilities and to prevent accidents. The number of these aids is being continually extended and it is impossible to list them all but included are items such as bathrails, non-slip mats, bookrests, specially designed cutlery, drinking vessels etc., safety devices for cookers and various devices to overcome inability to stoop. The Committee recommends that health authorities should keep themselves informed as to the needs of the aged in their areas for these special aids and should make arrangements for their supply.

Physiotherapy

6.10 Physiotherapy plays an important part in keeping old people fit and mobile. On an out-patient basis it can prevent deterioration and help to keep old people out of hospital. At present there are a large number of health authorities which do not provide physiotherapy even in County Homes. In a number of areas the reason for this situation is the inability of health authorities to recruit physiotherapists. The Committee understands that there is an acute shortage of physiotherapists for posts outside the larger cities. In view of the importance of physiotherapy, the Committee recommends that an investigation should be carried out into the reasons for the shortage of physiotherapists and the steps necessary to improve the position. The Committee also recommends that when the recruitment position improves health authorities should provide a service on an out-patient basis in all areas. A domiciliary service has been suggested to the Committee by some voluntary organisations. Such a service is sometimes justified, but normally it is wasteful of the time of scarce personnel. In addition, necessary equipment would be difficult to transport for use on a domiciliary basis. An out-patient service provided at a number of centres in each health authority area should be adequate in most cases. Such a
service would, of course, involve the provision of transport for patients between their homes and the centres. The Committee recommends that health authorities should arrange for the provision of transport in cases of need.

Occupational Therapy

6.11 The importance of providing occupational therapy on an out-patient basis is frequently not recognised. For patients living in their own homes it can be used to encourage self-help and independence and interest in social activities, and to provide, where necessary, training in the activities of daily living—the ability to look after themselves, to eat, to wash, to walk, to dress and to use the ordinary toilet facilities. Old people can be introduced to new hobbies and interests which will help them to lead a fuller life. As a follow-up service for elderly persons discharged from institutions it can ensure that hobbies and interests acquired in hospitals continue to be of benefit on return to the community. The Committee recommends that occupational therapy should be provided by health authorities on a community basis for aged persons who are in need of this service. Occupational therapists should be employed for this purpose, but they can encourage voluntary workers to provide occupational therapy of a supportive nature, e.g. to interest the aged in games and social activities.

Chiropody

6.12 A considerable proportion of the aged suffer from abnormal conditions of the feet—partly owing to the degenerative changes, e.g. the loss of the adipose tissue which provides the natural padding for the feet, and partly owing to the accumulation of aggravating factors such as ill-fitting shoes or boots. Many of the aged are unable to attend to these abnormalities because of conditions such as arthritis, obesity, dizziness on stooping, poor eyesight and inability to manipulate scissors. Many of the voluntary bodies met by the Committee stressed the importance of a chiropody service and gave several instances of old people who were totally or partly immobile and who suffered considerable hardship through foot conditions. Some foot conditions can be dealt with reasonably adequately by relatives, if they are available, but many conditions require the attention of a trained person. It is very necessary that the services of such a person should be available for the aged as painful feet, leading to difficulty in getting around, may well prove to be the beginning of physical deterioration. The Committee recommends that all health authorities should provide chiropody services both on an out-patient and on a domiciliary basis. In this, as in other countries, some persons who practise chiropody have had very inadequate training. Some have had little training other than that provided by a correspondence course. The matter has been considered by the Minister for Health who has decided that the only persons whose appointment will be approved are those who satisfy the standards necessary to be accepted as members of the Irish Association of Chiropodists, the qualifications necessary for acceptance normally being membership of either the Society of Chiropodists, or the Institute of Chiropodists. Unfortunately the number of such persons is limited. There are, in all, only about 60 to 70 members of the Association and many of these are located in Dublin and its surroundings. They are all engaged in private practice and many do not seem
interested in obtaining local authority employment. There is no training school in this country leading to an acceptable qualification and persons wishing to undergo training must do so in Britain. The Committee understands that discussions have been held between the Department of Health and the Association of Chiropodists about this situation and the possibility of setting up a training school has been considered. It seems, however, that the establishment of a school is not likely to take place in the near future. For the present, therefore, the position in regard to the supply of chiropodists is not likely to improve substantially. In order to avail of the services of the existing chiropodists to the greatest extent possible the Committee recommends that arrangements should be made for their employment on a part-time as well as on a whole-time basis. The Committee also recommends the use of nurses who have been given a short training course. While there are undoubtedly numbers of old people who require treatment which only a fully trained person can provide, a lot of the work to be carried out is relatively simple. The Committee considers that nurses, given suitable training, could do this work adequately under medical direction. The question of having courses in pedicure for nurses was raised during discussions between the Department and the Association and it is understood that the latter body was prepared to consider the idea. The Committee recommends that the question of having nurses trained in pedicure should be pursued, and that each area should have at least one nurse so trained. Apart from providing a service for patients in the hospitals and homes she could provide a service on an out-patient basis on the lines of the service suggested in the case of physiotherapy. A domiciliary service would also be necessary. For this purpose the Committee recommends that public health nurses should receive training in pedicure as they will, in the normal course of their duties, visit the homes of persons in need of chiropody.

Home Helps

6.13 In other countries, and to a very small extent in this country, the employment of home helps has been found to be of considerable help in enabling the aged to live in their own homes. A few hours service per week may be the means of keeping an old person out of an institution. The home help takes the place which frequently is filled by the daughter or daughter-in-law who looks after an aged relative. She visits the aged and gives them assistance in their own homes. The regularity and length of visits and the nature of help provided varies with the needs of the aged person; visits a few times a week to help with shopping and the heavier type of household duties may be adequate; visits every day to help the old person to get up and dress or undress and go to bed, may be necessary; more prolonged visits to help with meals and the general organisation of the living accommodation may be desirable. In some cases the services of the home help will be required for a good part of each day, but, normally, she attends for a limited time only. The provision of a home help on a full-time basis can be justified for a short period, but when the stage is reached that wholetime services are required for extended periods it will usually be found more practicable to have the elderly person provided with institutional care.

The selection of home helps is important. It is necessary to stress that the work involved is more than the performance of domestic work. An effort should be made to sell the job as a valuable form of social service for women who have a desire to
help. A good organiser has a very special contribution to make in the recruitment of home helps and in the encouragement of a sense of dedication in their work. The persons selected must be competent housekeepers; they must be interested in old people and be patient with them; and they must have an understanding of the peculiarities of personality and conduct which the aged may display. In some countries special courses, usually of short duration, for the training of home helps are provided. The persons selected are very frequently housewives who are prepared to take up part-time employment, and the main aim is to give them an understanding of the idiosyncrasies which may be met with in old people, rather than to teach them how to perform the practical tasks which they will be required to undertake. In some countries, e.g. Holland, extended courses are provided, but they are designed mainly for supervisors of home helps and "Home Makers" who care for households (e.g. where the mother of a family has to enter hospital) rather than individual elderly persons. The Committee considers that, initially, at least, no extended course of training is necessary. When experience of the operation of a home help service is obtained the matter can be reconsidered.

The employment of home helps is sometimes carried out by voluntary bodies and sometimes by health authorities. Where voluntary organisations are active the employment of home helps is probably a very suitable activity for them. They are in touch with old people and know those who can benefit from the services of home helps. They can select with a greater degree of flexibility than can a health authority, suitable persons to act as home helps. They will usually be in close touch and know whether the home help is satisfactorily carrying out her duties. In some areas, particularly rural areas, there may be no suitable voluntary organisation and health authorities may have to engage home helps. The district nurse should be in a position to arrange for such employment. There is no best method of organising and operating a home help service. There must be a flexible approach so that each area can develop the type of service best suited to local conditions. Needs are not confined to five days per week and the necessity for help on week-ends must be borne in mind.

The Committee recommends that health authorities should arrange for a home help service. Where the service is operated by voluntary bodies health authorities should contribute towards the cost involved.

The question is sometimes raised as to whether a relative should be employed as a home help. Where a relative is available to help an elderly person, the Committee considers that payment should not be made. Where, however, a relative has to give up employment or is unable to take up employment because of the need to look after an elderly person who does not receive an increase of pension for the relative under the schemes administered by the Department of Social Welfare, the Committee considers that she should be paid, but only at the rate and for the time which a non-relative would be paid.

Social Workers
6.14 In the case of many old people living in the community, particularly those who are living alone and without the regular assistance of relatives, a variety of needs frequently arises and it is important that trained workers should be available to assist them. In many instances the district nurse will be able to help but where
the needs are complex, as they frequently are, it is desirable that a trained social worker should be available to help. The services of the trained social worker are also required for a full assessment of the social and environmental factors when any question of long-term institutional care arises. She can improve contacts with the relatives and encourage them to retain old persons in the home, or to receive them back after a period of institutional care. The Commissions on Mental Handicap and Mental Illness have already recommended that social workers should be employed by health authorities. Whether a social worker will be engaged on all health authority work, or on specific tasks only, is a matter for decision having regard to the needs of particular areas. The Committee recommends that each health authority should employ, or should make arrangements for the employment by voluntary bodies, of sufficient trained social workers to meet the needs of the aged in its area. In making this recommendation the Committee appreciates that, in practice, public health nurses in rural areas at present provide many of the services normally provided by social workers. Social workers should work in close co-operation with the district public health nurses in their areas. The possible duplication of services and the creation of unnecessary rivalries between social workers and public health nurses must be avoided. This could probably best be achieved if social workers and nurses both work under the supervision of the Chief Medical Officer.

Boarding-Out

6.15 The practice of boarding out the mentally ill and the mentally handicapped has existed for a very long number of years—up to 100 years in some European countries—but the placing of elderly people with private householders is a comparatively recent development. Boarding-out can be a very desirable solution for the problems of certain elderly people—for those who are no longer fit to live alone but do not need hospital care; for those living in social isolation which may lead to a breakdown; for hospital patients who no longer need hospital care but have nowhere to go, or whose relatives are unable to look after them, or who are not fit to return to living alone. It can help to ease the demand for institutional beds and a shortage of suitable living accommodation for the aged. It can provide a more natural substitute for their own homes than can institutional accommodation. It can also be useful as a short-term arrangement to enable families caring for elderly relatives to take holidays, or to cope with an emergency or illness in the family. For hospital patients fit for discharge, boarding-out can provide a half-way house between hospital care and return to independent life in the community.

There is at present no statutory authority for the boarding-out of elderly persons by health authorities. At least one health authority has, however, boarded-out a number of elderly people, using public assistance funds for the purpose. Most health authorities have, however, been reluctant to adopt the practice as the cost has to be borne completely by local funds. The Committee recommends that health authorities should introduce boarding-out schemes as a normal feature of their services for the aged. Such schemes should include provision for adequate supervision by the health authority to ensure the welfare of the person boarded-out.

There is no tradition in this country of the boarding-out of elderly patients. It is essential, therefore, that proposals to board-out patients should be very carefully considered before they are implemented. The selection of places is not comparable.
to the compilation of a list of places in hotels or guest houses. If boarding-out is to be successful there must be most careful selection of the persons to be boarded-out and of the persons to receive them. There must also be most careful matching of the persons involved. The persons in charge of placement must have an intimate knowledge of the personality of the person to be boarded out, of his likes and dislikes, of his habits and possible idiosyncrasies; they must also have an intimate knowledge of the personality of the person willing to receive a boarder, of her likes and dislikes and of the way of life of the household. Where possible the persons concerned should meet, preferably more than once, before placement is completed. All this involves trouble and delay but haphazard or hurried placement is seldom successful. Too many failures get boarding-out a bad name. Some failures are probably inevitable but the number will be considerably reduced if adequate care is taken in placement. Health authorities should make it clear to a person who is taking in a boarder that alternative arrangements will be made if the boarder becomes ill or if the placement is not a success, or if the person wishes to go away on holidays. Acceptance as a member of a family often gives the elderly person that sense of being wanted and having a place in the community which is so important to happiness and well-being.

Boarding-out should not be confined to the placing of an elderly person with a younger person who will provide food and maintenance. Many elderly persons can look after their needs if suitable accommodation is obtained for them. Frequently an elderly person living alone can share a house or flat with another. This arrangement can sometimes solve the problems of both the persons concerned.

The amount to be paid by health authorities for persons boarded out must be determined from time to time, but it should be reasonably generous. In deciding the amounts to be paid, the cost of providing institutional care, including the capital cost, should be borne in mind. Some of those boarded out will be able to pay all or part of the cost.

When a person is boarded out, the health authority should not regard its responsibilities as at an end. It should arrange for community services in the same way as if the person concerned were living in his own home.

Day Hospitals

6.16 Day hospitals are hospitals where patients attend for treatment during the day, returning to their own homes at night. They have been a post-war development in several countries. They are still, to a large extent, at the experimental stage and no general pattern has yet evolved. Most are attached to, or linked with, parent general hospitals; some are separate buildings, others consist of a ward or wards of a hospital; some share facilities and day patients mix with resident patients, others provide their own facilities and day patients are kept separate from residents; some cater for the physically and mentally infirm, others cater for the physically ill only. Among the advantages claimed for day hospitals are:

(a) they obviate the traumatic effects and the severance of roots in the community which may result from the admission of elderly patients to residential hospitals.
(b) they obviate the necessity for admission to hospital to a greater extent than can ordinary out-patient services;

(c) they permit preliminary investigation and treatment of patients and lessen the length of necessary stay in hospital;

(d) they facilitate the early discharge of in-patients who can continue necessary treatment on a day basis;

(e) by supervision and continued therapy they prevent the deterioration of patients who have been discharged from in-patient care;

(f) they increase social contacts and prevent the mental deterioration of patients;

(g) they are cheaper than residential hospital care as only one shift of nurses and other staff is required.

The Committee is satisfied that day hospitals can fill a useful role. The medical function of a day hospital must be borne in mind, however, and it should not be used merely as a social prop. Patients will usually attend only once or twice each week. The type and size of the day hospital required in an area will vary according to local needs. In addition to medical care they should provide services such as physiotherapy, chiropody and occupational therapy. They should also supply a mid-day meal—the provision of proper meals can make an important contribution to the health of elderly people, especially those living alone. No day hospital has yet been developed in this country. The Committee recommends that they should be provided on an experimental basis in Dublin and Cork. As a result of the experience gained from the operation of these hospitals, the question of providing them in other areas can be considered. Health authorities should arrange for the provision of transport where necessary.

Day Centres

6.17 The Day Centre is similar to the Day Hospital and its work overlaps that of the Day Hospital to some extent. It operates at a different level as little, if any, medical care or investigation is carried out, but many other services, which may be provided in the home, can more readily be provided at a Day Centre, where patients attend during the day. Such services are physiotherapy, occupational therapy, diversional therapy, chiropody and a mid-day meal. In addition to facilitating the provision of these services the Day Centre improves social contacts and prevents the loneliness which some patients would otherwise suffer. It also relieves relatives, particularly those who have to go out to work, of the responsibility of looking after elderly persons during the day. Day Centres can vary considerably in the type and range of services they provide and in the time during the day and the number of days during the week on which they remain open. Some are operated solely by voluntary workers, but most have some paid staff. Factors which have to be taken into account are the population to be served and the extent to which Day Hospital services and Clubs are available. Like Day Hospitals, Day Centres can fill a very useful preventive role and obviate the necessity for having old people admitted to a residential centre. Many of those attending will be too frail to attend a Club. Transport may have to be provided. The Committee recommends that health
authorities should arrange for the provision of Day Centres in populous areas. The type and range of services should be determined according to the needs of particular areas.

**Clubs**

6.18 Many of the elderly follow the interests of a lifetime, others find new interests in their old age, but some are lonely and feel a loss of status and sense of purpose in life. Clubs provide leisure activities for many, help them to enjoy companionship and to remain interested in their surroundings. Clubs for the elderly differ from Day Centres in that their aim is primarily social—not the provision of treatment, although some treatment services may be provided. Clubs bring together old people living in an area and encourage them to cooperate in social activities and the development and pursuit of hobbies. They are a most useful means of preserving contacts, fostering friendships, giving the elderly new interests and maintaining a high standard of morale. Clubs, like Day Centres, can vary considerably—they may provide facilities for some or all of a wide range of activities, e.g. for card and similar games, for billiards, for hobbies such as photography, woodwork, arts and crafts, knitting, sewing, etc., for various educational courses, for keep-fit classes etc. In or in conjunction with the Club, services such as physiotherapy, occupational therapy and chiropody may also be provided. Some provide facilities for bathing, shaving and laundry—facilities which may not be available in the home. Many arrange for meals—a most desirable service for many of the elderly, particularly those living alone. Some open only in the evening or at night, others open on certain days of the week and others open every day. They are frequently provided by voluntary bodies, but it is desirable that the aged should be encouraged to participate to the greatest extent possible in their administration and management. Clubs give their members an interest in the welfare of one another to the benefit of all. It is very desirable that persons in charge of Clubs should pay particular attention to the shy and withdrawn type of person—the one who needs most the help of a Club, but who may not attend, or continue attending unless he receives considerable encouragement. The Committee considers that Clubs can be of considerable benefit to the aged. Several have already been developed by voluntary bodies. The Committee recommends that health authorities should encourage the development of clubs and should give financial support to voluntary bodies which provide them.

**Laundry**

6.19 For many old people the washing of personal clothing and, especially, bed clothing presents problems. Many are physically unable to carry out this chore and others have not the necessary facilities. The handling of soiled bed linen also presents a problem for people looking after incontinent relatives and often results in an effort to have institutional care provided.

Voluntary organisations are providing a laundry service for old people in a number of towns throughout the country. In some towns special centres have been equipped with washing machines and spin dryers and soiled clothing is collected from old people, washed and returned by voluntary workers. In many cases health authorities have helped by providing finance for the equipment of centres by means of
grants under Section 65 of the Health Act, 1953. In one city the service is based on the use of a commercial laundrette. Voluntary workers collect the clothing, process it in the laundrette and return it. The health authority meets the charges made by the laundrette. In other areas voluntary organisations have made arrangements with commercial laundries to provide a service for old people.

The provision of a laundry service is an activity well suited to voluntary effort. The Committee recommends that health authorities should take the lead in having a service introduced in their areas by approaching local voluntary organisations to run the service and offering the use of hospital laundries or financial assistance as appropriate. Where commercial laundries or laundrettes are available it will usually be found desirable to use them, as capital expenditure on equipment and premises is saved. In areas where a health authority institution which has a laundry is situated a service based on the use of the hospital facilities could be operated. In areas where other suitable arrangements cannot be made, health authorities should examine the possibility of having laundry done for old people by neighbours in return for a small weekly payment. Where possible, laundry services should cater specially for the needs of people looking after incontinent old relatives.

Concessions for the Aged

6.20 Some organisations arrange for concessions for the aged, e.g. for cinemas to charge reduced prices up to a fixed time. Some feel that the policy of seeking concessions for the aged is undesirable, that it makes them second-class citizens and that the proper approach is to seek for them adequate resources to meet their needs in the normal way. The Committee appreciates this view, but regards it as, perhaps, too idealistic. It recommends that voluntary organisations should interest themselves in obtaining concessions for the aged—not as a form of charity, but as a form of reward from the community to its older citizens.

Nutrition and Provision of Meals

6.21 A World Health Organisation Report* has stated that many old people are in a poor state of health to which malnutrition frequently contributes. The Committee received varied views as to the extent to which malnutrition is a problem in this country. It was, however, agreed in all areas visited and by the various bodies with whom discussions were held, e.g. the Irish Medical Association and the Society of Medical Officers of Health, that sub-clinical malnutrition is widespread amongst old people. It seems clear that many old people do not get a properly balanced diet. The usual picture seems to be a high carbohydrate, low protein diet with a bread and tea diet much too prevalent. Whilst lack of money is often a cause of bad diets, it is far from being the only cause. Old people living alone tend to become apathetic and to neglect themselves, particularly in relation to their diet. Ignorance in regard to the correct foods to buy and how to prepare them is also a factor. The Committee recommends that this situation should be tackled in two ways—through the education of old people in regard to correct diets and the pro-

vision of meals where necessary. Education in regard to diets can best be given by public health nurses in the course of visits. Chief Medical Officers should emphasise this aspect and should ensure that their public health nurses are competent to give sound advice on nutrition.

Meals are being provided for old people by voluntary organisations in a number of areas throughout the country. Various methods have been adopted. Some organisations have established special centres for the preparation of meals. In one area the meals are supplied to the voluntary organisation from the kitchen of the County Hospital. In other areas, kitchens in voluntary hospitals have been placed at the disposal of voluntary organisations whose members cook the meals. There are also areas where meals are prepared by members of voluntary organisations in their own homes, food being donated by hotels, restaurants and shops. Other voluntary organisations pay local restaurants to provide meals and some have made arrangements with neighbours to supply meals, the voluntary organisations bearing the cost of the food where necessary. The number of meals provided for each old person varies from area to area, from two per week to one every day. Delivery of meals to the homes of the old people is made by members of the voluntary organisation in their own cars. Insulated containers holding 6 to 8 meals are normally used.

The Committee recommends the operation of a domiciliary meals service, commonly called “Meals-on-Wheels”, in any area where the number of aged people in need of the service warrants it. It is a service best suited to voluntary endeavour. In most areas the need for a service could be met by the adoption of one or other of the methods described in the previous paragraph. Where no service is being provided, health authorities should endeavour to interest voluntary organisations in commencing a service. They should be prepared to provide meals from hospitals, or other institutions. This system has much to recommend it because, with the advantages of bulk purchasing and preparation of food, meals can be provided at the most economical cost and the number of meals involved should not necessitate the employment of extra staff. In larger towns where no hospital is situated health authorities may have to consider assisting voluntary organisations to provide special kitchens. In rural areas where voluntary organisations will not be in a position to give a service the best prospects seem to lie in having neighbours provide meals for old people. The Committee recommends that health authorities should accept responsibility for organising a service in these areas and be prepared, where necessary, to make payments to neighbours to supply meals.

