NATIONAL COUNCIL FOR THE AGED

COMMUNITY SERVICES FOR THE ELDERLY

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COMMUNITY SERVICES FOR THE ELDERLY

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Summary of Main Recommendations

GENERAL HEALTH SERVICES
1. All persons aged 75 years and over should be granted a medical card.

CHIROPODY SERVICES
2. A School of Chiropody should be established.
3. The position of persons holding a chiropody qualification which is not recognised should be examined with a view to providing a further course which could lead to a recognised qualification.

AURAL SERVICES
4. The service being provided by the National Rehabilitation Board should, subject to a charge, be extended to those in Category II.

DENTAL SERVICES
5. Sufficient resources should be allocated to fund the adult dental scheme to ensure that a uniform service is provided in all parts of the country.
6. Consideration should be given to the provision of mobile dental clinics in rural areas.

PUBLIC HEALTH NURSING SERVICES
7. The keeping of a register of elderly persons at risk should be regarded as a priority.
8. There should be special geriatric training for all public health nurses and specialist training for some.
9. Resources should be made available to allow Superintendent Public Health Nurses to arrange an acute nursing service for the terminally ill.
10. A public health nurse should be responsible for liaison with voluntary organisations at an operational level in each area.
11. Hospital liaison nurses should be appointed in all area.
PROFESSIONAL SOCIAL WORK SERVICES
12. A professional social work service to the elderly should be an integral part of the service provided by social work teams within the community care services of all Health Boards.

HOME HELP SERVICE
13. The Department of Health should undertake a review of the home help service.

BOARDING-OUT
14. The boarding-out of elderly persons in a suitable domestic environment should be encouraged and assisted. There should be supervision by the Health Boards.

FUEL SCHEMES
15. A uniform national fuel scheme should be adopted.

16. A fuel allowance should be given during the summer, but at half the value of the winter allowance.

VOLUNTARY ORGANISATIONS
17. All Health Boards should provide community organisers to work with voluntary groups.

18. There should be a representative from the voluntary sector as of right on each Health Board.

REPAIRS TO DWELLINGS
19. Local authorities should make arrangements to carry out the necessary work under the Essential Repairs Scheme.

20. Local authorities should be allowed discretion to carry out necessary work which is not of a structural nature.

21. The Task Force housing scheme for elderly persons should be continued for as long as is necessary.

ELDERLY IN RURAL AREAS
22. Subsidised transport should be provided for elderly persons in rural areas where public transport is inadequate.
23. Where it is not possible to provide a meals-on-wheels service in rural areas, Health Boards should endeavour to have meals provided on a one-to-one basis by neighbours.

**ORGANISATION**

24. Health Boards should have a statutory obligation to provide community geriatric services.

25. Community Geriatric teams should be established in each area covering a population of 25,000 to 30,000. Such teams should consist of a public health nurse, an area medical officer, a community physiotherapist and an occupational therapist.

26. Physiotherapists and occupational therapists should be appointed on a full-time basis or on a shared basis with hospitals.

The Council recognises that many of its recommendations will require additional resources and was conscious of this factor in preparing the report. However, the Council is not in a position to carry out detailed analysis of the short term/long term cost implications of these recommendations.

The emphasis in the report is on an improvement of services in the community with the objective of enabling as many elderly persons to remain in the community for as long as possible. Unless improvements are made in community services now, the demand for more costly and socially less beneficial institutional care will increase sharply in the years ahead. The financial implications of not providing adequate support in the community are substantial because failure to do so will result in or create a greater need for additional institutional care. It is in this context that the Council submits this report on community services for the elderly.
1 Introduction

The provision of adequate services for the increasing aging population represents a major challenge to all those concerned with the welfare of the elderly. The number of persons aged 60 and over has increased by one-third between 1926 and 1979. Over the same period, however, the population aged 75 and over increased by almost half (46.6%). Recent projections indicate that while the total population will continue to increase, the rate of increase will be much greater for those aged 75 and over. This will mean that the existing trend of an increasing proportion of elderly persons living alone will be accentuated. Inevitably, many of these will require services of a supportive nature if they are to live independent lives in their own homes for as long as possible. It is recognised that if this is to be achieved elderly persons will require, among other things, an income sufficient to provide a reasonable standard of living. The whole question of income support, however, will be considered in a subsequent report from the Council.