As indicated, the number of meals provided per week for each person varies from area to area. There was no agreement amongst the organisations with whom the Committee held discussions as to the number of meals which should be supplied each week. The Committee feels that the aim should be to supplement the diet of aged people to the extent of three or four meals per week for those in need. Elaborate meals are not required although every effort should be made to introduce variety, as old people quickly tire of the same type of meal given regularly. It is of the greatest importance that meals should have a high nutritional value. One of the biggest problems inherent in the operation of a meals-on-wheels service is to ensure that the meals have not lost their nutritional value by the time they are delivered. The Committee understands that research carried out in Britain indicated that a big number of meals supplied under meals-on-wheels schemes were of little value from
the point of view of nutrition because of the amount of time that elapsed between preparation and delivery. The delivery of a large number of meals by vans inevitably results in a fairly long delay before some of the meals reach the recipients. For this reason the Committee considers that this method of delivery is not to be recommended. The best way to ensure that there is not an undue time-lag would seem to be to have no more than six or eight meals delivered on any one run. In addition to “meals-on-wheels”, the Committee recommends that meals should be provided at fixed centres. These are particularly suitable for ambulant people who may lack facilities or skills to do their own cooking. Well balanced meals attractively served in pleasant surroundings may be the means of keeping an old person fit and well. For many, having a meal in company is nearly as enjoyable as the meal itself.

There seems to be general agreement amongst voluntary organisations that a small charge should be made for meals supplied but that old people should not be pressed to pay the charge. The making of a charge removes the impression that “charity” is being given and gives old people a feeling of independence.

Home Visiting

6.22 Loneliness can be one of the main causes of deterioration in the aged. It may lead to apathy and neglect and eventually, to both mental and physical breakdown. Fortunately, a large proportion of the aged have relatives and family interests but a proportion, particularly of those who live alone, have few relatives or friends and can suffer considerably from loneliness. The provision of some of the services already mentioned, such as home nursing, will help to counteract loneliness but its effect will be small compared with what can be done by good neighbours and by voluntary bodies. Where suitable neighbours are available and willing to visit the aged, there is little doubt that they can be of enormous help. Voluntary bodies, such as the Society of St. Vincent de Paul and the Legion of Mary, have, of course, been visiting the aged for a long time. Other religious bodies and many voluntary organisations have undertaken this task more recently. A development of considerable interest is that in a number of schools, students have interested themselves in visiting the aged, both in their own homes and in institutions. Similarly some voluntary bodies have encouraged their younger members to undertake the visiting of the aged. This visiting of elderly people is a most commendable work and the Committee recommends that it should be encouraged in every way and that the National Council for the Aged, recommended in Paragraph 10.11, should issue propaganda encouraging the visiting of the aged so that loneliness may be avoided.

Personal Services

6.23 As already stated the needs of the aged cover every facet of life. A number of the major forms of help have been mentioned, but there is a host of other forms of help which are also desirable. These include such personal services as the provision of various comforts, the arranging of social functions, parties, outings, holidays, the provision of transport (e.g. to attend religious services), help in correspondence and the sending of birthday and Christmas cards. These are types of services already being provided by good neighbours and by voluntary bodies and they help in no small way to make life more pleasant for the elderly concerned. Many of the ser-
Work of Voluntary Organisations

6.24 Particulars have been given in paragraph 2.50 regarding the very praiseworthy work being carried out by voluntary bodies. The complementary roles of voluntary bodies and health authorities have been emphasised in paragraph 6.1, and the formation of Councils of Social Service, as recommended in paragraphs 10.6 to 10.9, should help in this regard. Voluntary bodies have an important part to play in most domiciliary services. In the more specialised fields, such as medical services, their main role will be to encourage the aged to avail themselves of existing services and to draw the attention of health authorities to cases where these services are required. In less specialised areas such as the supply of aids in the home and the provision of meals, they may provide the services on their own, assisted financially by health authorities when necessary, or they may supply part of the services — the health authority supplying the remainder. Voluntary bodies can be of great assistance to health authorities in matters such as the securing of suitable places for the boarding-out of elderly patients. They can also supply many services on a more personal basis and in a quicker and more flexible manner than can health authorities, e.g. the provision of meals and the giving of various forms of assistance in times of urgency. Health authorities are bound to administer their services within the general framework of legislation, but voluntary bodies can, when necessary, adapt their services to meet individual needs not covered by legislation. Voluntary bodies can probably, however, make their greatest contribution in matters such as home visiting and various other measures to combat the feeling of isolation and loneliness which many of the aged may suffer, in the provision of clubs, in arranging for transport and outings and in helping to overcome crises in the home, either permanently or until the public services can be called upon. Voluntary bodies make a highly important contribution to the man-power needed to provide services for the aged. The vast majority of their workers are unpaid — the fact that some bodies may employ a limited number of paid staff does not diminish the voluntary nature of their work — and their activities represent a considerable saving to the public authorities. The field of voluntary effort is almost unlimited and the development of voluntary bodies should be encouraged in every way. While in many parts of the country the communities have shown very commendable public spirit in the formation of new bodies, or in extending or increasing the activities of existing bodies, there are areas where voluntary effort needs to be increased. The Irish Red Cross Society and bodies such as the Society of St. Vincent de Paul have already done much to improve services for the aged. If social workers are appointed by health authorities, as recommended by the Committee, the encouragement of local voluntary effort should be one of their functions. The National Council recommended
in paragraph 10.11 could do much to encourage voluntary effort. Some organisations have already interested pupils of schools and other young persons in the care of the aged. Old people are glad to feel that young people are interested in their welfare and they enjoy the contacts with youth. The channelling of the idealism of young people into the care of the aged is a most desirable development. The aged themselves are a source of particularly valuable workers which probably has not been sufficiently tapped. Many are in good health and have time to devote to voluntary work. They can be very suitable for work among their less able contemporaries, or among those older than themselves. Voluntary work frequently gives the aged an interest and sense of purpose, so that in helping others they also help themselves. The Committee recommends that health authorities should take an active role in encouraging voluntary bodies providing services for the aged and should support them financially. Some County Managers and Chief Medical Officers and their Assistants have already done much in this field.
Chapter 7

INSTITUTIONAL CARE

General

7.1 There are so many aged persons that even though the proportion in need of institutional care is small, the numbers involved are so great that they present, and will continue to present, the health and welfare services with one of their principal challenges. For some of the elderly who have to enter institutions little more than the facilities of a normal home are needed, for others varying degrees of medical and nursing care are required. In many countries, in former times, old people who required care, whether for medical or social reasons, were accommodated in premises which were originally intended for the destitute. Buildings were of a poor standard; the provision made for active treatment was limited; there was little, if any, attempt made to rehabilitate those admitted and frequently there was a resigned acceptance that a large proportion would remain until death. This pattern still obtains to some extent in many countries. In this country, the main institutional provision made for the aged, as such, is in County Homes which were formerly Workhouses. A number of Homes have been rebuilt or reconstructed, wholly or in part, but many buildings are still of an unsatisfactory standard. The Homes cater for a variety of patients—the sick, the infirm, the mentally handicapped and persons in need of shelter and maintenance because of social reasons (see paragraph 2.9). Persons are frequently admitted without any medical or social assessment and without any effort to determine whether some form of help in the community would obviate the need for admission. The provisions made for specialist treatment and the activation and rehabilitation of patients are limited, and it is too often accepted that many have taken their last leave of home. There is no organisation to sort out those who could benefit from active treatment and rehabilitation from those in need of long-term care. Many elderly patients are treated in general hospitals, but no special facilities for the aged, as such, are available and many hospitals feel that they have to provide services for elderly people which are not properly their responsibility. In most cases there is inadequate liaison between the general hospitals and the County Homes and little effort is made to co-ordinate the activities of the two types of institution, or to ensure that the best use is made of the accommodation and facilities in both. The Committee considers that the present pattern of care is inadequate. It feels that if those who are in need of hospital care, or can benefit from medical treatment and rehabilitation procedures, are to receive the services they need their care must be separated from the care of those whose primary need is for a home. In a centre where a considerable proportion of the patients are in need of little, if any, medical or nursing care, it is difficult to create the atmosphere of a
hospital with emphasis on treatment and the rehabilitation of patients. Experience has shown that much disability in the aged, formerly regarded as irremediable, is due to specific disease processes and may be mitigated or cured. A survey* in Britain showed that, apart from those admitted for terminal care, the proportion benefiting from hospital treatment among the older age group was almost as high as among younger patients. It has already been suggested that every effort should be made to provide community services, so that the aged do not have to enter institutions; it is similarly essential to ensure that if persons have to enter institutions every effort should be made to give them the help they need, and to rehabilitate them and restore them to the community when it is possible to do so. To permit of this, to cater adequately for the various categories of patients and to ensure that each is given the most appropriate form of care, it is necessary to provide different types of institutions and institutional facilities. A universal pattern has not yet developed but the Committee recommends that, basically, four main types of accommodation should be provided:

(a) general hospitals (as defined in paragraph 7.2);

(b) geriatric assessment units;

(c) long-stay units; and

(d) welfare homes.

The purpose of the different units is discussed in subsequent paragraphs and an indication is given of the types of patients which should be dealt with in each. However, old people often fluctuate to and fro across the dividing lines between frailty, sickness and health and there may have to be a certain amount of movement between the different units. Some consideration must also be given to the position of the individual, e.g. if a person has remained a very long time in a particular hospital or home the desirability of moving him to more suitable accommodation has to be weighed against the human problem of taking him away from everything with which he is familiar. In addition, it is always necessary to consider whether a particular condition is transitory only or is one which is likely to be permanent, or of long duration. Terminal care will also have to be provided for some in every type of institution. The care of the dying is a most essential service for many—particularly those who have no relatives to look after them, or those in need of the relief from discomfort which skilled nursing can provide, or the relief from great pain which modern therapy and skill can bring.

The Consultative Council on the General Hospital Services has submitted a report entitled "Outline of the Future Hospital System". A summary of this report, in so far as it relates to institutional services for the aged, is given in Chapter 13. In general, it can be said that the recommendations made by the Council and those being made by the Committee are substantially the same.

General Hospitals

Definition

7.2 The term "general hospital" is used here in the sense of a hospital providing specialised general medical and surgical care, but excluding any part of the hospital used as a geriatric assessment unit, or a unit for long-term care.

General

7.3 General hospitals, particularly the teaching hospitals, have traditionally aimed at dealing primarily with acute illness and attaining a quick turnover of patients. Many of the elderly require treatment for acute conditions, exactly as younger people do. They are not second-class citizens and there should be no bar on their admission to general hospitals, provided that their condition requires the services which the general hospital can give. The survey by Bourke and Coughlan (referred to in paragraph 2.13) showed, however, that many patients maintained in Dublin general hospitals do not need general hospital care. There is little doubt that a similar pattern obtains in other areas in this country. General hospital care is very expensive and it is obviously undesirable that patients should be maintained unnecessarily in beds for the acutely ill, at a far greater cost than that at which they could be maintained in other institutions, or even in good hotels. In addition, it is frequently difficult to obtain a bed for an elderly person in urgent need of hospital care. The general hospitals have a great contribution to make to the care of the aged, but it is necessary to try to use their facilities to the best advantage.

Classes of Patients

7.4 The Committee recommends that general hospitals should continue to admit the elderly who are acutely ill, or in need of urgent treatment as a result of an accident or other emergency. Some of the latter, may be found to be unsuitable for retention in the general hospital. In the case of many of the elderly it is difficult, if not impossible, to draw a clear distinction between what is normally regarded as an acute condition and a condition which is only an episode in a chronic or sub-acute illness. It is probably not necessary to try to draw such a clear distinction. If it is accepted that the primary purpose of the general hospital is to treat the acutely ill, and if alternative means of dealing with other patients are available, the general hospitals will not be anxious to admit patients who can more appropriately be dealt with in a geriatric assessment unit or a long-term unit. In any cases of doubt it is very desirable that the general hospital staff should consult with the staff in the geriatric assessment unit or, where appropriate, with public health staff.

Disposal of Patients

7.5 The majority of elderly patients admitted to general hospitals, excluding those admitted for terminal care, will be discharged to their own homes. Where they appear to require extended rehabilitation or long-term care they should be admitted to the geriatric assessment units in the same way as other patients. Where patients are discharged to their own homes, or to Welfare Homes, it is important that a full report on their condition should be sent to the family doctor and, where appropriate,
to the public health medical officer. A vital time in the after-care of patients is that immediately following their discharge from hospital and it is essential that community services, particularly the district nursing services, should be available as soon as the patient returns home.

Geriatric Assessment Units

Definition

7.6 Geriatric Assessment Units are specially equipped and staffed units for the full investigation and assessment of elderly patients, who are not clearly in need of the acute treatment which the general hospital can provide, for their short-term treatment and rehabilitation, where this is possible, and for the assignment to the most appropriate accommodation of those in need of long-term care. Further details regarding these units are given in the following two paragraphs; recommendations in regard to the location of units and their medical staffing are in paragraphs 7.29 and 7.33 respectively.

Need for Geriatric Assessment Units

7.7 A proportion of the aged in need of hospital care will be admitted to general hospitals, under the proposals contained in paragraphs 7.2 to 7.4, in exactly the same way as other patients. If, however, the general hospitals are not rapidly to become swamped with demands for the admission of elderly patients an alternative system must be devised to deal with elderly patients who may not need the type of services normally provided in general hospitals, or may need services not normally available in the general hospital (e.g. rehabilitation and social services), or whose need for a particular type of institutional care has not been established. This alternative system is also necessary for other reasons. The decision whether or not to admit an elderly patient to hospital is a serious one. For many, early admission, full investigation and prompt treatment are vitally important and may prevent a much more prolonged stay at a later stage. Long delays in admission frequently make relatives resentful and unwilling to accept their relatives on discharge. The advantages of admission to hospital must not be minimised, but the advantages have to be weighed against the possible disadvantages. Admission to hospital frequently produces a permanent patient. For many the removal from home and familiar surroundings can be a traumatic experience which may impair their ability to live in the community, possibly as much as or more than would the condition for which hospital treatment is sought. Particularly, where in-patient care is prolonged, there is a danger that the patient's roots in the community may be severed and that he may need some form of institutional care for the rest of his life. It is suggested in paragraph 7.9 that, where possible, patients, other than those acutely ill, should be seen on an out-patient or domiciliary basis before they are admitted to hospital and that there should be a social and environmental as well as a clinical assessment. If patients are admitted, it is essential to ensure that they are fully investigated and assessed to determine how further institutional care can be avoided, or reduced to the greatest extent possible. Many of the aged suffer from multiple disabilities and frequently
the resources of several disciplines are necessary to investigate and assess their disabilities and to determine whether care can more suitably be provided in a centre catering mainly for the physically ill, or in a centre catering primarily for persons suffering from mental illness. It is essential, in most cases, to have a social and environmental as well as a clinical assessment, before any decision is made that further hospital care, particularly extended hospital care, is desirable. Where any treatment, short-term or long-term, is required it is essential to ensure that the patient is given the most appropriate form of care. Experience has shown that many patients are sent to the unit which can most speedily provide a bed. Patients are thus often placed in accommodation which is not best suited to their condition and they do not do as well as patients who are properly placed, with the result that they have a higher mortality and a lower discharge rate. The transfer of patients from one type of institution to another is usually not very easy and errors of initial placement, even if they are recognised, are not readily rectifiable. Many of the aged who have to be admitted to hospital will require a period of rehabilitation. The aim of rehabilitation is to restore abilities which have been lost and to enable people to live independent or semi-independent lives. Some of the aged can be rehabilitated in the sense of being made able to resume employment; some can be rehabilitated to the extent of being made able to live independent lives in the community, although they have ceased to be gainfully employed; others can be rehabilitated to the extent that their dependency is limited and they are enabled to live in their own homes with the help and assistance which their relatives and friends and the community services can provide, or alternatively, they are enabled to live in a home provided for persons who have no home of their own. The provision of facilities for short-term rehabilitation, in association with assessment and short-term treatment, has the advantage of facilitating continuing supervision by the physician who is familiar with the condition of the patient. The Committee recommends that units, to be known as geriatric assessment units, should be established for the investigation and assessment of elderly patients and for their short-term care and rehabilitation where these are necessary. Recommendations regarding the location of geriatric assessment units are contained in paragraph 7.29.

Facilities Required

7.8 A geriatric assessment unit must have all the facilities of a modern hospital. In particular, it must have facilities for x-ray, laboratory tests, physiotherapy, occupational therapy, speech therapy, chiropody, electrocardiography and electroencephalography; it must have various other aids to diagnosis and assessment; it must be in a position to call upon the services of a variety of specialists and must be in a position to ascertain the circumstances and home background of its patients and to arrange for their after-care when necessary. It must have dayrooms to encourage ambulation. It should have facilities for the care of psycho-geriatric patients in need of assessment or short-term care. In the case of the elderly, rehabilitation frequently involves the teaching of the activities of daily living—the ability to look after themselves, to eat, to wash, to walk, to dress and to use the ordinary toilet facilities—and space and equipment for this teaching are essential. The closest liaison
and co-operation between the assessment unit and the domiciliary services is essential. This in practice will mean close contact between the Chief Medical Officer and the unit.

**Admissions**

7.9 Patients admitted directly to general hospitals will consist mainly of those who have already been seen on an out-patient basis, emergency cases in need of urgent treatment and persons whose need for treatment is clearcut and, usually, of short duration. It is desirable that all elderly patients outside these classes should, where possible, be visited in their own homes by a specialist physician (see paragraph 7.33) before any decision is made to admit them to the geriatric assessment unit. It may seem wasteful of the time of a specialist to have such visits carried out, but first-hand knowledge of the social and environmental conditions will help the physician considerably in the decision whether or not to admit the patient. In addition a domiciliary visit has other advantages—it helps considerably the acceptance of the idea that patients are not admitted to hospital except for good and sufficient reasons, it helps to obtain the co-operation of relatives, it increases knowledge of the conditions for which hospital care is regarded as necessary and desirable and it helps the hospital physician to decide whether discharge back to the home is desirable. The number of requests for admissions is usually greater than the number of available beds and a system of priorities has to be determined. A domiciliary visit enables the specialist to ensure that those most in need are admitted and thus to make the best possible use of the beds in the geriatric assessment unit. The visit also enables the specialist to decide that particular patients would not benefit from treatment in a general hospital, or a geriatric assessment unit, and that their admission to a long-stay unit is desirable. Where a visit by the specialist is not possible there should be a full clinical report by the family doctor and a report by a social worker, or some other person qualified to assess and report on social conditions.

**Length of Stay**

7.10 Geriatric assessment units are designed primarily to deal with patients on a short-term basis, although some patients, who are benefiting from treatment or rehabilitation, may have to be retained for several months. When patients have been investigated and assessed and can no longer benefit from treatment or rehabilitation in the units they should be discharged or transferred to other units—in particular patients who are permanently bedridden, or who are in need of prolonged and continuous nursing or medical care or both, should be passed on to long-stay hospital units. Close contacts with the relatives should be maintained and they should be encouraged to retain a continuing sense of responsibility for the patient and, from the date of admission, they should be conditioned to the idea of his discharge. On his discharge they should not be left with the impression that the hospital is finished with the patient, but should be assured that re-admission will be arranged when essential. Similarly, contacts with the community services should be maintained.

**Psycho-Geriatric Patients**

7.11 Various studies have shown that the prevalence of psychiatric disorders among the aged is very high, but it has similarly been shown that physical illness is com-
mon throughout the whole field of mental illness. Many elderly patients who display psychiatric symptoms do not need to be, and should not be, admitted to psychiatric hospitals. There is a tendency to regard the aged with mental disturbance as a homogenous group, which they are not. Admission to a mental hospital is usually easier than to another hospital and in order to make a case for hospital admission there is a tendency to over-emphasise the mental state of an aged person and to ignore the question of whether it is of a transient nature and whether there are physical causes underlying it. There is no doubt that patients are referred unnecessarily to mental hospitals, including many whose primary need is for physical treatment. Similarly, of course, there are patients in other centres who could more appropriately be in mental hospital accommodation. Elderly patients who are mentally disturbed should be examined both by the specialist physician and the psychiatrist. The Commission on Mental Illness recommended that assessment geriatric units should be available where the condition of the aged can be fully assessed, in its physical, psychiatric and social aspects, before an appropriate programme of care is formulated. The Committee recommends that the geriatric assessment units should act as the assessment geriatric units recommended by the Commission.

**Long-stay Hospital Units**

**General**

7.12 Many elderly patients require long-term institutional care, but it is not essential that all this care should be provided in a hospital setting. Some can most appropriately be dealt with in a home (see paragraph 7.15) even though some medical or nursing care may be required. It may be difficult to decide in a particular case whether a person can more appropriately be dealt with in a hospital or a home, but the geriatric assessment units will help in this regard. The Committee recommends that, in general, long-stay hospital units should be confined to:

(i) patients who are so mentally ill, or confused or disturbed, or mentally handicapped, that they require long-stay hospital care;

(ii) patients who need continuous nursing care;

(iii) patients who are bedfast and need nursing care;

(iv) patients who are incontinent.

Recommendations in regard to the long-term care of the mentally ill and the mentally handicapped have already been made by the Commissions on Mental Illness and Mental Handicap and the Committee’s recommendations relate only to the classes at (ii), (iii) and (iv). The Commission on Mental Illness suggested that, as rehabilitation services are developed in units for the long-term care of the mentally ill, the units should gradually be extended and the scope of their activities should include the rehabilitation of some patients with physical illness. The Committee sees no objection, in principle, to the recommendation of the Commission, but facilities for the long-term care of the mentally ill are not yet sufficiently developed to justify the joint use of facilities. The matter should, however, be borne in mind where new units have to be provided. Included in the patients to be dealt with in long-stay units will be many terminal cases.
Facilities Required

7.13 Long-stay hospital units should not be regarded as centres solely for irremedi­able cases, or centres where little, if any, treatment is provided. Many patients require active treatment and rehabilitation measures over a long period and the long­stay units should be in a position to meet their needs. Many of the facilities of the general hospital should be available—in particular facilities for physiotherapy, occupational therapy and chiropody. The need for nursing care is great and a high ratio of nurses to patients is essential. Should staffing difficulties arise consideration may have to be given to the offering of additional financial allowances to nurses working in long-stay units in order to ensure adequate recruitment.

Admissions

7.14 In normal circumstances patients should be admitted for long-term care only after investigation and assessment in the geriatric assessment units. The specialist in charge of the geriatric assessment unit should, however, be in a position to have patients admitted directly to the long-stay units.

Welfare Homes

General

7.15 All patients do not need care in a hospital setting, even though they may be in need of some nursing and medical care. Many of them require only the type of care which is normally given at home by relatives, supported when necessary by the district nurse and the family doctor. Where relatives or other suitable persons are not available to provide them with the help which they need in their own homes, it may be possible to meet their needs by home helps or the provision of sheltered housing and where possible this should be done. There will be, however, a proportion for whom institutional care will be required. The Commission recommends the establishment of Welfare Homes to cater for such persons. As indicated in paragraph 7.12, it may be difficult to decide in a particular case whether a person can be more appropriately dealt with in a hospital or a home but, in general, it is recommended that Welfare Homes should cater mainly for:—

(i) frail and infirm old persons who are not in need of continuous medical or nursing care, but who may need periodic medical and nursing care of the kind normally given by the public health nurse and the family doctor;

(ii) elderly persons who require terminal care but do not need, or could not benefit from, hospital care;

(iii) elderly persons suffering from minor illnesses who need institutional care for a short period and who require medical and nursing care, but not beyond that normally given by the public health nurse and the family doctor;

(iv) persons discharged from hospital but who, because of family circumstances, need a short period of adjustment before they can resume their place in the community;

(v) elderly persons who need help for a short time because of the illness of relatives, or because the relatives need a break from the provision of continuous care, e.g. to enable them to take a holiday.
With the development of the community services, including sheltered and reserved housing, it should be necessary to provide for few, if any, able-bodied persons in Welfare Homes and the residents generally will be advanced in years and more infirm, physically and mentally, than many catered for in County Homes at present. Some may be so incapacitated that they need help with dressing and meals or the use of a walking aid or wheelchair. Some may be temporarily confused, or continually confused but still not excited or unreasonable or in need of care in a mental hospital. The occasional accident of incontinence should not be regarded as a reason for transfer to hospital nor should incontinence be regarded as irremediable until the cause has been sought and any possible steps taken to rectify the condition.

Form of Accommodation

7.16 As substitutes for normal homes, Welfare Homes do not require many facilities beyond those found in the normal home. Most of the occupants, however, will be frail or infirm and it is very desirable that the homes should be specially designed to meet their needs, e.g. steps, trestles and other obstacles should be avoided, few patients should have to climb stairs, handrails should be available, toilet facilities should be readily accessible, baths and toilets should have grips for ease of use and there should be no loose mats or slippery surfaces. The aim should be to provide as far as possible the atmosphere of a normal home. Very large dormitories, day rooms and dining rooms are out of place. A large proportion of single and double rooms should be provided. Some accommodation for married couples will be necessary but as shown in paragraph 9.6 only a limited number of married couples seek institutional care. Residents should be able to use their single rooms like bed-sitting rooms, thus retaining privacy and independence. A few small sitting rooms are preferable to one large one, where residents are less inclined to form friendships or to share interests. Homes should not be large—around 30 to 40 places will usually be found suitable. Where existing large institutions have to be used as Welfare Homes it may be possible to obviate some of their disadvantages by dividing them up, apart from central services, into two, or more, self-contained units.

Admissions

7.17 Welfare Homes are designed to meet a need which cannot be met adequately in a normal home. Somebody has to determine whether this need exists and, where there are more applicants than places, to determine a system of priorities so that those most in need are given preference. The Committee recommends that overall responsibility for this work should be assigned to Chief Medical Officers. They would, of course, be helped by Assistant Chief Medical Officers, Public Health Nurses, Social Workers etc.. Patients would be referred to Chief Medical Officers by relatives, Public Health Nurses, Social Workers, voluntary organisations, family doctors and specialists in general hospitals and geriatric assessment units. It would be the duty of the Chief Medical Officer to ascertain the social and environmental circumstances of those referred. Where necessary a clinical report should also be received—usually from the family doctor. The reasons for admission to Welfare Homes are often more social than medical and it is not necessary that persons should be passed through the geriatric assessment units, but when necessary they should be referred
to those units for assessment in accordance with the procedure recommended in paragraph 7.9.

**The Purpose of Homes**

7.18 The purpose of Welfare Homes must always be borne in mind. They are intended to provide for certain needs of elderly persons which cannot be met in their own homes. They should not be used to relieve a shortage of normal housing—in particular, they should not be used to provide for casuals (see paragraph 2.9). At the other extreme it is necessary to ensure that they do not become second-class hospitals by being filled up by persons in need of hospital care. It is also necessary to ensure, as far as possible, that they are operated as homes and that the residents do not become institutionalised—inert, apathetic, dependent, depressed and careless in their dress and habits. Residents of necessity suffer some loss of occupation and privacy; they may be isolated from their families and friends and they may find it hard to form new friendships; unless they are helped they may drift into what has been described as institutional neurosis. Positive steps to prevent this are essential. Residents should be free, within reason, to come and go as they wish and to entertain visitors. While some persons will be admitted while they are relatively young the majority will be of very advanced years at the time of admission. They will not readily form friendships or engage in social activities and they can easily become institutionalised if preventive measures are not taken. They should be encouraged in every way to retain their interests, their independence and their self-respect. They should be encouraged, when they can, to collect their pensions, choose their own clothes and do their own shopping. A certain amount of discipline is essential but it should be kept to the minimum and rules and regulations which tend to destroy the initiative and independence of the residents should be avoided. Help should be provided where necessary, but patients should be allowed to do as much as they can for themselves and for one another.

**Non-Medical Staffing**

7.19 Whether a Welfare Home will have the atmosphere of a home or the atmosphere of an institution will depend, to a great extent, on the staff. All staff have an important part to play in the creation of a proper atmosphere, but the person in charge, who will probably be designated “Matron”, is in a key position. An otherwise excellent home can be made a miserable institution if the wrong person is in charge. Many of the residents will need periodic nursing care and it is desirable, therefore, that the Matron should have a nursing qualification, but her personality and approach to the elderly are more important than specific qualifications. The understanding of old people, a sympathy with their idiosyncrasies as well as an appreciation of their virtues, the ability to get on with them and the art of managing them without bossing them are essential attributes. The ability to administer a home, to guide and direct other staff and to create the elusive but vital quality of a good atmosphere are all attributes which are most desirable in a Matron. Many of the residents in Welfare Homes will be able to do a considerable amount for themselves and nursing and domestic staff will not be required on anything like the scale necessary in a hospital. Most residents will need only the type of nursing care required by elderly people in their own homes. Whether this care can be pro-
vided by the Public Health Nurse will depend on the size of the home and the extent of the other duties of the nurse, but it will usually be found desirable to have some nursing staff in the home. It must be remembered that residents will be older and more infirm than the average elderly person cared for in the community. Even where homes have their own nursing staff it may be necessary to seek help and advice from the public health department. Residents should be assisted by home helps in the same way as in their own homes. The question of whether special home helps should be appointed for the home, or whether they should combine work in the home with other work, will depend on the circumstances in each case, but in most cases it will probably be found best to combine the duties of home helps with the duties of other staff, which will be required, in any event, to look after the communal portions of the home. Meals will have to be provided for residents and kitchen staff will be required. The provision of occupational therapy for residents is important and the services of an occupational therapist or of a teacher of arts and crafts will be necessary. Recommendations in regard to medical staffing are contained in paragraph 7.35.

**Numbers of Beds Required**

**General**

7.20 Apart from the fact that it is generally accepted that it is better for the elderly to remain in their own homes, when they can possibly do so, a number of countries seem to believe that it would put an unbearable strain on the economy to try to institutionalise a large proportion of the elderly. An expert committee of the World Health Organisation* stated—

"The point that requires emphasis, is however, that even under existing conditions, the small core of 3%–4% of old people cared for in institutions in most of the more developed countries is weighing down the health and welfare services. There is also a marginal group, a still larger number of aged people whose survival in the community is precarious and bought at the cost of hardship to relatives or friends. If the adjustment of a high proportion of individuals in this group were disturbed, an overwhelming burden would fall on the health and welfare services."

The 3% to 4%, mentioned by the Expert Committee, would represent in this country approximately 3.4 to 4.5 beds per thousand of the population or 30 to 40 beds per thousand of those aged 65 years and over. There is, however, no absolute standard as to the number of beds required for the care of the elderly. The ratio of beds to population will vary from place to place, as it will be affected by factors such as the proportion of elderly people in the population, the financial resources of the elderly, the extent to which services (including housing) are developed in the community, the extent to which services in institutions are geared to rehabilitate patients and to restore them to the community and the extent to which women go out to work and are thus not available for the care of elderly relatives. In addition, the number of beds in different types of hospitals and homes will be dependent on a consider-

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able extent and the number of beds required specifically for the elderly will be affected by the provisions made for the mentally ill and the mentally handicapped and for psycho-geriatric patients.

**Beds in Other Countries**

7.21 The following table shows the total provision made or recommended for the elderly in some countries:

<table>
<thead>
<tr>
<th>Country or Source of Information</th>
<th>Per 1,000 Population</th>
<th>Per 1,000 Population aged 65 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital Beds</td>
<td>Welfare Beds</td>
</tr>
<tr>
<td>Hospital Plan for England and Wales</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Health and Welfare Services in England and Wales</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Hospital Plan for Scotland</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Health and Welfare Services in Scotland</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Northern Ireland Hospitals Authority</td>
<td>1.5</td>
<td>—</td>
</tr>
<tr>
<td>Review of Geriatric Services in Northern Ireland Hospitals</td>
<td>1.5</td>
<td>1.5/2.0&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Scottish Health Services Council</td>
<td>2.0</td>
<td>—</td>
</tr>
<tr>
<td>Review of the Medical Services in Great Britain (Porritt Report)</td>
<td>2.0</td>
<td>—</td>
</tr>
<tr>
<td>The Care of the Elderly in Scotland (Report of Committee of Royal College of Physicians of Edinburgh—Publication No. 22)</td>
<td>2.0&lt;sup&gt;4&lt;/sup&gt;</td>
<td>2.5</td>
</tr>
<tr>
<td>Sweden</td>
<td>2.6&lt;sup&gt;4&lt;/sup&gt;</td>
<td>6.4&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Denmark</td>
<td>6.0</td>
<td>—</td>
</tr>
<tr>
<td>U.S.A.</td>
<td>3.4</td>
<td>—</td>
</tr>
</tbody>
</table>

1. Equivalent to 1.4 beds per 1,000 total population; includes provision for the elderly confused who do not need treatment in a psychiatric hospital; assumes a high standard of services inside and outside hospital.

2. It is considered that knowledge is too limited to enable standard ratios of places to population to be laid down and that local conditions will call for different levels. It is concluded that below 15 is inadequate and that a ratio of between 15 and 25 will be found appropriate.

3. Equivalent to 1.65 beds per 1,000 total population.

4. 1.5 in Belfast; 2.0 elsewhere.

5. It is suggested that an additional 1.5 beds per 1,000 of the general population should be provided for mental illness or for mental and physical illness combined.

6. These are approximate figures. “Fact Sheets on Sweden” (August, 1965) issued by the Swedish Institute states that there are about 1,400 old age homes in Sweden with accommodation for 50,000 pensioners and that, in addition, there are about 20,000 places at hospitals and nursing homes for the chronically ill, the vast majority of whom are old people. A number of the homes consist, to a large extent, of single rooms and flatlets and could possibly be regarded as in the category of sheltered housing.

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Beds in Ireland

7.22 The main provision for the aged is in county homes, but they are also catered for in a number of general and other hospitals and in homes and similar centres. The following is the total approximate number of persons aged 65 years and over in the various types of institution:

<table>
<thead>
<tr>
<th>Type of Institution</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Homes</td>
<td>8,057</td>
</tr>
<tr>
<td>Voluntary and private general hospitals and nursing homes</td>
<td>1,510</td>
</tr>
<tr>
<td>Regional Hospitals</td>
<td>400</td>
</tr>
<tr>
<td>County Hospitals</td>
<td>793</td>
</tr>
<tr>
<td>District Hospitals</td>
<td>960</td>
</tr>
<tr>
<td>District Mental Hospitals</td>
<td>4,577</td>
</tr>
<tr>
<td>Private Mental Hospitals</td>
<td>450</td>
</tr>
<tr>
<td>Private homes for the aged and similar centres</td>
<td>3,470</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20,217</strong></td>
</tr>
</tbody>
</table>

The total of 20,217 represent about 7 beds per thousand of the total population, or 63 beds per thousand of the population who are aged 65 years and over. There seems little doubt that these ratios are exceptionally high, even though they are probably not directly comparable with the ratios shown in paragraph 7.21, or with the figure of 3%—4% mentioned by the Expert Committee of the World Health Organisation (paragraph 7.20).

Total Provision Suggested

7.23 The Committee shows in paragraphs 9.3 to 9.7 the extraordinary anomalies which exist in regard to the numbers in institutions and to the type of institutional care provided in different areas. It is obvious that much more research than the Committee was able to undertake will be necessary before the exact number and type of beds which should be provided for the aged are known. The Committee regarded it as essential, however, to suggest ratios which can be used as a guide, but which can be amended, if necessary, when more knowledge as to the requirements of the aged is obtained. In considering the problem the Committee made no attempt to estimate the number of beds required for the aged in general hospitals (as defined in paragraph 7.2). In considering the number of beds to be provided in geriatric assessment units, long-stay units and welfare homes the Committee excluded the mentally ill, the mentally handicapped and casuals. The Commissions on Mental Illness and Mental Handicap have already made recommendations in regard to the care of the adult mentally ill and mentally handicapped. A number of persons, e.g., itinerants, seek accommodation in county homes for a short period because they have nowhere else to stay. There were about 120 such persons, aged 65 years and over, in county homes on 31st March, 1966. At present most county homes try to make separate provision for casuals. They constitute a social problem but the Committee considers that it is not an appropriate problem for consideration in connection
with the care of the aged. Excluding those in general hospitals and mental hospitals, the mentally handicapped and casuals there are approximately 11,725 beds for the elderly made up as follows:

- (a) County Homes ... 7,295
- (b) District Hospitals ... 960
- (c) Private homes for the aged and similar centres ... 3,470

Total 11,725

This represents 4.1 per thousand of the total population or 36.3 per thousand of the population aged 65 years and over. Of course all these patients are not necessarily suitable for, or in need of, care in the geriatric assessment units, long-stay units and welfare homes visualised by the Committee. On the other hand, there is little doubt that a proportion of those in general hospitals would be so suitable. The Committee recommends a ratio of approximately 40 beds per thousand of the population aged 65 years and over as a reasonable target. Before a greater number of beds is provided the provision for community care should be thoroughly reviewed to see whether, with improved community service, a lesser number of beds would be adequate. Where it can be done, such an investigation should be carried out before even the ratio of beds recommended by the Committee is provided. A suggested division of the total number of beds between the different types of units is set out in paragraphs 7.24 to 7.26.

**Beds in Geriatric Assessment Units**

7.24 It is essential to consider together units for investigation, assessment, treatment, and rehabilitation. In England and Wales the number of beds suggested for these purposes is 0.3 per 1,000 of the population. The Royal College of Physicians of Edinburgh has suggested that about 20% of the total geriatric beds should be devoted to assessment and rehabilitation. This would give 0.4 per 1,000 of the population for Scotland on the basis of the total provision they suggest. Until experience is gained in the operation of some units in this country the Committee recommends that planning should be on the basis of 0.5 beds per 1,000 of the population for Scotland on the basis of the total provision they suggest. Until experience is gained in the operation of some units in this country the Committee recommends that planning should be on the basis of 0.5 beds per 1,000 of the whole population, i.e. approximately 4.5 beds per 1,000 of the population aged 65 years and over. A ratio higher than in England, Wales, or Scotland is recommended in view of the fact that the general hospitalisation rate in this country is high. Of the number of beds recommended, about 20% to 25% would be required for diagnosis, assessment and intensive treatment and the remainder for rehabilitation.

**Long-Stay Hospital Units**

7.25 On 31st March, 1966, there were, according to returns received by the Committee, 4,574 persons aged 65 years and over in County Homes because of chronic medical conditions, i.e. patients "with a medical condition which requires constant medical and nursing attention of a type that could not be provided outside a hospital". Patients in need of assessment and rehabilitation would be included. This number represents 1.6 beds per 1,000 of the population or 14.2 beds per 1,000 of...
those aged 65 years and over. In all County Homes the proportion of patients with chronic medical conditions was 56.8%, but figures varied from 26.2% to 97.5%. It is unlikely that there is this wide difference in the types of patients dealt with, and it is probable that in some County Homes a generous view was taken of what constituted a "chronic medical condition", so that the number of patients described as being chronically ill is probably over-estimated. In addition, community services are poorly developed and not enough effort is being made to keep patients from going into hospital, nor to have them discharged from hospital. On the other hand, there are significant numbers of patients in other institutions (see paragraph 7.22) who should probably be in long-stay hospital units. The Committee recommends that planning of long-stay hospital units should be based on about 15 beds per 1,000 of those aged 65 years and over.

Welfare Homes

7.26 According to the returns received there were in County Homes on 31st March, 1966, 2,052 elderly patients who were maintained because of frailty, i.e. frail old people unable to maintain themselves unaided but who could be maintained in old persons' homes or hostels, or in their own homes, if supported by suitable domiciliary services. There were also 1,431 elderly persons maintained mainly because of social reasons, e.g. lack of suitable living accommodation and persons who were mentally handicapped. Of these, 642 were mentally handicapped and 120 were casuals so that the total number who could be regarded as suitable for welfare homes for the aged was 2,721 (2,052 + 669). As indicated in the preceding paragraph, the proportion of those who were regarded as suffering from chronic medical conditions was probably high so that the number estimated to be in need of accommodation because of frailty or because of social reasons was probably under-estimated and the total number was probably about 10 per 1,000 of those over the age of 65 years. The provision suggested in other countries is 15 to 25 per 1,000 of the population aged 65 years and over. It must be remembered that County Homes cater, to a very large extent, for the poor only. If it is accepted that, in future, some provision must be made for those outside the lower income group a total provision of about 20 beds per 1,000 of the population aged 65 years and over would not be unreasonable and the Committee recommends this figure as a target for the future. The actual number of welfare beds required will depend on a number of factors such as the provision made for special housing, the extent of the provision made for community services and the provision made for the adult mentally ill and mentally handicapped. Needs will also vary from place to place. The need for research into all these imponderables is stressed in paragraph 9.2.

Beds in Different Areas

7.27 Target figures put forward represent the suggested provision for the country as a whole. The basing of ratios on the proportion of the population who are aged 65 years and over should meet, to some extent at least, the differences in the age structures in different counties. The age structure is, however, only one of the matters which have to be taken into account—see paragraphs 7.29 to 7.31.
Location of Different Units

7.28 The Consultative Council on the General Hospital Services has already submitted a Report regarding the future general hospital system and the Government has accepted, in principle, the Council's Report. The Report visualises a big reduction in the number of general hospitals. Building considerations alone will result in a considerable lapse of time before the Council's recommendations can be implemented so that many of the present general hospitals will probably remain for several years.

Geriatric Assessment Units

7.29 The geriatric assessment units visualised by the Committee are acute units, they need the full facilities of the general hospital, and they will usually be too small to justify a duplication of the facilities of the general hospital. The Committee, therefore, recommends that geriatric assessment units should be located at general hospitals. It does not consider, however, that it would be feasible to provide geriatric assessment units in all the existing general hospitals; the total number of beds required is not large enough to justify adequate units; in them all and some general hospitals may not wish, or may not be able, to provide geriatric assessment units as visualised by the Committee. The Committee recommends that geriatric assessment units should be provided at least in the main teaching hospitals and in the hospitals which it is proposed to develop as "General" and "Regional" hospitals as visualised by the Consultative Council on the General Hospital Services. In addition to these units the Committee recommends that other units should be provided on a geographic basis in order to bring services closer to the people for whom they are intended and to facilitate liaison between these units and the community services. As indicated in paragraph 7.28 there will probably be a considerable lapse of time before many of the present general hospitals are discontinued. Assessment centres at selected centres would serve a very useful purpose for many years and their future could be determined in the light of the circumstances obtaining when it is found possible to discontinue the use of the hospitals concerned.