This report is concerned primarily with a review of existing community care services for the elderly and with making recommendations for their improvement. It does not purport to be a comprehensive statement on the subject. The emphasis in the report is on statutory-based services and to a lesser extent on the role of voluntary organisations. Neither does it deal with the central role of family members, relatives and friends in caring for the elderly. The elderly without close family members represent a special challenge to statutory and voluntary services. The importance of social contact and support services for elderly persons living alone has been highlighted in the report of a survey carried out by the Society of St. Vincent de Paul. The development of community services would lessen the demand for more costly forms of institutional care. It is preferable both for economic and social reasons to provide services for elderly persons in their own homes rather than in institutions. Many patients in long-stay geriatric units are there for social rather than medical reasons. This is confirmed by a recent survey. Among the contributing factors is the pressure on the medical profession to admit elderly persons to long-stay beds. Admission may also arise from a crisis associated with
accommodation. Thus, for example, the dwelling may have deteriorated with age or neglect or a physical impediment of the elderly person may lead to problems with stairs or steps. An adequate community care service can help obviate or delay admissions to long-stay institutions. Admissions other than for medical reasons should, where possible, be avoided. Once admitted, elderly persons can quickly become institutionalised and dependent thus inhibiting the process of rehabilitation.

Certain principles are important and should, in the Council's opinion, be the foundation of policy for caring for the elderly in the community:

1. Elderly persons should, as far as possible, be enabled to live out their lives in their own domestic environment.
2. When that environment becomes or threatens to become unsuitable, the first priority should be to correct this.
3. Defective housing should be corrected rapidly. This presupposes a mechanism for detection of defects and for their immediate rectification. It should be possible to identify the need for special housing adaptation in the majority of cases.
4. Support services such as medical, nursing, paramedical, welfare, home help, and the services of voluntary organisations should be provided on a co-ordinated basis.
5. The maximum support should be made available to the elderly to enable them to cope with their domestic environment, and there should be the minimum restriction of their freedom and activity consistent with safety.
6. Because of increasing fraility and/or mental or physical handicap, the ability of elderly persons to cope with the domestic environment may be reduced. Only when this problem becomes insuperable should recourse be had to hospital or long-stay units.

The recommendations made in this report for improvements in community services are based on the foregoing principles.
II Review of Services

1. GENERAL PRACTITIONER SERVICES

At present about 35% of the total population are eligible for the full range of health services including general practitioner services. In this category are persons who are considered to be unable to afford general practitioner services for themselves and their dependants. Medical cards are issued to persons in this group for presentation when services are required. Eligibility for medical cards is usually determined by reference to income guidelines which are adjusted annually. From January 1983, for example, the income limits are £53.50 per week for a single person (living alone) and £77.00 per week for a married couple.

In addition, those persons receiving the full amount of certain means-tested or non-contributory pensions and allowances from the Department of Social Welfare or Health Boards will normally be entitled to receive a medical card without having their means further assessed. These include the old-age (non-contributory) and widows (non-contributory) pensions.

Furthermore, medical cards may be granted on a temporary basis to persons who would otherwise experience hardship arising from costs incurred on health services.

The availability of a medical card is an important asset to elderly persons. The possession of a medical card represents a form of security in the event of illness. Furthermore it removes the considerable anxiety which is often associated with medical expenses, an anxiety which is a particular characteristic of old age. The majority of elderly persons how have a medical card. The Council recommends that all persons aged 75 years and over be granted a medical card. The additional cost to the Exchequer of implementing this recommendation would not be significant.

At present General Practitioners are faced with an impossible task in looking after old people. Much of the morbidity of old people is related to the domestic environment.

Accommodation may be unsuitable, e.g. stairs may be a problem, heating may be inadequate or the heating method may be
difficult to operate; performance of full domestic chores may have become an unbearable burden. These and other factors are outside the capacity of the G.P. to deal with, and yet the well-being and health of the patient are being adversely affected.

Faced with this dilemma, the G.P. has no alternative, in many cases, but to seek institutional accommodation. The "organisation" recommendations later in this report are designed to deal with such problems through the anticipation of these environmental difficulties. In this way the care of the elderly can be improved and medical frustration eased.

The present Choice of Doctor Scheme has put first class medical care within reach of all eligible patients on a dignified basis. It's very success has, however, led to increased pressure on G.P.'s time. It is desirable that Health Boards provide adequate time and facilities for refresher courses for G.P.'s. Such courses would have a clinical content. More important they would enable G.P.s to be briefed on plans for development of services, and would contain contributions from para-medical disciplines such as physiotherapists, occupational therapists, speech therapists. In this way G.P.s would become aware of the help forthcoming from these disciplines and would be enabled to make better use of their services.

2. CHIROPODY SERVICES

Chiropody services for the elderly are provided by health boards and by local voluntary organisations, such as Social Service Councils and Care of the Aged Committees. The availability of services varies from area to area. The main difficulty in providing services is a shortage of suitably qualified personnel.