Long-Stay Units

7.30 It is desirable that, where possible, long-stay hospital units should be in, or near to and closely associated with a general hospital. A relatively large number of beds will be required in many areas and it may not be possible to locate the units in or near to a general hospital. In addition it may be necessary to use existing buildings which are not very suitably located. Even if a unit has to be some distance away it should be closely associated with the general hospital. As already stated the long-stay units require many of the facilities of the general hospital—in particular physiotherapy and occupational therapy and a high level of nursing staff. It is more likely that these facilities will be available if the units are in or near to and closely associated with the general hospital. The staffing, at nursing level, of long-stay units is already difficult and will probably become more difficult. Freedom to rotate nursing staff between short-stay units and long-stay units is desirable. Continuity of care is important and it is desirable that the doctor dealing with the patient in the acute
phase of his illness should have responsibility for, or be associated with, his long-term care. The increase in the number of elderly persons in the population and the high morbidity among them means that a substantial and increasing proportion of the time of all doctors is devoted to the aged. It is essential that instruction in the treatment and management of elderly persons should be available in teaching hospitals. In view of these considerations, the Committee recommends that, where possible, long-stay hospital units should be in, or near to, a general hospital and that, wherever located, a long-stay unit should be associated with a general hospital.

Welfare Homes

7.31 Welfare homes, subject to organisational and economic factors, should be located reasonably convenient to the persons they are intended to serve. They should be designed to keep residents in the stream of life and should be near to shops, churches etc. They do not require the same level of staffing or facilities as hospitals and several of the considerations which apply to the location of other units do not apply to them.

Medical Staffing

General Hospitals

7.32 The functions of the general hospital in regard to the elderly are set out in paragraphs 7.2 to 7.5. The Committee did not consider it necessary to make any recommendations regarding staffing for the exercise of these functions.

Geriatric Assessment Units

7.33 The main problem in regard to medical staffing arises in regard to geriatric assessment units. The elderly in such units may need the services of a wide range of specialists, but there should be one with particular responsibility for the beds specifically allocated to elderly patients. Who this specialist should be is the subject of considerable debate. Some maintain that the work is appropriate to a specialist in general medicine, others that a separate specialist, usually referred to as a geriatrician or geriatric specialist, is required. Some points of view which are advanced in favour of basing services on the specialist in general medicine are the following:—

(a) There is no fundamental difference between the disabilities of those over 65 years and those under 65 years and there is, therefore, no justification for a separate speciality to deal with the aged. The position in this regard is not comparable to that in paediatrics.

(b) In general hospitals, where most specialists in general medicine are employed, a large and growing proportion of the patients are elderly and, of necessity, a large part of the work of the specialists must be concerned with the elderly.

(c) There should be continuity of care and the concept, entailed in the two types of specialist, that one deals with the acute and the other with the chronic condition is, in many cases, unrealistic and undesirable. Some elderly persons may
require treatment for what is normally regarded as an acute medical (as opposed to surgical) condition, e.g. broncho-pneumonia, and they may recover or die in a few weeks, but in many cases the acute condition is only an episode in a chronic condition and in its treatment the general physician has to have regard to social and environmental factors.

(d) Since the short-term care of the aged, or the treatment of what are regarded as acute conditions, will be undertaken by the specialist in general medicine, the work left to the geriatrician will not be generally popular and, while it may attract very able and dedicated men, it may also become a last choice for many who have not succeeded in other specialities with a consequent dilution in the quality of the service. An additional factor, where the specialist has to depend to some extent on private practice, is that the scope in this field is much more narrow in chronic than in acute conditions.

(e) No specialist can be competent to treat all the pathological conditions which at other periods of life called for the experience, skills and techniques of a variety of specialists.

Some points of view which are advanced in favour of a separate specialty are:

(f) The care of the elderly differs in many ways from the care of others in that—
   (i) the elderly may show differences in anatomy and physiology, e.g. in regard to body temperature, pulse, reflexes, mental outlook and reaction to disease;
   (ii) the elderly usually suffer from multiple disabilities, up to 10 or 12 at the same time, whereas younger people usually suffer from only one disability and rarely from more than two or three;
   (iii) disease is often silent or atypical in elderly people so that diagnosis is difficult.

(g) General medical care of the elderly cannot be separated from their social care—something in which the specialist in general medicine is not usually interested.

(h) Psychological factors play a very important part in the illnesses of the aged and the specialist dealing with them must pay greater attention to these factors than that normally paid by the specialist in general medicine.

(i) The specialist in general medicine normally deals with a quick turn-over of patients and with an “in and out” basis of treatment and he is not usually interested in rehabilitation, resettlement or the long-term care which the elderly frequently require.

(j) The specialist in general medicine, who frequently has a heavy load of general medical work, finds it impossible to devote enough of his energies to the time-consuming task of looking after the elderly and frequently leaves their care to juniors, with the result that the elderly take second place to the more acute cases and services for them are allowed to drift along without skilled advice or direction and without the stimulating drive which can be given by a person in authority whose principal interest is in the aged.
There is among specialists in general medicine some of the former attitudes under which the chronic sick tended to be dumped in Poor Law institutions and were given a minimum of medical attention.

Much of the care of the chronic sick is undertaken conscientiously by general practitioners, but they would benefit from advice from specialists with a particular interest in the elderly.

Diseases can be complicated as a result of senescence and the necessary modification of general care calls for special skills.

It is difficult to weigh the relative merits of the various arguments. There is no doubt that a number of geriatric physicians have produced splendid results. There is no doubt that general physicians, who were interested and had the time to devote to the work, have produced similar splendid results. It is of interest to record the conclusions on this matter of teams appointed by the Ministry of Health in Britain to survey services provided for old people:

"The appointment of a geriatric physician for the chronic sick patients is often more successful than that of a general physician with a dual responsibility in the acute and in the chronic wards.

Geriatrics is not a speciality demanding clinical knowledge denied to other hospital staff. The geriatric physician should be a good general physician with a knowledge of the mental confusional states and with an appreciation both of the sociological factors influencing illness in the aged and of the other statutory and voluntary services.

The geriatric physician should be allocated sufficient junior medical staff, and have sufficient time to allow him to act as consultant to associated hospitals in his own or adjoining groups and to establish closer co-ordination with the other services. Because of the dependence of the hospital, welfare and domiciliary services on each other it is desirable that the advice of the geriatric physician should be easily available to the welfare officer and the Medical Officer of Health. The purpose of the geriatric unit is to provide skilled medical and nursing attention for the chronic sick patient who needs more individual attention because of his age than would normally be expected in the general wards of the hospital.

The problems confronting the physician in the chronic sick wards are essentially different from those in the other parts of the hospital. The speed with which the patients in the chronic sick wards can be restored to health, however active the treatment provided for them is slower than that for younger patients, and it is doubtful whether the tempo of a busy medical ward could provide the most effective environment for their recovery. It is possible that general physicians, because the problems are often as much social as medical, would not have the opportunity to acquire the necessary special experience to deal with them. Not only must the disease in old people which warrants hospital admission be cured but there are special problems in restoring the patient to a degree of mental and physical independence which will allow him to return home.

An increasing number of patients in the general wards of hospitals are elderly and the decision whether or not to establish a separate geriatric service must dé-
pend, on the extent to which the existing hospital services are meeting the problem. Geriatrics is practised in geriatric units and in the general wards of hospitals; local circumstances will influence the decision. In some places the appointment of a general physician to the part-time supervision of this service will be found successful; in other places, particularly where heavily populated, it may prove more successful to appoint a geriatric physician.

The creation of a geriatric unit is not the sole answer to the problems of the elderly sick and infirm in the area; it will make a valuable contribution to one aspect of the problem; but its success will be influenced by the adequacy of the other services.

The creation of geriatric units will entail the appointment of physicians with the necessary clinical experience and with a clear understanding of the social problems influencing the health of the elderly patient."

While there seems to be wide divergence of view between those who favour the appointment of a geriatrician and those who do not, the differences are perhaps more apparent than real. There seems to be a considerable amount of agreement that the person to be chosen should have specialised in general medicine and that he should be of consultant status. In 1964 the Royal College of Physicians of London referred to special training in geriatrics and recommended that after three to four years in hospital, obtaining much the same type of post-graduate education as for a general physician, four more years should be devoted to medicine or geriatrics with at least two of these years as a senior registrar (trainee consultant) in geriatrics. The Committee considers that, in addition to the basic qualification of specialisation in general medicine, the person selected must be interested in the care of the aged and have experience in that care including rehabilitation and social care, he must be in a position to devote the necessary time to the work, including the provision of out-patient and domiciliary services, and he must have the ability to co-ordinate his own work with that of other specialists and with the various community services. The Committee recommends that persons having these qualifications should be appointed to the geriatric assessment units. Provided the persons selected have the qualifications specified the Committee does not regard it as a vital issue whether they are regarded as general physicians, geriatric physicians or geriatricians. On the whole, it is inclined to the view that they should be regarded as general physicians with a particular interest in the care of the aged. There are in existence, in this country, no specific posts as geriatricians and their creation may give rise to unnecessary difficulties. The question of whether the person appointed should have responsibilities in regard to other classes, as well as the aged, can be determined in the light of circumstances obtaining in particular areas.

**Long-Stay Units**

7.34 Patients in long-stay hospital units are still in need of medical care and they may require the services of different medical specialists from time to time. Most of them, however, will have been thoroughly assessed and given any specialist treatment necessary before their admission to the long-stay units and their normal care can be carried out by general medical practitioners and other non-consultant staff.
It is very desirable, however, that there should be continuity of care and that the staff who dealt with them at general hospital or geriatric assessment unit level should not be divorced from their long-term care. They may also need periodic re-assessment. The Committee recommends, therefore, that overall responsibility for the long-stay beds should rest with the consultant in the geriatric assessment unit. He could be assisted in the day-to-day care of patients by local general practitioners. The services of other consultants should be available as required.

**Welfare Homes**

7.35 Patients in Welfare Homes are mainly those who require no more medical treatment than that given by the family doctor. The Committee recommends therefore, that the Homes should be staffed by family doctors—the patients being given choice of doctor where it is feasible to do so. Provision for the help and advice of consultants will be necessary.

**Role of Voluntary Bodies in Institutional Care**

**General Hospitals and Geriatric Assessment Units**

7.36 A number of general hospitals are under the control of voluntary bodies and these bodies will, therefore, be concerned with the provision of services for the aged in general hospitals and geriatric assessment units. There are already arrangements under Section 10 of the Health Act, 1953, for the treatment of patients in voluntary hospitals on behalf of health authorities. Health authorities make capitation payments in respect of patients sent, or deemed to have been sent by them to the voluntary hospitals. The Committee recommends that these arrangements should be continued and extended where necessary.

**Long-Stay Units**

7.37 A number of voluntary institutions catering for the aged have been approved, under Section 10 of the Health Act, 1953, for the provision of long-term hospital care on behalf of health authorities. The Committee recommends the extension of arrangements of this type to all voluntary institutions which provide suitable services and are willing to accept patients sent by health authorities.

**Welfare Homes**

7.38 Many voluntary institutions and homes catering for the aged do not provide a sufficient range of services to justify their recognition as long-stay hospital units, but many would be suitable as welfare homes. At present no centres are recognised as providing welfare type of accommodation only on behalf of health authorities. The Committee recommends that suitable homes which are willing to enter into arrangements with health authorities should be recognised as Welfare Homes and that capitation fees should be payable by health authorities in respect of patients sent by them. It should be a condition of recognition that the homes will be open to inspection by the health authority and the Minister for Health.
Use of Existing Buildings

General

7.39 Reasons of economy and expediency make it essential that the greatest possible use should be made of existing buildings. The Report of the Consultative Council on the General Hospital Services recommends that many of the existing general hospitals should cease to be used as such and that, where suitable, they should be used, inter alia, for the care of elderly patients. The Committee agrees, in principle, with this recommendation, but the hospitals, in many cases, will not be available for the elderly until new general hospital beds are built. Where this will take a considerable time new accommodation for the aged may have to be provided. If careful thought is given in the planning of new buildings to their possible use in the future it seems most unlikely that any buildings will be provided surplus to requirements, having regard to the fact that a great many old hospital buildings are in need of replacement. The figures given in paragraph 7.22 show that many district hospitals are catering for aged persons to a considerable extent. On the re-organisation of services it may be found possible to use several of these buildings as long-stay units or as Welfare Homes. This applies also to County Homes—particularly those dealt with under the County Home schemes (see paragraph 2.8) which have been built to a good standard. When detailed consideration was given to the question of adapting and reconstructing County Homes it was found that the buildings had many inherent defects. To remedy these defects and at the same time to adapt the accommodation to meet modern requirements would have been extremely costly. It was decided to reconsider the planning approach and to give priority to the provision of new units designed to cater for the chronic sick patients. In the design of the new units particular attention was placed on the need to avoid an institutional atmosphere. The new units are in single-storey construction. Small ward units replace the long dormitories. The wards are well-lit and ventilated and brightly decorated. Ample sanitary and bathing facilities are provided. Each unit has ample day-space for ambulant patients. In conjunction with the erection of new nursing units, the schemes undertaken provided also for the upgrading of accommodation for social cases, in buildings separate from the nursing units, and improvement of services facilities and accommodation for staff. New boilerhouses, kitchens and staff homes are being erected. In some cases facilities for physiotherapy, occupational therapy and chiropody are being made available and these will also be provided in the remaining cases at an early date. This planning approach was referred to in the White Paper on the Health Services and their Further Development issued in January, 1966. The White Paper mentioned that it was intended that the County Homes should be developed as long-stay hospitals adequately staffed and equipped to deal with the care and rehabilitation of patients and that provision for shelter and maintenance for persons, not ill, but unable through age or disability to care for themselves should be provided in separate accommodation.
Chapter 8

PREVENTIVE MEASURES

General

8.1 Old age cannot, of course, be prevented but the lives of the majority of the elderly show that old age, or at least a great part of it is not necessarily a time of ill-health and disability. Experience has shown, that by appropriate measures, the onset of much ill-health and many disabling conditions can be prevented, or considerably deferred or minimised. It is obviously most desirable that careful consideration should be given to all measures which reduce dependency among the elderly. Prevention aims at eliminating the factors which induce illness or disability, at discovering illness or disability as early as possible, so that prompt and effective treatment can be given at a stage when the condition is most susceptible to treatment, and at preventing or minimising the after-effects and residual disabilities arising from an illness or disability which has developed. All general measures taken to improve the health and welfare of the aged have, of course, a preventive aspect, but the Committee recommends that specific schemes of prevention should also be developed. Some of the measures which the Committee considers suitable for immediate adoption are set out in paragraphs 8.2 to 8.7 but the list, by no means, covers all the steps which are at present known and new knowledge in this field is continually being discovered. If properly trained staff are appointed, they will probably initiate new steps from time to time. The National Council recommended in paragraph 10.11 should also keep in touch with developments and publicise additional measures which are found to be desirable.

Age of Retirement

8.2 On retirement, most people suffer a considerable reduction in income and many lose contact with fellow-workers and feel a lack of purpose in life. In these circumstances retirement frequently results in physical and mental deterioration. It is open to question whether or not early retirement is generally a desirable development. On the one hand, early retirement and the provision of pension schemes are marks of social progress as persons are not forced to work when their physical capacity has become impaired through age. On the other hand, early retirement comes at a time when technological progress has, in many employments, lessened the importance of a high standard of strength and physical fitness, the result being that many people are retired while still fit and willing to work. There are other considerations and, indeed, conflicting interests involved and, at this stage, the Committee is unable to make any general recommendation in the matter. The problem is, of course,
Preparation for Retirement

8.3 With the increasing number of persons over the age of 65 years and the greater tendency to have compulsory retirement at a fixed age, more and more people are being faced with the problem of what to do with their lives when they cease to be productive members of the community. To many, retirement conjures up visions of plenty of rest and leisure. Unfortunately, too much opportunity for rest and leisure speedily leads, in many cases, to boredom and the realisation of the less attractive aspects of retirement—a reduction in income, loss of occupation, fewer contacts with other people and, frequently, loneliness and a feeling of no longer having a useful role in life. Hobbies and games learned earlier in life can provide a reservoir of interests which will be of considerable help in reducing the problems met with on retirement, but few have developed sufficient recreational and leisure outlets to fill all the time which had been devoted to work. It is very desirable, therefore, that people should prepare for retirement and try to plan so that they can lead full lives even after retirement. By co-operation between employers, trade unions and voluntary bodies, much can be done to prepare people for retirement by teaching them how to make best use of the leisure time which retirement will bring. The Committee recommends that the National Council for the Aged should encourage the development of courses on the problems, both social and economic, of retirement and on the making of plans regarding such matters as finance, health and nutrition, leisure activities and the development of interests after retirement.

Early Diagnosis

8.4 Early diagnosis of illness and disability is probably one of the most effective preventive measures. Experience shows that young people usually report when they are ill, but that the elderly regularly put up with disabilities, which are frequently serious, and do not approach their doctors about them as they regard them as part of the penalty of growing old. Often the family doctor is not consulted until disease or disability is well advanced and when the chances of successful treatment are diminished. Frequently elderly persons are admitted to hospital with evidence of longstanding neglect. Particularly where psychiatric features are present, cases frequently do not come under notice until some crisis, social or medical, has arisen. By then the family may be demoralised and the situation as a whole difficult if not impossible to rectify. Early discovery could be expected if persons were to attend their family doctor at regular intervals. The Committee recommends that nurses coming in contact with the aged should receive special training in the recognition of the early signs of physical or mental deterioration, so that they can advise the persons concerned to seek appropriate help. Similarly other workers, voluntary and lay, should encourage the elderly to attend their family doctors at regular in-

tervals. The Committee has recommended in paragraph 6.4 the establishment of special clinics for the aged. The establishment of such clinics should result in the early discovery of many remediable defects and should, through early admission, reduce the length of stay when hospital care is necessary.

Keeping of Register

8.5 The tragedies of old people dying alone and not being discovered for days are fortunately rare but regrettably they still occur. Occasionally elderly persons are discovered in great need, although they have not sought help from any source. As indicated in the previous paragraph the elderly themselves in many cases do not take action in regard to illness and disability. To help to overcome these difficulties it is frequently suggested that a register of all old persons should be compiled, so that a regular check could be carried out of all elderly persons. If, however, a register is maintained of all old persons it would, in many areas, become so big and unwieldy as to be unmanageable and it would obviously contain the names of many persons who would not be in need of help and who, indeed, might resent having their names placed on a register. In addition a register of all old persons would single them out as a problem group, whereas the majority are healthy, lead independent lives and have relatives or friends to help them in time of need. The Committee therefore recommends that there should be a register maintained by the public health nurse in each district of elderly persons “at risk”. This list would include people who had looked for some form of help, persons for whom help had been sought by relatives, friends or voluntary organisations and persons who become known from any source to be in need or likely to be in need of help. It should contain the names of all persons living alone and with no relatives to visit them regularly—particularly persons who through illness or other cause had recently lost a spouse or near relative and who, experience shows, are consequently very vulnerable. It could also contain the names of all those who are very old, say, over the age of 80 years.

Dissemination of Information

8.6 More knowledge on matters such as the extent to which they should take exercise and how best they could cope with disabilities would be of great use to many of the aged. The value of advice in regard to nutrition has already been stressed in paragraph 6.21. The Committee recommends that the dissemination of information on how best the aged can preserve their health should be one of the functions of the National Council for the Aged recommended in paragraph 10.11

Prevention of Accidents

8.7 Because of failing senses the elderly are particularly vulnerable to domestic accidents. The results of accidents are also more serious in the elderly than in younger persons—the fatality rate is much higher and chronic handicap or deformity is a frequent consequence. The more common types of accident to which the elderly are prone are falls, burns and scalds and gas poisoning. Most accidental injuries are probably caused by falls. Broken bones are a frequent result, a particularly common
injury being fracture of the hip. Some of the steps that can be taken to reduce the possibility of accidents occurring are:—

**Falls:** Waxed floors and loose mats and rugs cause many falls. There are non-slip polishes and non-slip floor coverings available and if mats and rugs must be used they should at least be rubber-backed. Elderly persons should be encouraged to ensure that their shoes are a good fit and have plastic or rubber soles as these slip less easily than leather. They should avoid wearing slippers for walking around the house—slippers do not give a firm foothold and can trip the wearer if a loose fit. Dim lighting in corridors and stairways is another regular source of trouble. Falls from bed also occur frequently. If old people are in a confused state or restless in their sleep side rails should be fitted to the bed.

**Burns and scalds:** The open fire is a particular hazard. Because they feel the cold severely old people tend to sit or stand too close to an open fire with consequent risk of their clothes catching fire. There is also the danger that they may fall on open fires. Strong fireguards should always be fitted. Electric heaters, especially the bar and coiled wire types, have proved to be fire hazards. Even when guards are fitted clothing can slip between the meshes and catch fire. The elements should therefore be totally enclosed. Scalds from boiling water, fat and oil are fairly common. Kettles, pots and pans should be so designed that they will not spill or tip over easily. Cigarettes and pipes are a constant source of danger, especially when used in bed. Elderly people should be discouraged from smoking in bed except when another adult is present in the room.

**Gas poisoning:** Elderly persons may not notice escaping gas because of a poor sense of smell. All gas appliances should have safety taps which cannot be turned on accidentally. Defective or badly connected pipes and fittings often cause leakages of gas and regular inspection of equipment by qualified persons is necessary.

The correction of defective sight and hearing can do much to lessen the risk of accidents to the aged. Public health nurses and other visiting health staff can help by pointing out hazards in the home and seeing that they are corrected. The Committee recommends that the National Council for the Aged recommended in paragraph 10.11 should collect statistics and information about domestic accidents involving elderly persons and should organise educational and propaganda services for the prevention of accidents.
Chapter 9

RESEARCH

General

9.1 Despite the enormous problem presented by a very high and growing proportion of the population who are over the age of 65 years, practically no research is being carried out in Ireland—neither basic research into the ageing process, nor operational research into the efficacy of different forms of care and possible methods of prevention. Last year, health authority expenditure on the institutional care of the aged was in the region of £6 millions; payments to the aged under the Social Welfare income maintenance services cost in the region of £33 millions; and expenditure by the Department of Local Government and housing authorities on housing for the aged was in excess of £1 million. If to these figures are added private expenditure and health authority expenditure on community care it will be clear that the total amount spent on the aged is substantial. Even though the major part of the expenditure relates to income maintenance the Committee considers that the spending of a considerable sum on research would be justified.

Nature of Research

9.2 Research is a field where firm guidelines cannot be laid down. The most desirable forms of research have to be determined from time to time in the light of current knowledge and current ideas as to the most fruitful lines of enquiry. The Committee recommends, however, that a medico-social investigation of the numbers of aged persons in institutions and of the reasons why they are admitted and retained should be carried out as soon as possible. It was outside the resources of the Committee to have an investigation of this nature carried out but the need for it is clearly shown by the large numbers of the aged in institutions (see paragraph 7.22) and by the anomalies between different areas, as shown in returns received by the Committee, (see remaining paragraphs of this chapter). It seems clear that an investigation must be carried out by a body, such as the Medico-Socio Research Board, to provide reliable data on the reasons why persons enter and are retained in institutions, on the number of beds of different types necessary, on the interdependence of different forms of care and on the efficacy of different forms of care. The Committee also recommends that research should be carried out in this country into the problems, both social and economic, of retirement (see paragraph 8.2).

Numbers in County Homes

9.3 Table I shows the numbers in County Homes in the different areas. It shows that there are extraordinary variations. The ratio of patients, per thousand of the total population, varied from 1.7 in Donegal and Dublin to 4.4 in Tipperary (N.R.)
and 5.0 in Sligo. The ratio of patients per thousand of the population who are aged 65 years and over varied from 12.1 in Donegal to 44.8 in Kildare. County Homes are intended to cater primarily for the poor and it would be natural to expect that there would be greater provision in the poorer than in the richer counties. This pattern does not hold, however, and, prima facie, it appears that there must be excessive provision in some counties or inadequate provision in others.

**TABLE I.**

<table>
<thead>
<tr>
<th>County</th>
<th>County Home, Patients aged 65 years and over</th>
<th>Patients per 1,000 total Population</th>
<th>Patients per 1,000 Population aged 65 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carlow</td>
<td>116</td>
<td>3.5</td>
<td>31.1</td>
</tr>
<tr>
<td>Cavan</td>
<td>198</td>
<td>3.7</td>
<td>26.1</td>
</tr>
<tr>
<td>Clare</td>
<td>309</td>
<td>4.2</td>
<td>29.0</td>
</tr>
<tr>
<td>Cork</td>
<td>1,094</td>
<td>3.2</td>
<td>27.8</td>
</tr>
<tr>
<td>Donegal</td>
<td>185</td>
<td>1.7</td>
<td>12.1</td>
</tr>
<tr>
<td>Dublin</td>
<td>1,371</td>
<td>1.7</td>
<td>20.8</td>
</tr>
<tr>
<td>Galway</td>
<td>364</td>
<td>2.5</td>
<td>19.0</td>
</tr>
<tr>
<td>Kerry</td>
<td>301</td>
<td>2.7</td>
<td>19.8</td>
</tr>
<tr>
<td>Kildare</td>
<td>249</td>
<td>3.7</td>
<td>44.8</td>
</tr>
<tr>
<td>Kilkenny</td>
<td>206</td>
<td>3.4</td>
<td>28.5</td>
</tr>
<tr>
<td>Laoighis</td>
<td>112</td>
<td>2.5</td>
<td>21.3</td>
</tr>
<tr>
<td>Leitrim</td>
<td>92</td>
<td>3.0</td>
<td>17.9</td>
</tr>
<tr>
<td>Limerick</td>
<td>545</td>
<td>4.0</td>
<td>37.9</td>
</tr>
<tr>
<td>Longford</td>
<td>115</td>
<td>4.0</td>
<td>30.1</td>
</tr>
<tr>
<td>Louth</td>
<td>171</td>
<td>2.5</td>
<td>25.7</td>
</tr>
<tr>
<td>Mayo</td>
<td>250</td>
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<td>14.2</td>
</tr>
<tr>
<td>Meath</td>
<td>173</td>
<td>2.6</td>
<td>24.6</td>
</tr>
<tr>
<td>Monaghan</td>
<td>161</td>
<td>3.5</td>
<td>27.4</td>
</tr>
<tr>
<td>Offaly</td>
<td>146</td>
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</tr>
<tr>
<td>Roscommon</td>
<td>235</td>
<td>4.2</td>
<td>26.4</td>
</tr>
<tr>
<td>Sligo</td>
<td>255</td>
<td>5.0</td>
<td>34.7</td>
</tr>
<tr>
<td>Tipperary (N.R.)</td>
<td>238</td>
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<td>36.5</td>
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<tr>
<td>Tipperary (S.R.)</td>
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<td>30.9</td>
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<tr>
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<tr>
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<td>29.1</td>
</tr>
<tr>
<td>Wicklow</td>
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<td>24.2</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>8,057</strong></td>
<td><strong>2.8</strong></td>
<td><strong>24.9</strong></td>
</tr>
</tbody>
</table>

**Total Numbers**

9.4 The numbers for whom County Homes provision is necessary in any area should be affected by the numbers catered for in district hospitals, district mental hospitals and private nursing homes and similar institutions. Table II, shows, in addition to the numbers referred to in Table I, the numbers from each area who were in such institutions. This table shows approximately the total numbers who were in non-acute institutional care. The incidence is altered but the extraordinary anomalies between areas still remain.
### TABLE II.

<table>
<thead>
<tr>
<th>County</th>
<th>County Home Patients</th>
<th>District Hospital Patients</th>
<th>District Mental Hospital Patients</th>
<th>Private Homes etc. Patients</th>
<th>Total Patients</th>
<th>Patients per 1,000 pop. aged 65 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carlow</td>
<td>116</td>
<td>12</td>
<td>67</td>
<td>23</td>
<td>218</td>
<td>6.5</td>
</tr>
<tr>
<td>Cavan</td>
<td>198</td>
<td>—</td>
<td>114</td>
<td>36</td>
<td>348</td>
<td>6.4</td>
</tr>
<tr>
<td>Clare</td>
<td>309</td>
<td>48</td>
<td>189</td>
<td>45</td>
<td>591</td>
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</tr>
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<td>604</td>
<td>2,546</td>
<td>7.5</td>
</tr>
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<td>59</td>
<td>174</td>
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<td>433</td>
<td>4.0</td>
</tr>
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<td>Dublin</td>
<td>1,371</td>
<td>—</td>
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<td>1,642</td>
<td>3,653</td>
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</tr>
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<td>65</td>
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</tr>
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<td>39</td>
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</tr>
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<td>—</td>
<td>73</td>
<td>44</td>
<td>366</td>
<td>5.5</td>
</tr>
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<td>450</td>
<td>7.4</td>
</tr>
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<td>24</td>
<td>91</td>
<td>23</td>
<td>250</td>
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</tr>
<tr>
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<td>5</td>
<td>101</td>
<td>35</td>
<td>233</td>
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</tr>
<tr>
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<td>—</td>
<td>236</td>
<td>90</td>
<td>871</td>
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</tr>
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<td>Longford</td>
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<td>86</td>
<td>23</td>
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</tr>
<tr>
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<td>638</td>
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<tr>
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<td>—</td>
<td>100</td>
<td>26</td>
<td>299</td>
<td>4.4</td>
</tr>
<tr>
<td>Monaghan</td>
<td>161</td>
<td>—</td>
<td>80</td>
<td>19</td>
<td>260</td>
<td>5.7</td>
</tr>
<tr>
<td>Offaly</td>
<td>146</td>
<td>15</td>
<td>110</td>
<td>30</td>
<td>301</td>
<td>5.8</td>
</tr>
<tr>
<td>Roscommon</td>
<td>235</td>
<td>29</td>
<td>204</td>
<td>28</td>
<td>496</td>
<td>8.8</td>
</tr>
<tr>
<td>Sligo</td>
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<td>—</td>
<td>110</td>
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<td>62</td>
<td>34</td>
<td>364</td>
<td>6.8</td>
</tr>
<tr>
<td>Tipperary (S.R.)</td>
<td>246</td>
<td>39</td>
<td>113</td>
<td>36</td>
<td>434</td>
<td>6.3</td>
</tr>
<tr>
<td>Waterford</td>
<td>281</td>
<td>43</td>
<td>164</td>
<td>192</td>
<td>680</td>
<td>9.3</td>
</tr>
<tr>
<td>Westmeath</td>
<td>202</td>
<td>32</td>
<td>115</td>
<td>22</td>
<td>371</td>
<td>7.0</td>
</tr>
<tr>
<td>Wexford</td>
<td>288</td>
<td>13</td>
<td>149</td>
<td>73</td>
<td>523</td>
<td>6.3</td>
</tr>
<tr>
<td>Wicklow</td>
<td>154</td>
<td>18</td>
<td>76</td>
<td>89</td>
<td>337</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>8,057</strong></td>
<td><strong>960</strong></td>
<td><strong>4,577</strong></td>
<td><strong>3,470</strong></td>
<td><strong>17,064</strong></td>
<td><strong>5.9</strong></td>
</tr>
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</table>

**Numbers of Chronic Sick and Others**

9.5 Table III shows the numbers in County Homes, divided between the chronic sick and the non-chronic sick. The chronic sick were defined as those "with a medical condition which requires constant medical and nursing attention of a type that could not be provided outside a hospital". Table III would be helpful in determining the relative amounts of provision which should be made in hospitals and Welfare Homes, if the figures could be relied upon. It is difficult to believe, however, that needs differed to the extent shown by the wide variation between areas. It seems probable that the criteria laid down to determine the classifications were interpreted in different ways. Similar information to that obtained from County Homes was obtained from a number of private homes. Again the criteria laid down were obviously interpreted in different ways, e.g. two homes were known to cater for similar types of patients but one home described all its patients as chronic sick, while the other described all its patients as non-chronic sick.
### TABLE III.

<table>
<thead>
<tr>
<th>County</th>
<th>County Home Patients aged 65 years and over</th>
<th>Percentage of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chronic Sick</td>
<td>Others</td>
</tr>
<tr>
<td>Carlow</td>
<td>48</td>
<td>68</td>
</tr>
<tr>
<td>Cavan</td>
<td>112</td>
<td>86</td>
</tr>
<tr>
<td>Clare</td>
<td>274</td>
<td>35</td>
</tr>
<tr>
<td>Cork</td>
<td>639</td>
<td>455</td>
</tr>
<tr>
<td>Donegal</td>
<td>63</td>
<td>122</td>
</tr>
<tr>
<td>Dublin</td>
<td>655</td>
<td>716</td>
</tr>
<tr>
<td>Galway</td>
<td>168</td>
<td>196</td>
</tr>
<tr>
<td>Kerry</td>
<td>79</td>
<td>222</td>
</tr>
<tr>
<td>Kildare</td>
<td>154</td>
<td>95</td>
</tr>
<tr>
<td>Kilkenny</td>
<td>78</td>
<td>128</td>
</tr>
<tr>
<td>Laoisighis</td>
<td>46</td>
<td>66</td>
</tr>
<tr>
<td>Leitrim</td>
<td>47</td>
<td>45</td>
</tr>
<tr>
<td>Limerick</td>
<td>323</td>
<td>222</td>
</tr>
<tr>
<td>Longford</td>
<td>51</td>
<td>64</td>
</tr>
<tr>
<td>Louth</td>
<td>117</td>
<td>54</td>
</tr>
<tr>
<td>Mayo</td>
<td>105</td>
<td>145</td>
</tr>
<tr>
<td>Meath</td>
<td>58</td>
<td>115</td>
</tr>
<tr>
<td>Monaghan</td>
<td>52</td>
<td>109</td>
</tr>
<tr>
<td>Offaly</td>
<td>95</td>
<td>51</td>
</tr>
<tr>
<td>Roscommon</td>
<td>147</td>
<td>88</td>
</tr>
<tr>
<td>Sligo</td>
<td>202</td>
<td>53</td>
</tr>
<tr>
<td>Tipperary (N.R.)</td>
<td>232</td>
<td>6</td>
</tr>
<tr>
<td>Tipperary (S.R.)</td>
<td>193</td>
<td>53</td>
</tr>
<tr>
<td>Waterford</td>
<td>186</td>
<td>95</td>
</tr>
<tr>
<td>Westmeath</td>
<td>136</td>
<td>66</td>
</tr>
<tr>
<td>Wexford</td>
<td>180</td>
<td>108</td>
</tr>
<tr>
<td>Wicklow</td>
<td>134</td>
<td>20</td>
</tr>
</tbody>
</table>

#### Marital Status of Patients

9.6 Table IV shows the numbers in County Homes who were married, single and widowed. It is common experience in other countries that the strength of marriage and family ties is one of the most potent factors in keeping old people in their own homes and that the single and widowed are much more likely to seek institutional care than those who are married. The same position clearly obtains in this country. The percentage of the population, aged 65 years and over, who are married is 40.1%. The percentage of patients in County Homes who were married was, however, only 6.4%. It is of interest to record that in all County Homes there were only 58 married couples. This may reflect the fact that married couples generally manage to maintain themselves outside institutions, or it may reflect the fact that couples are reluctant to enter County Homes as most Homes have not accommodation to permit couples to live together.
TABLE IV.

County Home Patients aged 65 years and over

<table>
<thead>
<tr>
<th>County</th>
<th>Single</th>
<th>Married</th>
<th>Widowed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>TOTAL</td>
</tr>
<tr>
<td>Carlow</td>
<td>41</td>
<td>32</td>
<td>73</td>
</tr>
<tr>
<td>Cavan</td>
<td>83</td>
<td>41</td>
<td>124</td>
</tr>
<tr>
<td>Clare</td>
<td>125</td>
<td>75</td>
<td>200</td>
</tr>
<tr>
<td>Cork</td>
<td>348</td>
<td>328</td>
<td>676</td>
</tr>
<tr>
<td>Donegal</td>
<td>73</td>
<td>62</td>
<td>135</td>
</tr>
<tr>
<td>Dublin</td>
<td>242</td>
<td>468</td>
<td>710</td>
</tr>
<tr>
<td>Galway</td>
<td>164</td>
<td>100</td>
<td>264</td>
</tr>
<tr>
<td>Kerry</td>
<td>125</td>
<td>82</td>
<td>207</td>
</tr>
<tr>
<td>Kildare</td>
<td>103</td>
<td>46</td>
<td>149</td>
</tr>
<tr>
<td>Kilkenny</td>
<td>92</td>
<td>48</td>
<td>140</td>
</tr>
<tr>
<td>Laoighis</td>
<td>55</td>
<td>19</td>
<td>74</td>
</tr>
<tr>
<td>Leitrim</td>
<td>40</td>
<td>18</td>
<td>58</td>
</tr>
<tr>
<td>Limerick</td>
<td>149</td>
<td>124</td>
<td>273</td>
</tr>
<tr>
<td>Longford</td>
<td>39</td>
<td>32</td>
<td>71</td>
</tr>
<tr>
<td>Louth</td>
<td>52</td>
<td>54</td>
<td>106</td>
</tr>
<tr>
<td>Mayo</td>
<td>104</td>
<td>54</td>
<td>158</td>
</tr>
<tr>
<td>Meath</td>
<td>79</td>
<td>33</td>
<td>112</td>
</tr>
<tr>
<td>Monaghan</td>
<td>65</td>
<td>45</td>
<td>110</td>
</tr>
<tr>
<td>Offaly</td>
<td>66</td>
<td>19</td>
<td>85</td>
</tr>
<tr>
<td>Roscommon</td>
<td>86</td>
<td>53</td>
<td>139</td>
</tr>
<tr>
<td>Sligo</td>
<td>81</td>
<td>70</td>
<td>151</td>
</tr>
<tr>
<td>Tipperary (N.R.)</td>
<td>105</td>
<td>58</td>
<td>163</td>
</tr>
<tr>
<td>Tipperary (S.R.)</td>
<td>93</td>
<td>64</td>
<td>157</td>
</tr>
<tr>
<td>Waterford</td>
<td>86</td>
<td>74</td>
<td>160</td>
</tr>
<tr>
<td>Westmeath</td>
<td>78</td>
<td>47</td>
<td>125</td>
</tr>
<tr>
<td>Wexford</td>
<td>119</td>
<td>70</td>
<td>189</td>
</tr>
<tr>
<td>Wicklow</td>
<td>66</td>
<td>33</td>
<td>99</td>
</tr>
<tr>
<td>TOTALS</td>
<td>2,769</td>
<td>2,149</td>
<td>4,918</td>
</tr>
<tr>
<td>Percentage of Total Patients</td>
<td>61.0%</td>
<td>6.4%</td>
<td>32.6%</td>
</tr>
</tbody>
</table>

Sex of Patients

9.7 Table V shows, by age groups, the numbers and percentages of males and females in County Homes in different areas. Women generally live longer than men. In this country the average expectation of life for men is 68.13 years and for women 71.86 years. According to the Census of 1966, of the persons aged 65 years and over 46.4% were male and 53.6% female. The excess of females is more marked in the upper age limits. Of the total aged 85 years and over 39.9% were male and 60.1% were female. Men generally tend to marry women who are younger than they are. This, combined with the fact that women live longer than men, results in a far greater number of widows than of widowers. The 1966 Census showed that in this country there were 125,888 widows and 40,665 widowers. The percentage of all women aged 65 years and over who were single or widowed was 71.7% and of men 46.3%. Table IV shows that the single and widowed are much more likely to seek institutional care than the married. All these factors, other things being equal, should result in a far greater demand for institutional care for women than for men. Experience shows that this is the pattern of demand in most countries. In Glasgow, for instance, it is estimated that for every 200,000 of the population 360 long-stay beds are required for females and 100 for males. Table V, however, shows that in several areas in this country there are more males than females in County Homes, e.g. in Laoighis (66.1%) and Offaly (61.6%). In some areas the proportion of elderly males in the population is very high—probably due to migration or emigration. Even when allowance is made for this fact the proportion of men in County Homes seems exceptionally high.

105
## TABLE V.

<table>
<thead>
<tr>
<th>County</th>
<th>County Home Patients</th>
<th></th>
<th></th>
<th>Totals</th>
<th>Percentages of Males and Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65—74 years</td>
<td>75—84 years</td>
<td>85 years and over</td>
<td></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Carlow</td>
<td>17</td>
<td>24</td>
<td>31</td>
<td>27</td>
<td>8</td>
</tr>
<tr>
<td>Cavan</td>
<td>38</td>
<td>29</td>
<td>60</td>
<td>41</td>
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<td>271</td>
<td>78</td>
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<td>34</td>
<td>50</td>
<td>15</td>
</tr>
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<td>236</td>
<td>190</td>
<td>443</td>
<td>60</td>
</tr>
<tr>
<td>Galway</td>
<td>69</td>
<td>48</td>
<td>101</td>
<td>68</td>
<td>32</td>
</tr>
<tr>
<td>Kerry</td>
<td>67</td>
<td>39</td>
<td>87</td>
<td>60</td>
<td>23</td>
</tr>
<tr>
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<td>63</td>
<td>25</td>
<td>70</td>
<td>51</td>
<td>17</td>
</tr>
<tr>
<td>Kilkenny</td>
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<td>21</td>
<td>48</td>
<td>49</td>
<td>21</td>
</tr>
<tr>
<td>Laoishe</td>
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<td>19</td>
<td>17</td>
<td>31</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Limerick</td>
<td>77</td>
<td>88</td>
<td>119</td>
<td>152</td>
<td>34</td>
</tr>
<tr>
<td>Longford</td>
<td>16</td>
<td>24</td>
<td>30</td>
<td>27</td>
<td>8</td>
</tr>
<tr>
<td>Louth</td>
<td>26</td>
<td>27</td>
<td>40</td>
<td>49</td>
<td>12</td>
</tr>
<tr>
<td>Mayo</td>
<td>55</td>
<td>33</td>
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<td>49</td>
<td>26</td>
</tr>
<tr>
<td>Meath</td>
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<td>19</td>
<td>60</td>
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<td>20</td>
</tr>
<tr>
<td>Monaghan</td>
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<td>21</td>
<td>39</td>
<td>42</td>
<td>6</td>
</tr>
<tr>
<td>Offaly</td>
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</tr>
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<td>51</td>
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<td>38</td>
<td>55</td>
<td>66</td>
<td>9</td>
</tr>
<tr>
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<td>48</td>
<td>36</td>
<td>76</td>
<td>45</td>
<td>16</td>
</tr>
<tr>
<td>Tipperary (S.R.)</td>
<td>51</td>
<td>37</td>
<td>54</td>
<td>64</td>
<td>21</td>
</tr>
<tr>
<td>Waterford</td>
<td>42</td>
<td>38</td>
<td>58</td>
<td>81</td>
<td>26</td>
</tr>
<tr>
<td>Westmeath</td>
<td>35</td>
<td>22</td>
<td>49</td>
<td>48</td>
<td>21</td>
</tr>
<tr>
<td>Wexford</td>
<td>58</td>
<td>56</td>
<td>76</td>
<td>51</td>
<td>30</td>
</tr>
<tr>
<td>Wicklow</td>
<td>39</td>
<td>15</td>
<td>45</td>
<td>35</td>
<td>8</td>
</tr>
</tbody>
</table>

| Totals       | 1,454 | 1,234 | 1,845 | 1,981  | 594  | 949 | 3,893 | 4,164  | 48.3 | 51.7 | 46.4 | 53.6 |
ORGANISATION AND CO-ORDINATION OF SERVICES

Chapter 10

General

10.1 It will be clear that the care of the aged is a major problem to which there is no ready or complete solution. The needs of the aged vary to such an extent that they can be met only by a very wide variety of services, designed to cover most aspects of human living. In the provision of these services, different central and local authorities, voluntary and private organisations and many individuals are involved. Unless services are carefully planned and co-ordinated there will be wasteful duplication of effort in respect of some of the aged, while others will receive little, if any, of the help they require. While the Committee considers that planning and co-ordination are essential, it is also satisfied that there must be a considerable degree of flexibility to meet the particular needs of different areas and different individuals. Services are so varied and numerous that co-ordination at various levels is essential. The Committee considered the matter in relation to:

(a) co-ordination at Ministerial level;
(b) co-ordination of public services at local level;
(c) co-ordination of voluntary services and public services at local level;
(d) co-ordination of voluntary and public services at national level.

Co-ordination at Ministerial Level

Ministerial Responsibilities

10.2 Insofar as the aged are concerned, the primary responsibility of the Minister for Health is for health services, of the Minister for Local Government for housing and of the Minister for Social Welfare for income maintenance. The Committee sees no reason for recommending any major change in this position (see, however, the following paragraph).

Extension of Social Work Services

10.3 On the establishment of separate Departments of Health and Social Welfare, in 1947, the Department of Social Welfare became primarily an income maintenance department dealing with social insurance and social assistance. It dealt with social work services* to some extent, for example schemes of blind welfare, cheap fuel and home assistance as described in paragraphs 2.44, 2.45 and 2.46 and schemes of cheap footwear and school meals. Other schemes of social work service in existence in 1947 (e.g. the care of unmarried mothers and their children, the boarding out of

*“Social work services” is used in this paragraph to denote desirable social services other than income maintenance.
children, the maintenance of aged persons not in need of medical care and the care of the mentally and physically handicapped) became the responsibility of the Department of Health. These arrangements did not cover all social work services. Services such as home helps and the provision of meals for elderly persons were not made the responsibility of either Department and grants to voluntary agencies, dealing with the general problem of the care of the aged, could be given only by health authorities and only in respect of services which were “similar or ancillary” to a service which a health authority itself could provide. Despite these difficulties admirable social work services are provided by voluntary bodies which give advice and support in resolving personal and social difficulties. The Committee hopes that these bodies will continue and extend the scope of their activities, but regards it as essential that their work should be supplemented by, or financially assisted by, public bodies, so that a full social work service may be available to the aged. (Whether this service should be available to other classes is outside the Committee’s terms of reference). The Committee recommends that the additional social work services necessary to help in the solution of the personal and social difficulties of elderly persons should come under the auspices of the Department of Health.

Departmental Co-ordination

10.4 It is stated in the White Paper on the Health Services that the Department of Health, in co-operation with the Departments of Social Welfare, Local Government and the various voluntary agencies, will encourage local co-ordination of the various public and voluntary services available to the aged. In order to achieve co-ordination between the different Departments, the Committee recommends that a permanent Liaison Committee, which would meet as required, should be established to achieve the necessary co-ordination of the activities of the Departments of Health, Local Government and Social Welfare. The proposed Committee should consult with the Department of Labour and any other Government Departments as the necessity arises. To achieve the Government’s aim of encouraging the co-ordination of the various public and voluntary services for the aged the proposed Liaison Committee should keep in touch with the National Council for the Aged suggested in paragraph 10.11.

Co-ordination of Public Services at Local Level

Position of Chief Medical Officer

10.5 The White Paper on the Health Services stated that the Government proposes that legislation should be introduced to transfer the administration of the health services from the existing local health authorities to special regional boards. The overall responsibility for the co-ordination of all health authority services will, of course, rest with the proposed regional boards, but the Committee considers that it should be the responsibility of one individual officer in each area to act as co-ordinating and liaison officer between the different health services and between the health services and the other public services, such as housing. If there is to be greatly increased emphasis on community care it is essential that there should be close liaison between, and co-ordination of, the different services. The Committee recommends
that responsibility in regard to these matters should be assigned to the Chief Medical Officer of each area. He is already concerned with housing and with several aspects of the health services and he has many contacts with the community. He is not, however, concerned at present with the hospital and general practitioner services. The Committee considers that he should be given responsibilities in regard to these services—not as overlord but as a co-ordinator and as a link between the different services. The Committee recommends that he should have access to all hospitals and homes providing services for the aged. This would give him an opportunity of seeing the patients while they are receiving institutional care and of advising the doctors in the hospitals and homes regarding environmental and social conditions and of advising on, and arranging for, the help which could be provided in the community. In regard to general medical practitioners, the Committee recommends that the Chief Medical Officer's function should be, where necessary, to act as the link between them and the hospital or home and to arrange, in appropriate cases, for services such as home nursing, home helps, and aids in the home and, in general, by mobilising all the services available to give general practitioners the optimum facilities for treating patients in the community.

Co-ordination of Voluntary and Public Services at Local Level

General

10.6 As indicated in paragraph 10.4, there is a proposal in the White Paper on the Health Services to encourage local co-ordination of the various public and voluntary services available to the aged. In Circular No. 48/65 (copy at Appendix K) the Minister for Health stated that he considered it—

"essential that there should be available in one central location in each health authority's area, an information centre at which details will be readily obtainable regarding all the different services available for the aged in the area, whether such services are administered by the health authority itself or provided by voluntary organisations or groups".

With a view, inter alia, to facilitating co-ordination and making available information regarding all services obtainable the Committee recommends that local Social Service Councils should be established in all areas on the lines set out in paragraphs 10.7 to 10.9. While the Committee uses the term "Social Service Council" it does not regard it as essential that the local body should be called by this name. It also visualises that there will be differences between areas, as some Councils may deal only with the services for the aged, while others may deal with services for other classes as well as the aged.

Need for Social Service Councils

10.7 Many public and voluntary organisations and individuals are concerned with the provision of a very wide range of services for the aged. Happily, there is a greatly increased interest in the care of the aged and many existing bodies tend to expand the scope of their activities to include the aged and many new bodies are being
formed to deal specifically with the problems of the aged. If all these bodies work in isolation and without regard to each other's activities, a fragmented and inadequate service is bound to result. Some of the elderly will obtain help from a number of agencies, sometimes too much and sometimes too little, while others will be almost, or completely, over-looked and will fail to obtain the service to which they are entitled. It is essential that some body should try to ensure that from the multiplicity of services and from the abundance of good-will available, an integrated service will be provided which will, as far as possible, meet the essential requirements of all those in need and will prevent elderly persons from being sent from one agency to another, frustrated, bewildered, and unable to obtain the help they require. The Committee recommends that Social Service Councils should be set up for this work. While the primary function of the Social Service Council would be to achieve co-ordination and make available information on all services obtainable it could serve a useful purpose in many other ways, e.g.—

(i) by creating understanding between health authorities and voluntary bodies and providing lines of communication between health authorities and voluntary bodies and between the various voluntary bodies;

(ii) by acting as a central agency to which anyone could turn in time of need;

(iii) by bringing together informed and forward-looking people and giving a lead in the development of services;

(iv) by providing or encouraging the provision of personal services in a way which a public authority cannot;

(v) by building up from the various bodies and interests with which it comes in contact a fund of knowledge and experience which is far greater than that of the individual bodies it represents;

(vi) by undertaking tasks, requiring a team approach, which an individual organisation would be unable to do;

(vii) by acquiring, as a unit representative of local interests, an intimate and comprehensive knowledge of local needs from which it could build up information on unmet needs and encourage the development of new or extended services to meet these needs;

(viii) by demonstrating the acceptance by the community as a whole of its responsibility for its weaker members;

(ix) by giving members the opportunity to use any special knowledge or experience which they may have and which it may not be possible to use in a smaller organisation;

(x) by publicising its own work and the work of its constituent bodies and so attracting helpers and funds;

(xi) by encouraging elderly people to take an active part in services for the aged, thus contributing to the resources of the community and giving their own lives additional content and purpose;

(xii) by advising bodies thinking of starting services for the aged as to what is there already and as to where there is fruitful ground for activity;
(xiii) by serving as the mouth-piece for local bodies and so avoiding unnecessary individual effort by these bodies;

(xiv) by employing, in appropriate cases, skilled staff which many voluntary bodies by themselves could not afford to do.

Area to be Served by a Social Service Council

10.8 The area to be served by a Social Service Council would have to be determined on an *ad hoc* basis by factors such as:

(i) what is regarded as a local community—whether a parish, a group of parishes, a town, a city or a geographic area;

(ii) the number and variety of voluntary bodies serving the area which it is proposed to serve.

Subject, however, to these considerations the Committee recommends that the area should not be too small and, where possible, should cover more than one parish. As indicated in the following paragraph, a number of interests should be represented on the Council and it would be impracticable for them to be represented on a multiplicity of small Councils.

Constitution of Social Service Councils

10.9 As a Social Service Council will be concerned with achieving the co-ordination of all local activities, public and voluntary, with the dissemination of information in regard to all the services available and with the fostering of community services, the Committee makes the following recommendations in regard to its constitution:

(i) it should be representative of all the bodies (including religious bodies) providing services for the aged which are willing to act on the Council (see paragraph 10.10);

(ii) it should also contain individuals particularly interested in the care of the aged and representatives of local industry and similar persons willing or in a position to help;

(iii) it should contain some ex-officio members, such as Chief Medical Officers, because of their special responsibilities in regard to the aged;

(iv) it should not be dominated or dictated to by any individual or group as its aim is to achieve the co-operation of all for the common good.

Attitude of Voluntary Organisations

10.10 Most voluntary organisations seem to accept, without question, the need for co-ordination at local level and steps towards the co-ordination of services and towards the making available of information regarding all services available have already been taken in a number of areas. The Committee found, however, a certain amount of misgiving among some voluntary bodies regarding any integration or co-ordination of their activities with those of other voluntary or public bodies. They seemed to suspect that "co-ordination" was a euphemism for "control" and that their freedom and independence would be seriously curtailed by any co-ordinating body. The Committee understands that similar misgivings have been felt by some voluntary
bodies in other countries. It feels that these suspicions should be considerably allayed if the purpose of a co-ordinating body were properly understood. However, it considers that no one’s interests would be served by compelling any organisation against its will, to join in a co-ordinating body and it accordingly recommends that if any voluntary body wishes to remain outside the local Social Service Council its wishes should be respected.

Co-ordination of Voluntary and Public Services at National Level

Creation of National Body

10.11 Just as there is need for a local Social Service Council, there is need for a national body which will endeavour to achieve co-ordination of all public and voluntary effort on behalf of the aged. A national body can serve a very useful purpose in many other ways, e.g.——

(i) by promoting the establishment of a network of social service councils throughout the country (it is of interest that a National Old People’s Welfare Council was established in Britain in 1940—there were then 40 but there are now over 1,600 old people’s welfare committees in Britain and Northern Ireland);

(ii) by creating understanding between voluntary bodies and central public authorities and providing lines of communication between them;

(iii) by acting as a central agency to which local associations can turn for advice and help;

(iv) by collecting and disseminating information regarding the activities of all voluntary organisations and regarding all services for the aged;

(v) by reviewing the work of voluntary associations and making suggestions as to how deficiencies can be met;

(vi) by achieving some publicity for all voluntary bodies providing services for the aged;

(vii) by providing training courses for those concerned with the care of the aged, e.g. wardens;

(viii) by reviewing, at national level, the needs of the elderly and promoting measures for their well-being;

(ix) by providing advice for anybody who wishes to obtain it (it is not only the under-privileged and less educated who need and appreciate advice)——a National Council is often in a position to give this advice more suitably than a local organisation;

(x) by maintaining contacts with other countries and disseminating information regarding new developments in these countries;

(xi) by providing a common forum for the different professional and other workers and persons interested in the problems of the aged.

The Committee recommends the establishment of a National Council for the Aged. Its aim should be, as set out above, to promote in every way possible, the general welfare of the aged. As a national body it should be representative of all the voluntary bodies providing services for the aged. The Minister for Health should encourage the formation of the Council and should give it financial assistance if it so requires.
Chapter 11

EDUCATION AND TRAINING

General

11.1 The quality of the services available for the aged will depend, to a very large extent, on the availability of properly trained workers. Some workers, such as physiotherapists, will require little in addition to their normal professional training except skilled guidance and experience of work with the aged. The present training of other professional workers will need to be extended. New training will have to be provided for some. The more important areas where, in the Committee's view, training should be extended are set out in paragraphs 11.2 to 11.9 hereunder.

Medical Students

11.2 Notwithstanding the fact that a large part of the work of most doctors is concerned with the aged, the amount of undergraduate training devoted to the aged is very small. The Report of a Committee of the Royal College of Physicians of Edinburgh* stated—

"a substantial and increasing proportion of hospital facilities is now devoted to the care of the elderly. The increase in the numbers of the elderly has meant that doctors, whether in hospital, general practice, or public health work, spend a greater proportion of their time treating these patients. During the last twenty years certain principles in the treatment and management of geriatric patients have been evolved, and it would seem desirable that this knowledge should be taught to undergraduate and post-graduate students. If it is accepted that teaching hospitals should contain geriatric beds, it would seem a logical step that the unit should be used for teaching."

In this country most practical training is provided in general hospitals where there is little emphasis on the many problems of the aged. Some students are given no training in long-stay hospitals and others are given very limited training. No training is provided in community care. The Committee recommends that there should be greater emphasis on the care of the aged in the undergraduate curriculum.

Nurses

11.3 Like medical students, most nurses are trained in general hospitals where there is little, if any, emphasis on the care of the aged. Many are not sufficiently aware

of, and do not feel any particular responsibility for the problem of the aged. The Committee recommends that some experience in the care of the aged should be an essential part of the training of all nurses.

Enrolled Nurses

11.4 The Committee understands that consideration is being given to the creation of the grade of enrolled nurses. It considers that enrolled nurses would be of considerable value in the care of the aged and recommends that, if the grade is created, their work should extend to the care of the elderly in welfare homes.

Home Helps

11.5 The Committee does not visualise that, initially at least, any extended courses of training should be provided for home helps. The aim should be to select people who are suitable for the work which they are to perform. However, some instruction would be desirable, even for persons who are already competent housekeepers. It would help to ensure a high standard and stimulate pride and interest in the work. Particularly important is instruction in the understanding of the idiosyncrasies which some of the aged may display. The Committee recommends that the National Council for the Aged and the local Social Service Councils should arrange short courses of instruction for home helps.

Voluntary Workers

11.6 Voluntary workers have a vital role to play in the care of the aged. Frequently their effectiveness could be considerably improved if suitable training or guidance were available for them. This is particularly true of key workers in voluntary organisations, such as secretaries and other officers. Voluntary workers should be taught to recognise and understand the needs of old people and to know what can be done to meet these needs. They should know when to rely on themselves and other voluntary workers and when to call for professional help. They should be given an understanding of the idiosyncrasies of old people and an appreciation of the fact that strange conduct may be part of the process of ageing, that those who appear difficult, stubborn, grumpy, critical, or ungrateful may be too proud to accept help gracefully, or they may have had many bitter disappointments in life which shattered their faith in their fellow men. The young in particular may need help to understand the anxieties and awkwardness of some solitary old people who may be most in need of help and friendship. The Committee recommends that the National Council and local Social Service Councils should arrange courses of instruction, both by professional workers and by their own skilled and experienced members.

Education of the Public

11.7 The successful development of services for the aged requires the support of the whole community. A wealth of goodwill can probably be created by providing more enlightenment on the needs of the aged and on the means by which these needs can be met and by constantly reminding younger people that they too will be old
some day. There should be a positive programme of public education and the Committee recommends that this should be regarded as one of the primary responsibilities of the National Council for the Aged.

Wardens

11.8 The success of any scheme of old people’s dwellings will depend to a large extent on the temperament and ability of the warden who must act as friend, adviser and good neighbour of the tenants. The warden must endeavour to promote a sense of reassurance and security, and preserve and encourage the independence of tenants. Personal qualities such as common sense, patience, resourcefulness and a sense of humour will go a long way but there is also a need for training, particularly since this is a new sphere of employment and few applicants will have any previous experience. Inexperienced wardens must be given an understanding of old people and a knowledge of the statutory and voluntary services available. The Committee recommends that the National Council for the Aged should arrange training courses to which housing authorities could send newly appointed wardens.

Chief Medical Officers and Assistant Chief Medical Officers

11.9 To enable them to carry out the duties suggested in paragraph 10.5 in regard to the care of the aged special training for Chief Medical Officers and their assistants is necessary. A number have already been awarded fellowships to study abroad. The Committee recommends that this system should be extended so that all are given an opportunity to make a special study of the problems associated with the care of the aged.
Chapter 12

LEGISLATION

General

12.1 Special legislation is, of course, necessary in regard to pensions and social assistance for the aged. In regard to other social and health services the Committee considers that, as far as possible, the aged should be dealt with under legislation which applies to the population as a whole. There are, however, a few fields where modification and clarification of the existing legal provisions is necessary and new legislation will be required for the implementation of some of the recommendations of the Committee. The main points which require to be covered are set out in the following paragraphs.

Home Helps

12.2 There is at present no statutory provision for the employment of home helps. In some areas they have been remunerated from public assistance funds. The Committee considers that their employment should be under the aegis of health authorities and it recommends that health authorities should be given statutory authority to employ home helps or to arrange for their employment by other bodies.

Boarding-Out

12.3 Health authorities have at present no statutory authority to provide for the boarding-out of elderly patients. The Committee recommends that they should be given this authority.

Meals

12.4 Health authorities have not at present statutory power to provide, or arrange for the provision of, meals for old people in the community. The Committee recommends that they should be given the necessary authority. This authority should extend to the giving of financial assistance, both capital and revenue, to voluntary organisations operating “meal-on-wheels” schemes and lunch clubs, payments to neighbours in rural areas and the provision of meals from the kitchens of hospitals and other health authority institutions.

Compulsory Admissions to Institutions

12.5 Reference has already been made in Paragraph 8.5 to the tragedy of an old person dying alone and possibly remaining undiscovered for some time. This naturally shocks many and results in demands that something be done. One method of preventing the occurrence of the occasional tragedy of this nature would be to remove
all elderly persons at risk compulsorily to institutions and to detain them there—a completely unjustifiable procedure which would conflict with the right of the individual to personal freedom. It must be accepted that many old people in good mental health prefer to live alone and they would receive firm public support in this attitude. The development of services such as home nursing and home visiting by voluntary bodies would help to reduce the problem of the elderly dying alone, but good neighbours remain, as they always have been, the best protection. Greater interest by the community generally should reduce the numbers of aged persons who die alone but the Committee can see no reasonable way of overcoming the problem completely. There are, of course, elderly persons who suffer from mental illness to some extent and who are clearly a danger to themselves and possibly to others. The Commission on Mental Illness stressed that compulsory powers of detention should be used only as a last resort, e.g. when positive efforts to persuade the patient to accept treatment voluntarily have failed. The Committee agrees with this view and recommends that in the consideration of future mental health legislation particular attention should be paid to the question of the extent to which it is necessary to admit elderly patients to mental hospitals.

Charges in Hospitals

12.6 The question of charges for services provided for the aged is a very vexed one—particularly in regard to charges for institutional care. At present hospital care is provided free for the lower income group and at a reduced charge for the middle income group. Those in the higher income group have to pay the full cost except where the charge is reduced owing to hardship. As non-contributory old age pensions are given on a means test basis the recipients have little, if any, means and they are usually given medical cards which entitle them to the services of the local district medical officer. They are thus in the lower income group, at least in regard to general medical care, and when they go into hospital, particularly for short-term care, they are accepted in most cases as being in the lower income group and given services free of charge. Some health authorities maintain, however, particularly where care is prolonged, that their position alters when they are in hospital—that in addition to their pensions (and any other income they may have) they are now being provided with food and maintenance and thus put outside the lower income group and subject to a charge. If they are detained in a mental hospital and in receipt of non-contributory old age pensions the Social Welfare Acts provide that their pensions can be appropriated towards the cost of their maintenance but the resident medical superintendent may, at his discretion, arrange for them to receive for their own use a sum not exceeding £1 per week and may also make payments out of the pension towards their commitments for rent, rates, house purchase, insurance or assurance premiums etc. This is equivalent to making a charge on them as is done by some health authorities for patients who are not compulsorily detained. The position generally is difficult. On the one hand, the aged should be treated with every consideration and if they have dependants or need the money for purposes such as the payment of rent, they should be given services free. On the other hand, institutional care which may not really be necessary should not be made unduly attractive to them by the fact that their financial position would be much better while in an institution than when living in the community. The Committee therefore recommends that
for short-term hospital care, or hospital care which is not likely to be permanent, the same principle should apply as to all other persons, i.e. that services should be provided free, or at a reduced cost, depending on means. Where elderly persons are maintained on a long-term basis the Committee recommends that health authorities should not be debarred from making a charge for maintenance, but in assessing the charge due regard should be had to whether or not the persons concerned have dependants, or need the money to meet legitimate expenses, such as the payment of rent (see also paragraph 12.9).

**Charges in Welfare Homes**

12.7 Persons maintained in county homes are not subject to the same provisions as persons maintained in hospitals. They are given care and maintenance and where they have an income over £1 a week they may be required to pay all or part of the excess over that figure, at the health authority's discretion, towards the cost of their maintenance. The Committee recommends that in the welfare homes suggested the same principles should apply as have already been recommended in regard to hospital care.

**Community Services**

12.8 The Committee recommends that for services provided in the community the same principles in regard to charges should apply to the aged as in the case of the rest of the community.

**Pocket Money**

12.9 As indicated in paragraphs 12.6 and 12.7 there is provision for giving certain persons detained in mental hospitals a sum not exceeding £1 per week from their pensions for their own use, and patients in county homes may be charged only on the part of their income which exceeds £1 per week. The Committee suggests that all aged persons in long-stay accommodation or in welfare homes should have some money for their own use, provided they are likely to use it for their own benefit. In most cases the persons concerned will have some income, either from private means or from social welfare benefits. The Committee recommends that charges on them should be so adjusted that they will have some money for personal use. A limited number between the ages of 65 and 70 will have no means. The Committee recommends that there should be provision for the payment of pocket money to such persons.

**Extern Welfare Institutions**

12.10 As indicated in paragraph 7.36 health authorities may make arrangements under section 10 of the Health Act, 1953, to send patients to voluntary hospitals and nursing homes. The Committee recommends that similar powers should be provided to enable health authorities to send patients to homes which would be suitable as Welfare Homes (see also paragraph 7.38).
Charges in Extern Hospitals and Other Extern Institutions

12.11 The Committee recommends that aged persons sent by health authorities to extern hospitals or welfare homes should be subject to the same conditions in regard to charges by health authorities as if they were maintained in health authority institutions. Under the Institutional Assistance Regulations a person admitted to a county home may be charged so much of his income, exceeding £1 a week, as the health authority considers appropriate. These Regulations do not at present apply to persons sent to extern institutions.

Assistance for Voluntary Organisations

12.12 In paragraph 6.25 the Committee has recommended that health authorities should encourage and support financially voluntary bodies providing services for the aged. Under the provisions of section 65 of the Health Act, 1953, a health authority may give financial and other forms of assistance to any body providing a service "similar or ancillary to a service which the health authority may provide." The Committee recommends that this power should be extended to enable a health authority to assist financially, or in any other way, a voluntary body providing a service for the aged which is in general accord with services designated by Regulations for the purpose by the Minister for Health.
Chapter 13

MISCELLANEOUS

Information Services

13.1 It is very important that information should be available at both national and local level regarding all services available for the aged. This work could probably be most appropriately performed by the National Council for the Aged and by the local Social Service Councils. The Committee recommends that the task of coordinating information concerning all available services should be the responsibility of the Minister for Health. In addition to booklets and leaflets setting out the services available it is very desirable that there should be information centres to which people can turn in time of doubt or need. Provision should be made for week-ends and bank holidays as the needs of the aged do not disappear at these times. The mass media of communication should be used to give information regarding services which are not being used to the full extent, or regarding which there seems to be doubt or difficulty.

Persons, Other Than Aged, in County Homes

13.2 As indicated in paragraph 7.23 the Committee did not regard it as necessary to make recommendations in regard to the institutional care of casuals or of the aged mentally ill and mentally handicapped. It regarded the residents under the age of 65 years as being outside its terms of reference to a great extent. While the Committee does not make recommendations in regard to these classes it has recorded in paragraph 2.9 the information it received in regard to the numbers and types of residents involved.

Report of the Consultative Council on the General Hospital Services

13.3 The Consultative Council on the General Hospital Services made the following main recommendations in regard to the aged:—

Paragraph 3.33: “We recommend, however, that most of the District Hospitals should become District Nursing Homes staffed by general practitioners from the area. . . . The Homes, would, in addition, provide accommodation . . . for some geriatric patients.”

Paragraph 3.38: “. . . certain County Hospitals will cease to provide an acute medical service . . . We consider that these hospitals should become Community Health Centres providing in-patient services similar to that already suggested for the District Nursing Homes, but backed by somewhat increased diagnostic facilities and a more comprehensive consultant out-patient organisation.”

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Summary of Main Conclusions and Recommendations — Paragraph 27: “It is urgently necessary that special provision should be made for the needs of geriatric patients. As far as possible, the elderly patient should be cared for in his own home; if admission to an institution is necessary he should initially be investigated, and perhaps treated, in a Regional or General Hospital. Recommendations have been made to ensure the best possible intermediate and long-stay accommodation.”

Paragraph 6.50: “Old people are especially illness and accident prone and, as they form an increasing proportion of our population, it is urgently necessary that special provision should be made for their needs for hospital beds. The large number of elderly patients unnecessarily and, perhaps, to their own detriment occupying beds in acute care hospitals for social reasons or because they are chronically infirm, emphasises the need to make more suitable arrangements for them. While there is some variation of opinion from country to country, in Scotland where the structure of the population is similar to our own it is accepted that 12 to 15 beds per 1,000 of the population over 65 years of age should be provided. If we accept the recommendations of the Royal College of Physicians, Edinburgh, 20 per cent of the geriatric beds provided should be allocated to assessment and rehabilitation and 80 per cent to long-stay wards. Experience in this country and elsewhere indicates that geriatric beds for females should exceed those for males in the proportion of at least 3 to 1.”

Paragraph 6.51: “Our bed requirements will need to be looked at further in the light of particular population features such as the high number of unmarried persons, the number of elderly people living alone, and the considerable variation throughout the country of the proportion of the population in the elderly age groups. We are aware that there is an Interdepartmental Committee which is studying this question, and their findings should prove valuable in determining our particular requirements.”

Paragraph 6.52: “A major influence on our requirement of geriatric beds will be the extent to which social services for the old are developed. As far as possible, the infirm elderly person should be cared for in his own home rather than in an institution. If this is to be done to the fullest extent possible, it will be necessary to extend the domiciliary services and, particularly, to expand the public health nursing services. The wider application of boarding-out arrangements and the extension of a system of home helps and ‘meals on wheels’ should also be considered as methods for easing the lot of the old person. An expansion in this direction of voluntary effort, both religious and lay, should be most rewarding.”

Paragraph 6.53: “In the investigation and treatment of old people a full range of hospital facilities is necessary. For this reason geriatric assessment units should be included in all the Regional and General Hospitals and should be staffed and administered by physicians of consultant status who would be trained in geriatrics. All persons referred to long-stay units should be investigated initially in one of the above-mentioned hospitals, its assessment unit or out-patient department. No person should be admitted to long-stay units without the direction of a consultant from the acute hospital. If it is in the interests of a patient later to transfer him back to the acute hospital this should be made administratively easy.”
Paragraph 6.54: "The long-stay wards should provide accommodation for four times the number of patients catered for in the assessment and rehabilitation wards. It is not essential that long-stay wards should be situated in the main hospital, but they should be associated with it and remain under the general clinical supervision of the consultants attached to the assessment unit. The physical medicine department of the general hospital should be closely linked with the care given in the long-stay units."

Paragraph 6.55: "In order to provide the maximum care for the elderly, while using the minimum number of acute-care hospital beds, a domiciliary consultation service with the family doctor, an out-patient clinic and a day hospital service should form part of the organisation for geriatric care. However, it is inevitable that some patients, although ambulant, will require institutional care on a permanent basis, and residential homes will be needed for them as near their own locality as possible. Later sections of this Report contain recommendations regarding specific arrangements in various regions."

There are no major differences, in principle, between the recommendations of the Council and those of the Committee. There are, however, two important points of detail to which the Committee desires to draw attention:

(i) The Committee recommends that geriatric assessment units should be provided at General and Regional Hospitals and also at some selected centres. The Council visualised the provision of units at General and Regional Hospitals only.

(ii) The Committee recommends that persons should be admitted to long-stay hospital units by the specialists in charge of the geriatric assessment units. It could be inferred from the recommendations of the Council that persons should be admitted to long-stay accommodation on the recommendation of any specialist in the General or Regional Hospitals.

Tribute to Secretary

13.4 We wish to record our appreciation of the very valuable services rendered by our Secretary, Mr. G. W. Devey. His Competence in dealing with the secretarial work, including the detailed arrangements and recording involved in the discussions with interested organisations and groups, simplified our task considerably. The excellent documentation provided by him and his major share in the production of this Report are a measure of his ability and efficiency. His courteous and unfailing co-operation at all times deserves our highest commendation.
Signatures to the Report

J. J. Darby (Chairman)

P. MacCaolte

J. B. McKenna

C. N. O'Sullivan

P. F. Tormey

J. H. Walsh

G. W. Devey (Secretary)

29th November, 1968
APPENDIX A

Organisations and individuals who submitted written evidence

Athy and District Committee for the Care of the Elderly.
Church of Ireland Social Service.
Clonmel Social Service Council.
College of General Practitioners.
Divisional Union of Republic of Ireland, Soroptomist International Association.
Dr. M. Naughton, Chief Medical Officer, Tipperary (S.R.) Health Authority.
Dublin Central Mission.
Fermoy Geriatrics Co-ordinating Committee.
Irish Countrywomen's Association.
Irish Nurses' Organisation.
Iveagh Trust.
Kildare Town Association for the Care of the Elderly.
Legion of Mary.
Maynooth Old People's Committee.
National Institution and Molnyneux Asylum for the Blind of Ireland.
Newbridge Association for the Care of the Elderly.
Portlaoighise Old People's Association.
St. John Ambulance Brigade of Ireland.

APPENDIX B

Organisations and individuals who gave oral evidence

Mr. G. Cannon, Manager, Dr. P. J. Deery, Chief Medical Officer, and other officials of Monaghan Health Authority.
Mr. J. F. Cassidy, Acting Manager, Dr. D. O'Brien, Chief Medical Officer, Dr. B. Blake, R.M.S., St. Dympna's Hospital, and other officials of Carlow Health Authority.
Cork Senior Citizens Service Council.
Mr. D. F. Donovan, Manager, and Dr. V. Barry, Chief Medical Officer, Kilkenny Health Authority.
Dublin Council for the Aged.
Dún Laoghaire Old Folk's Association.
Enniscorthy Old People's Society.
Mr. M. Flannery, Manager, Dr. D. F. McCarthy, Chief Medical Officer, Dr. T. Egan, R.M.S., Newcastle Hospital, and other officials of Wicklow Health Authority.
Irish Association of the Sovereign Order of Malta.
Irish Medical Association.
Irish Red Cross Society.
Kilkenny Social Service Council.
Mr. T. P. MacDiarmada, Manager, Dr. R. Hayes, Chief Medical Officer, Dr. C. E. Moloney, R.M.S., St. Camillus' Hospital, Dr. J. Nash, R.M.S., Regional Hospital, and other officials of Limerick Health Authority.
Mr. C. Ó Conchubhair, Manager, Dr. M. M. J. Maughan, Chief Medical Officer, Dr. F. L. Corrigan, R.M.S., Ardkeen Hospital, and other officials of Waterford Health Authority.
Dr. J. St. L. O'Dea, R.M.S., and members of the staff of St. Kevin's Hospital, Dublin. Representatives of voluntary organisations in the Limerick area.
Society of Medical Officers of Health.
Society of St. Vincent de Paul.
Waterford Committee for the Care of the Aged.

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APPENDIX C

County Homes

Sacred Heart Home, Carlow.
St. Felim’s County Home and Hospital, Cavan.
St. Joseph’s Hospital, Ennis, County Clare.
Heatherside Hospital, Buttevant, County Cork.
Mount Carmel Home, Clonakilty, County Cork.
*Nazareth House, Mallow, County Cork.
Our Lady of Lourdes Home, Midleton, County Cork.
*St. Joseph's, Mount Desert, Cork.
St. Joseph’s Home, Stranorlar, County Donegal.
Bru Bríde, Crooksling, Dublin.
Brú Caoimhín, Cork Street, Dublin.
St. Clare’s Home, Ballymun, Dublin.
St. Brendan’s Home, Loughrea, County Galway.
St. Columbanus’ Home, Killarney, County Kerry.
St. Joseph’s Hospital, Listowel, County Kerry.
St. Vincent’s Hospital, Athy, County Kildare.
St. Columba’s Hospital, Thomastown, County Kilkenny.
St. Vincent’s Hospital, Mountmellick, County Laois.
St. Patrick’s Home, Carrick-on-Shannon, County Leitrim.
St. Ita’s Home, Newcastlewest, County Limerick.
St. Joseph’s Hospital, Longford.
St. Joseph’s Hospital, Ardee, County Louth.
St. Mary’s Hospital, Drogheda, County Louth.
Sacred Heart Home, Castlebar, County Mayo.
St. Joseph’s Home, Trim, County Meath.
St. Mary’s Hospital, Castleblayney, County Monaghan.
St. Vincent’s Hospital, Tullamore, County Offaly.
Sacred Heart Home, Roscommon.
St. John’s Hospital, Sligo.
Hospital of the Assumption, Thurles, County Tipperary.
St. Patrick’s Hospital, Cashel, County Tipperary.
St. John’s Hospital, Dungarvan, County Waterford.
St. Patrick’s Hospital, Waterford.
St. Mary’s Hospital, Mullingar, County Westmeath.
St. John’s Hospital, Enniscorthy, County Wexford.
St. Colman’s Hospital, Rathdrum, County Wicklow.

Hospitals with County Home Sections

St. Finbarr’s Hospital, Cork.
St. Patrick’s Hospital, Fermoy, County Cork.
St. Kevin’s Hospital, Dublin.
St. Columcille’s Hospital, Loughlinstown, County Dublin.
St. Mary’s Hospital, Phoenix Park, Dublin.
James Connolly Memorial Hospital, Blanchardstown, County Dublin.
Western Regional Sanatorium, Merlin Park, Galway.
St. Camillus’ Hospital, Limerick.
Blessed Oliver Plunkett Hospital, Dundalk, County Louth.
Grianán Charmain, Enniscorthy, County Wexford.

*These are voluntary institutions but they have been included in this list because their beds are reserved for patients sent by Cork Health Authority and these patients were included in the survey carried out by the Committee.
## APPENDIX D.
### STAFFING OF COUNTY HOMES

<table>
<thead>
<tr>
<th>COUNTY HOME</th>
<th>Doctors (W/T)</th>
<th>Nurses (W/T)</th>
<th>Social Workers (W/T)</th>
<th>Physiotherapists (W/T)</th>
<th>Occupational Therapists (W/T)</th>
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<td>Granainin Charmain, Ennisboro</td>
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</table>

The services of the various personnel listed are available to aged patients in these hospitals as required.
APPENDIX E

Homes and institutions catering for the aged and for persons suffering from chronic ailments, and convalescent homes

Cheshire Home, Tullow, Co. Carlow.
Bon Secours Nursing Home, Mountshannon, Co. Clare.
Stella-Maris Convent Convalescent Home, Lisdoonvarna, Co. Clare.
Clifton Convalescent Home, Montenotte, Cork.
General Hospital, Cobh, Co. Cork.
Honan Home, Montenotte, Cork.
Rockville, Bellevue Park, Military Hill, Cork.
St. Joachim and Anne, Anglesea Street, Cork. *St. Joseph's, Mount Desert, Cork.
St. Laurence Cheshire Home, Lota Park, Glanmire, Co. Cork.
St. Luke's Home, Military Road, Cork.
St. Martin's, Eversleigh House, Montenotte, Cork.
St. Mary's, Montenotte, Cork.
St. Monica's Home for the Blind, Infirmary Road, Cork.
St. Patrick's Hospital, Wellington Road, Cork.
Shanakiel Hospital, Sunday's Well, Cork.
Skiddy's Home, Pouladuff Road, Cork.
Albert House, Brabazon House and Pax House, Gilford Road, Dublin 4.
Alexandra Guild House, 30 Leinster Road West, Dublin 6.
Asylum for Aged Females, 21 New Street, Dublin 8.
Auburn House, Harold's Cross, Dublin 6.
Brighton House Nursing Home, 11 Brighton Road, Dublin 6.
Carysfort Nursing Home, 7 Arkendale Road, Glenageary, Co. Dublin.
Convent of the Sisters of Our Lady of Charity of Refuge.
72 Lr. Sean McDermott Street, Dublin 1.
42 Dartmouth Square, Ranelagh, Dublin 6.
Drumcondra Protestant Retreat, 29 Lr. Drumcondra Road, Dublin 9.
Gascoigne Home, Camden Row, Dublin 8.
23 Hazelbrook Drive, Terenure, Dublin 6.
Hazeldean Nursing Home, 80 Park Ave., Sandymount, Dublin 4.
High Park Convent, Drumcondra, Dublin 9.
Holy Family Home, Roebuck, Dublin 14.
Home for Aged and Infirm Jews, Denmark Hill, Leinster Road, Dublin 6.
Home for Aged Governesses, 22 Harcourt Terrace, Dublin 2.
Home for Aged Presbyterian Ladies, 4 Vesey Place, Dún Laoghaire, Co. Dublin.
Kilbarron, Sea Front, Sandycove, Co. Dublin.
Linden Convalescent Home, Blackrock, Co. Dublin.
Leopardstown Park Hospital (British Ministry of Health), Foxrock, Co. Dublin.
Mageough Home, Cowper Road, Dublin 6.
Margaretholm, 31 Claremont Road, Sandymount, Dublin 4.
Morning Star Hostel, Morning Star Ave., Dublin 7.
Old Men's Home, Northbrook Road, Dublin 6.

*Also included in list of County Homes at Appendix C.
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<th>Name</th>
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<td>Rathdrum Nursing Home</td>
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<td>Royal Hospital for Incurables</td>
<td>Donnybrook, Dublin 4</td>
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<td>Mrs. B. Royce, S.R.N.</td>
<td>4 Willow Bank, Dun Laoghaire, Co. Dublin</td>
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<td>St. Brigid's</td>
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<tr>
<td>St. John's House of Rest</td>
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<td>Tudor House Nursing Home</td>
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<td>Lourdesville Nursing Home</td>
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</table>
APPENDIX F

Standards of Design and Accommodation for Dwellings provided for Elderly Persons by Charitable Organisations and Local Authorities

ACCOMMODATION PROVIDED BY CHARITABLE ORGANISATIONS

(a) Where the accommodation to be provided is intended as a home for elderly persons and includes the provision of meals, medical attention, etc.

General:

The standards of construction, thermal insulation, sound reduction, etc., should be in accordance with the Department’s minimum standards applicable to dwellings.

Sizes of buildings:

As it is the intention that such dwellings will be made available for the permanent use of the occupants, care should be taken in the design to avoid creating an institutional atmosphere.

Number of persons to be accommodated:

The maximum number of persons to be accommodated in any one building should not normally exceed 60, and, in addition, the number of storeys should be kept to a minimum, i.e., not more than 2 storeys, if possible. It is recommended also that a number of self-contained blocks or units should be placed, rather than one large building.

Aspect of bedrooms:

Aspect is particularly important, and bedrooms should not be designed in such a way that windows obtain light from the north only.

Sizes of bedrooms:

Bedrooms or bed-sitting rooms should be in the range of 100 to 140 square feet for single persons or 160 to 180 square feet for double rooms. Provision should be made in each room for a wash-hand basin, call-bell, and adequate heating. The width of doors should be not less than 30" to allow for entry of wheelchairs.

Communal, recreation and dining-rooms:

Bearing in mind the various requirements such as TV, radio, reading, writing, etc., communal rooms to be used for recreational purposes should be provided by way of a number of small rooms rather than as one or two large rooms. The recommended space provision is 25 square feet per person, distributed throughout the rooms. A minimum of 15 square feet per person is recommended for dining-room accommodation.

Sanitary accommodation:

The provision of at least one bathroom per floor, and one for each 15 residents is suggested. Grips or handrails should be provided above baths. Toilet facilities should be on the basis of one W.C. to each six residents and grip handles should be provided above baths. At least one W.C. apartment on each floor should be designed to accommodate wheelchair users and to permit staff aid. Doors should be either outward opening or sliding and should be capable of being unlocked from the outside.
Handrails should be provided on both sides of corridors, linked where necessary with the staircase handrails.

The need for the following types of rooms should also be considered:—
Offices, Visitors and interview, sluice, linen, used linen, drying and airing, storage and box room.

Adequate arrangements for food preparation, storage, refrigeration and for laundry facilities should be provided.

Due regard should be given to the question of fire hazard and the evacuation of the occupants if fire were to break out. Staircases, with safety doors and direct access to the exterior should be provided for. Alternative stairs at either end of corridors, etc., should be included, where necessary.

(b) Where the accommodation to be provided is intended for living purposes only

Each dwelling unit should be entirely self-contained and provision should be made for separate hall door, living/sleeping room, kitchenette and toilet facilities. The kitchenette and bathroom should each be ventilated direct to the open air and adequate window space should be included. Adequate cooking and washing-up facilities including water heating should be provided in the kitchenette. A sink and drainer, electric power or gas point, will also be necessary.

Where central heating is not intended, a fire-place should be provided in the living-sleeping space. Adequate provision should be made for lighting points and power plugs which should be placed at least three feet from the floor to obviate stooping.

Adequate storage accommodation should be provided.

Grips or handrails should be provided above baths, grip handles in W.Cs. are also recommended.

The living/sleeping space, excluding kitchenette and bathroom, for single persons should normally be at least 100 square feet and for couples 160 square feet.

In the larger projects it would be desirable to have a resident warden or caretaker and provision should be made for living accommodation.

It would be desirable to have a public telephone installed in the larger projects. Provision might also be made for a recreational room and, possibly, sleeping units for the use of occasional visitors.

ACCOMMODATION PROVIDED BY LOCAL AUTHORITIES

The Minister for Local Government has advised local authorities that in the design of dwelling units for elderly persons the accommodation standard should not be less than, in the case of a two-person family, a livingroom of 140 square feet plus kitchenette and a bedroom of 110 square feet. For a single-person unit, a livingroom of not less than 170 square feet and a bed recess and a kitchenette are recommended. In both cases an additional apartment of not less than 35 square feet to accommodate a bathroom and W.C. are also recommended. In the equipment of the dwellings, local authorities have been asked to take account of the particular needs of the elderly.
APPENDIX G
Statistical Information in regard to Old Age Pensions
A. Old Age (Contributory) Pension

<table>
<thead>
<tr>
<th>Weekly rate of pension</th>
<th>No. of pensions in payment on 31st August, 1968</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>From 3rd January, 1969</td>
<td></td>
</tr>
<tr>
<td>Pensioner with adult dependant:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>117 6</td>
<td>132 6</td>
<td>14,111</td>
</tr>
<tr>
<td>114 6</td>
<td>129 6</td>
<td>808</td>
</tr>
<tr>
<td>111 6</td>
<td>126 6</td>
<td>585</td>
</tr>
<tr>
<td>108 6</td>
<td>123 6</td>
<td>499</td>
</tr>
<tr>
<td>105 6</td>
<td>120 6</td>
<td>463</td>
</tr>
<tr>
<td>Basic pension only:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 0</td>
<td>72 6</td>
<td>23,887</td>
</tr>
<tr>
<td>62 0</td>
<td>69 6</td>
<td>1,168</td>
</tr>
<tr>
<td>59 0</td>
<td>66 6</td>
<td>899</td>
</tr>
<tr>
<td>56 0</td>
<td>63 6</td>
<td>702</td>
</tr>
<tr>
<td>53 0</td>
<td>60 6</td>
<td>547</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>43,669</td>
</tr>
</tbody>
</table>

Note 1. Of the pensioners with adult dependants, 815 receive increases of pension in respect of 1,392 children.

Note 2. Marital status of pensioners:

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Married</th>
<th>Widowed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>6,835</td>
<td>17,265</td>
<td>9,050</td>
<td>33,150</td>
</tr>
<tr>
<td>Women</td>
<td>6,363</td>
<td>1,173</td>
<td>2,983</td>
<td>10,519</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>43,669</td>
</tr>
</tbody>
</table>
### B. Old Age (and Blind) (Non-Contributory) Pension

<table>
<thead>
<tr>
<th>Yearly Means</th>
<th>Weekly rate of pension</th>
<th>No. of pensions in payment on 31st August, 1968</th>
</tr>
</thead>
<tbody>
<tr>
<td>£ s. d.</td>
<td>s. d.</td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>65 0</td>
<td>19,985</td>
</tr>
<tr>
<td>Nil</td>
<td>60 0</td>
<td>54,841</td>
</tr>
<tr>
<td>26 5 0</td>
<td>55 0</td>
<td>23,257</td>
</tr>
<tr>
<td>52 10 0</td>
<td>50 0</td>
<td>3,790</td>
</tr>
<tr>
<td>65 10 0</td>
<td>45 0</td>
<td>2,900</td>
</tr>
<tr>
<td>78 10 0</td>
<td>40 0</td>
<td>3,883</td>
</tr>
<tr>
<td>104 15 0</td>
<td>35 0</td>
<td>1,205</td>
</tr>
<tr>
<td>117 15 0</td>
<td>30 0</td>
<td>977</td>
</tr>
<tr>
<td>130 15 0</td>
<td>25 0</td>
<td>732</td>
</tr>
<tr>
<td>143 15 0</td>
<td>20 0</td>
<td>586</td>
</tr>
<tr>
<td>156 15 0</td>
<td>15 0</td>
<td>248</td>
</tr>
<tr>
<td>169 15 0</td>
<td>10 0*</td>
<td></td>
</tr>
<tr>
<td>182 15 0</td>
<td>5 0*</td>
<td></td>
</tr>
</tbody>
</table>

Total: 112,404

*These two new rates were first introduced on 2nd August, 1968; no pensions at these rates had become payable by 31st August, 1968.

**Note 1.** The means limit of £195 15s. 0d. is increased in cases where allowances for children are payable (see Note 2).

**Note 2.** Increases where pensioners have a qualified child or children, increases of pension are payable at the rate of 12s. 6d. for each of the first two children, and 7s. 6d. for each child in excess of two. On 31st August, 1968, increases of pension were in payment to 1,322 pensioners in respect of 2,505 children.
APPENDIX H

Summary of Rules for Assessment of Means

Old Age and Blind (Non-Contributory) Pension

and

Widows’ (Non-Contributory) Pension

1. In calculating a person's yearly means, account is taken of:—

(A) the income which the person may reasonably expect to receive during the succeeding year in cash, such as earnings or allowances, the following items being excluded:—

(i) home assistance paid by a local authority;
(ii) income from the investment or profitable use of property, not being property personally used or enjoyed by the person (but see (B) below as to the method of assessment of the capital value of the property);
(iii) any sums received by way of pension, allowance, assistance or benefit under the Old Age Pensions Acts, the Unemployment Assistance Acts, the Widows' and Orphans' Pension Acts, the Children's Allowances Acts or the Social Welfare Acts;
(iv) any income arising from a bonus under a scheme administered by the Minister for the Gaeltacht for the making of special grants to parents or guardians resident in the Gaeltacht or Breac Ghaeltacht of children attending primary schools;
(v) (a) any income from a charitable organisation i.e. a body whose activities are carried on otherwise than for profit (but excluding any public or local authority) and one of whose functions is to assist persons in need by making grants of money to them, and
(b) any income (other than income of the kind specified in clause (a) of this subparagraph) from voluntary or gratuitous payments in so far as it does not exceed £52.5.0d. per year.
(vi) allowances paid by a local authority under the Health Act, 1947, to persons suffering from certain infectious diseases, or, under the Health Act, 1953, to certain disabled persons;
(vii) any allowance, special allowance, dependant's allowance, disability pension or wound pension under the Army Pensions Acts, 1923 to 1964, or pension under the Military Service Pensions Acts, 1924 to 1964, or the Connaught Rangers (Pensions) Acts, 1936 to 1964, or combination of such allowances and pensions, except so far as the amount exceeds £80 a year (a British war pension is treated as if it were a pension or allowance under the Army Pensions Acts)—this limitation of £80 does not apply in the case of pensions or allowances in respect of service in the War of Independence between 23rd April, 1916 and 30th September, 1923;
(viii) in the case of a blind person his or her earnings up to a limit of £65 increased by £52 if the person has a dependent wife or husband and by £39 in respect of each qualified child; if the blind person is a widower or a single man and is wholly or mainly maintaining a female person over the age of sixteen years for the purpose of having the care of one or more qualified children, up to £52 of his earnings are excluded (as in the case of a dependent wife) in respect of her;
(ix) any income arising from a grant or allowance given by a local authority under the Blind Persons Act, 1920;
(x) where the claimant is a husband separated from his wife, any payments made by him to her under a separation order;
(xi) earnings of handicapped persons from work performed at home on materials supplied under schemes that are, in the opinion of the Minister for Social Welfare, charitable in character and purpose, so far as they do not exceed £52 a year;
(xii) in the case of a person who is not a blind person and who has a qualified child or qualified children his or her earnings up to a limit of £39 in respect of each qualified child;

135
(xiii) any income by way of annuity under Section 6 of the Land Act, 1965, except in so far as it exceeds £156 per annum;

(xiv) any moneys in respect of redundancy or change of residence paid under a statutory scheme administered by the Minister for Labour;

(xv) in the case of widows' (non-contributory) pension, any means of qualified children (other than cash, income from personal exertions) insofar as they do not exceed £26 per year where there is one child or £52 per year where there are two or more children.

(B) the yearly value of any property belonging to but not personally used by the claimant, such as money in bank. The rule for calculating the yearly value of such property for old age and blind pension purposes is as follows:

(1) the first £25 is excluded;

(2) the next £375 is calculated at 5% and

(3) the excess over £400 is calculated at 10%.

In the case of widows’ (non-contributory) pensions, the first £100 is excluded, plus £100 in respect of each qualified child and the balance is calculated at 5%.

(C) The yearly value of any advantage to the person from the use or enjoyment of property (other than furniture or personal effects) which is personally used or enjoyed by him or her, such as a farm.

2. Means of married couples: The means of a person who is one of a married couple living together, are taken to be one half of the total means of the couple. However, in the case of married couples living together, both of whom are over sixty years of age, and wholly or mainly dependent on each other, up to £165 a year of their cash income may be left out of account in reckoning the means of the older member. Any sums already excluded under (v), (vii), (viii) and (xl) of paragraph 1 (A) above will be regarded as forming part of the £165 except in those cases under (vii) where the £80 limitation does not apply.

APPENDIX I

Voluntary Organisations, including Religious Orders, providing Community Care Services for the Aged

A. National organisations providing services in different areas throughout the country:

British Legion.
Catholic Women's Federation.
Church of Ireland Social Service.
Civics Institute of Ireland.
Incorporated Society for Relief of Distressed Protestants.
Irish Association of the Sovereign Order of Malta.
Irish Countrywomen's Association.
Irish Housewives' Association.
Irish Red Cross Society.
Irish Sisters of Charity.
Irish Wheelchair Association.
Knights of Columbanus.
Legion of Mary.
Lions International.
Little Sisters of the Assumption.
Little Sisters of the Poor.
Muintir na Tíre.
National Association for the Aged.
National Council for the Blind.
Presentation Sisters.
St. John Ambulance Brigade of Ireland.
Sisters of Bon Secours.
Sisters of Charity of St. Vincent de Paul.
Sisters of the Little Company of Mary.
Sisters of Mercy.
Society of St. Vincent de Paul.
Soldiers', Sailors' and Airmen's Families' Association.
Soroptomist International Association.

B. Local organisations:

County Carlow:
Carlow Old People's Committee.
Muinebeag Old People's Committee.

County Cavan:
Cavan Old People's Committee.
Cootehill Committee for the Aged.

County Clare:
Ennis Committee for the Care and Welfare of the Aged.
Kilrush Association for the Aged.

County Cork:
Bandon Geriatric Association.
Charleville Geriatric Committee.
Cobh Geriatric Committee.
Cork Junior Chamber of Commerce.
Cork Penny Dinners Association.
Cork Senior Citizens Service Council.
Cork Sick Poor Society.
Cork Voluntary Nursing Service.
Cork Youth Charity Association.
Donna Club, Cork.
Douglas Housing Welfare Association.
Dunmanway Geriatric Committee.
Fermoy Geriatric Committee.
Lough Parish Group, Cork.
Macroom Geriatric Committee.
Mallow Geriatric Committee.
Mitchelstown Geriatric Committee.
St. Mary's of the Isle Social Service Centre, Cork.
The Beggars, Cork.
Youghal Geriatric Committee.

County Donegal:
Ardara Old People's Committee.
Ballintra and Laghey Old People's Committee.
Ballybofey Old People's Committee.
Ballyshannon Old People's Committee.
Bruckless Old People's Committee.
Buncrana Old People's Committee.
Carndonagh Old People's Committee.
Carrigart Old People's Committee.
Convoy Old People's Committee.
Creeslough Old People's Committee.
Donegal Old People's Committee.
Dungloe Old People's Committee.
Dunkineely Old People's Committee.
Fahan Old People's Committee.
Frosses Old People's Committee
Glenties Old People's Committee
Kilcar Old People's Committee
Kilcarney Old People's Committee.
Killybegs Old People's Committee.
Letterkenny Old People's Committee.
Mountcharles Old People's Committee.
Moville Old People's Committee.
Pettigo Old People's Committee.
Ramelton Old People's Committee.
Rathmullan Old People's Committee.
St. Johnston Old People's Committee.

County Dublin:
Alexandra Guild.
Associated Guild of St. Francis.
Ballyfermot Social Information Centre.
Catholic Housing Aid Society.
Catholic Social Service Conference
Catholic Social Welfare Bureau.
Clontarf Senior Citizen Service
Committee for the Co-ordination of Social Services—Killester, Edenmore, Raheny.
Dublin Central Mission.
Dublin Council for the Aged.
Dublin Council of Churches.
Dún Laoghaire Old Folk's Association.
Glasnevin Parish Old Folk's Meals Committee.
Howth Geriatric Committee.
Ivagh Trust.
Liberty Creche Old Folk's Club.
Mary Aikenhead Social Service Centre, Crumlin.
Mary Aikenhead Social Service Centre, Mt. St. Anne's, Milltown.
Mary Aikenhead Social Service Centre, Stanhope Street.
Mary Aikenhead Social Service Centre, Temple Street.
Mater Del Social Services Council, Cabra West.
 Rathmines Social Service Centre.
St. Catherine's Meals-on-Wheels Committee, Meath Street.
Sandymount-Ringsend Old People's Group.
Sick and Indigent Roomkeepers' Society.
Strangers' Friend Society.
Third Order Clothing Guild.

County Galway:
Galway Social Service Centre.
St. Joseph's Nursing Society, Galway.

County Kildare:
Athy and District Committee for the Care of the Elderly.
Kilcock Old People's Committee.
Kildare Town Association for the Care of the Elderly.
Maynooth Old People's Committee.
Naas Care of the Aged Committee.
Newbridge Association for the Care of the Elderly.

County Kilkenny:
Callan Social Service Council.
Kilkenny Social Service Council.

County Laois:
Dorrow Social Services Group.
Portarlington Old Folk's Committee.
Portlaoighise Old Persons' Association.

County Leitrim:
Ballinamore Committee for the Aged.
Dromahaire Committee for the Aged.
Kinlough Committee for the Aged.
Manorhamilton Committee for the Aged.

County Limerick:
Limerick Meals-on-Wheels Committee.
Limerick Social Service Council.
Limerick/Shannon Rotary Club.
Penny Dinners Committee, Limerick.
St. Anne's Housing Guild, Limerick.
St. John's Social Group, Limerick.
Unitas, Limerick.

County Louth:
Dundalk Over 60s Club.

County Mayo:
Foxford Social Service Council.

County Offaly:
Tullamore Social Centre.

County Roscommon:
Boyle Senior Citizen Committee.
Castlerea Old Folk's Committee.
Roscommon Old Folk's Club.

County Sligo:
Sligo Junior Chamber of Commerce.
Sligo Rotary Club.

County Tipperary:
Carrick-on-Suir Benevolent Society.
Clonmel Social Service Council.
Fethard Voluntary Committee.
Nenagh Care of the Aged Committee.
Roscrea Community Services.
Templemore Youth Club.
County Waterford:
Christian Mothers' Association, Waterford.
Friends of St. Martin, Dungarvan.
Ladies Auxiliaries of the Sisters of Charity, Waterford.
Mercy Sodality, Waterford.
Ursuline Sodality, Waterford.
Waterford Committee for the Care of the Aged.

County Westmeath:
Athlone Community Centre for the Aged.
Mullingar Old Folk's Club.

County Wexford:
Enniscorthy Old People's Society.
Gorey Old Folk's Committee.
St. Brigid's Social Committee for the Aged, Wexford.

County Wicklow:
Bray Old Folk's Committee.
## APPENDIX J

### Housing Needs of Elderly Persons as Assessed by Housing Authorities

<table>
<thead>
<tr>
<th>County (County Boroughs shown separately)</th>
<th>No. of Persons in need of re-housing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. able to look after themselves in new house</td>
<td>No. requiring help in new house</td>
</tr>
<tr>
<td>Carlow</td>
<td>13</td>
<td>51</td>
</tr>
<tr>
<td>Cavan</td>
<td>15</td>
<td>107</td>
</tr>
<tr>
<td>*Clare</td>
<td>31</td>
<td>25</td>
</tr>
<tr>
<td>Cork</td>
<td>127</td>
<td>471</td>
</tr>
<tr>
<td>Cork Co. Borough</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>*Donegal</td>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td>Dublin</td>
<td>70</td>
<td>130</td>
</tr>
<tr>
<td>Dublin Co. Borough</td>
<td>440</td>
<td>3,960</td>
</tr>
<tr>
<td>Galway</td>
<td>266</td>
<td>214</td>
</tr>
<tr>
<td>Kerry</td>
<td>48</td>
<td>148</td>
</tr>
<tr>
<td>Kildare</td>
<td>115</td>
<td>125</td>
</tr>
<tr>
<td>Kilkenny</td>
<td>15</td>
<td>75</td>
</tr>
<tr>
<td>Laoighis</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Leitrim</td>
<td>50</td>
<td>62</td>
</tr>
<tr>
<td>Limerick</td>
<td>17</td>
<td>196</td>
</tr>
<tr>
<td>Limerick Co. Borough</td>
<td>9</td>
<td>77</td>
</tr>
<tr>
<td>*Longford</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Louth</td>
<td>54</td>
<td>141</td>
</tr>
<tr>
<td>*Mayo</td>
<td>—</td>
<td>26</td>
</tr>
<tr>
<td>Meath</td>
<td>—</td>
<td>4</td>
</tr>
<tr>
<td>Monaghan</td>
<td>7</td>
<td>25</td>
</tr>
<tr>
<td>Offaly</td>
<td>45</td>
<td>80</td>
</tr>
<tr>
<td>Roscommon</td>
<td>—</td>
<td>80</td>
</tr>
<tr>
<td>Sligo</td>
<td>15</td>
<td>195</td>
</tr>
<tr>
<td>Tipperary (N.R.)</td>
<td>32</td>
<td>128</td>
</tr>
<tr>
<td>Tipperary (S.R.)</td>
<td>3</td>
<td>209</td>
</tr>
<tr>
<td>Waterford</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Waterford Co. Borough</td>
<td>60</td>
<td>90</td>
</tr>
<tr>
<td>Westmeath</td>
<td>18</td>
<td>43</td>
</tr>
<tr>
<td>Wexford</td>
<td>16</td>
<td>97</td>
</tr>
<tr>
<td>Wicklow</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>1,510</td>
<td>6,858</td>
</tr>
</tbody>
</table>

*Figures are for urban districts only—figures for county area not yet available.*
A Chara,

1. I am directed by the Minister for Health to state that he has had under examination the services provided by health authorities for the care of the aged.

2. Health authorities are obliged to provide for the aged a general medical service for those in the lower income group and a hospital and specialist service for those in the lower and middle income groups. They may provide a nurse or nurses to give advice or assistance on matters relating to health and to assist sick persons. They may provide assistance for any body which provides or proposes to provide a service similar or ancillary to a service which a health authority may provide.

3. A statement is attached setting out the number of persons aged 65 years and over in each area, the number (and percentage) of such persons living alone and the corresponding details in relation to urban and rural areas. These figures give some idea of the extent of the problem generally.

4. It will be generally accepted that it is desirable that, wherever possible, the aged should continue to live in their own homes, or in the homes of their relatives, and that institutional care should be provided only for those for whom such care is essential. In order to achieve this objective it will sometimes be necessary to provide assistance so that their retention in the home will not cause undue hardship to themselves or create an intolerable burden for their relatives. The Minister is having the whole problem examined, but he desires that, as an interim measure, health authorities should interpret as liberally and as sympathetically as possible the powers they already possess to provide services for the aged. Some health authorities have already tackled this problem and have shown most commendable initiative in the range of services which they have found it possible to provide.

5. As a first step, each health authority should review its district nursing services. It is desirable that home nursing for the aged should be made available in each area, either through public health nurses or through nurses employed by voluntary organisations. The necessary expansion of this type of service will undoubtedly necessitate the employment of additional nursing staff. In addition to domiciliary nursing, it is most important that emphasis should be placed by the nurses concerned on preventive aspects and that they should seek out and visit on a regular basis the elderly, particularly those living alone or known to be in need of help. Advising them regarding nutrition, hygiene, etc., and encouraging them, where necessary, to obtain any help which may be available. Too often, aged persons come under observation only after some medical or social crisis has arisen, necessitating admission to an institution. The consequent severing of social roots frequently results in permanent institutionalisation. The nurse should keep in close contact with the public assistance authority for her area and should endeavour, in appropriate cases, to obtain, through that authority, such helps or financial assistance as might be needed to help the person to live at home. The nurse should also keep in contact with the local housing authority and should advise them, in appropriate cases, of the need for new or improved housing.

6. In the provision of medical care for the aged, family doctors are in a key position. Health authorities should enlist their co-operation and should ask them not to refer elderly patients to hospitals or homes unless they are satisfied that they cannot be cared for except in an institution. Where application is made for the admission of a person to a County Home, a full investigation of that person’s condition and home circumstances should be made with a view to ensuring that all possible steps are taken to avoid unnecessary institutional care. Such a procedure would also be useful in bringing to light the inadequacies of the existing community services of the health authority. Family doctors should be invited to utilise the services of nurses for domiciliary nursing and visiting. They should be advised of the possibility of home helps, financial assistance
and help in housing. They should also be advised of the possibility of obtaining appliances, etc., such as are mentioned in the next paragraph.

7. Health authorities should, in cases of need, supply or lend items such as bed pans, rubber sheets, bed rests, foam mattresses and hoists which will make possible the retention in the home of persons who, otherwise, would have to enter a hospital or home.

8. In suitable cases, physiotherapy and chiropody for out-patients should be provided wherever feasible. These services should be provided at hospitals and at suitable clinics and arrangements should be made for the transport of the persons concerned to enable them to secure the benefits of the treatments.

9. Voluntary organisations and charitable individuals can be of enormous assistance in the care of the aged and, in addition to nursing, they can frequently arrange more readily than local authorities for the provision of services such as home-visiting, meals, home helps, social clubs, laundry services, help in shopping etc. Health authorities should encourage voluntary organisations where possible and should co-operate with them and, where necessary, provide them with financial assistance under Section 65 of the Health Act, 1953.

10. The Minister considers it essential that there should be available in one central location in each health authority's area, an information centre at which details will be readily obtainable regarding all the different services available for the aged in the area, whether such services are administered by the health authority itself or provided by voluntary organisations or groups. The services available should be publicised through suitable media.

11. The Minister desires that, as a matter of urgency, all health authorities, who have not already done so, should consider to what extent their services for the aged can be improved along the lines suggested above and along such other lines as they may consider desirable. A full report on the matter, together with any necessary proposals for improved and expanded services should be submitted not later than 1st December next.

12. A separate communication will be sent to you as soon as possible in connection with the institutional care of the aged.

APPENDIX L

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