Although there is no statutory registration of chiropodists in Ireland, a list of persons eligible for employment as chiropodists with public bodies is kept by the Department of Health. To be placed on this list chiropodists must have satisfactorily completed a three year course in a recognised school in Britain or Northern Ireland (there is no Irish School) or otherwise satisfy a Committee known as the Chiropodists Assessment and Advisory Committee that their qualifications and experience indicate that they have reached an adequate professional standard. This Committee was set up some years ago by the professional bodies
with the encouragement of the Department of Health. There are currently 92 chiropodists on the official list. Forty of these are based in Dublin. Most chiropodists are in private practice and work for health boards or hospitals on a sessional basis. There are only two or three chiropodists employed full-time by health boards. A recent manpower study carried out by the Department highlighted the areas where chiropodists are in short supply. The study indicated that the position was as follows:

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Estimated Minimum Number of Chiropodists Required</th>
<th>Number of qualified Chiropodists Available</th>
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<tbody>
<tr>
<td>East</td>
<td>43</td>
<td>42</td>
</tr>
<tr>
<td>Midland</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Mid-West</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>North-East</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>North-West</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>South-East</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>South</td>
<td>24</td>
<td>9</td>
</tr>
<tr>
<td>West</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>148</strong></td>
<td><strong>89</strong></td>
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</table>

It will be noted that the greatest shortfalls are in the Southern, North-Eastern and Western Health Board areas.

In addition to the chiropodists who appear on the approved list there are a considerable number of chiropodists in private practice who do not have a recognised qualification and so may not be employed in the health services. The Irish Chiropodists Organisation which represents these people claims to have 600 members.

The Council considers that chiropody is a vital service for elderly persons in that the lack of an adequate service can severely restrict mobility. The present level of service is inadequate and should be increased especially in rural areas.

**The Council therefore recommends that a School of Chiropody be established.** Alternatively, it is possible that the existing
School of Chiropody in Belfast could accommodate students from the Republic. This possibility should be explored. The Council also recommends that the position of persons holding a chiropody qualification which is not recognised should be examined with a view to providing a further course which would lead to a recognised qualification.

3. OPTHALMIC SERVICES

Eligibility

Persons with full eligibility for health services, i.e. medical card holders and their dependants are currently eligible for ophthalmic services, including the supply of spectacles, from health boards.

In addition to the health board services, persons insured under the Social Welfare Acts, who satisfy prescribed insurance contribution requirements, are eligible for optical services under the Treatment Benefit Scheme operated by the Department of Social Welfare. This scheme covers a sight test and the provision of spectacles, but does not cover medical or surgical ophthalmic treatment.

Organisation of Services

Up to recently, persons eligible for free ophthalmic services from the health board were referred to ophthalmologists in health board clinics or hospital out-patient departments for an eye examination, and prescriptions were dispensed by an optician contracting with the health board for the supply of standard spectacles.

To make services more readily available, a separate sight testing service giving a choice of ophthalmologist/optician in private practice for eligible adults was introduced in late 1979. The existing county ophthalmologist continues to provide a full eye examination and treatment service. As part of this scheme, all eligible persons are now entitled to have spectacles dispensed by the optician of their choice.

Persons eligible for optical benefit under the Social Welfare Scheme can have their eyes tested, free of charge, by an ophthalmic surgeon, doctor or optician on the department’s Optical Panel. If glasses are prescribed the insured person can get these from an optician on the panel.
The vast majority of opticians are on the panels providing services under the health and social welfare schemes.

The Council recognises that, in general, the operation of the ophthalmic services is satisfactory. It recognises, however, that the main problem relating to these and other similar services is access by elderly persons living in rural areas. Furthermore, the Council notes with concern the length of time that persons have to wait to have cataract operations performed.

4. **AURAL SERVICES**

**Eligibility**
The categories of people eligible for aural services, including the supply of hearing aids, from health boards are the same as for ophthalmic services.

Under the Social Welfare Treatment Benefits Scheme an insured worker who satisfies certain contribution requirements can claim up to half of the cost of a hearing aid obtained through an approved supplier.

**Organisation of Services**
An eligible person with a hearing difficulty can be referred by his doctor to an ear, nose and throat specialist, or if the doctor considers a hearing aid is necessary, to the local health board. The health board arranges for the supply of a hearing aid through the National Rehabilitation Board. The N.R.B. provides assessment of hearing loss throughout the country. It operates permanent clinics in Dublin, Cork and Galway, and regular clinics in several other centres.

The Council is concerned about the cost and quality of aids for persons outside of the eligible categories outlined above and it therefore recommends that the service being provided by the NRB should be extended to those in Category II (persons with an income of less than £11,000 in 1982/83). Persons in this category, however, should be liable for the cost price of aids and should also be charged for audiometry.

5. **DENTAL SERVICES**

There are two types of free dental schemes, i.e., a Social Welfare scheme and a Health Board scheme.
The Social Welfare scheme applies to those persons paying the full social insurance contribution: Only the insured person is covered, not dependants. In the case of fillings, extractions and scalings there is no charge. For dentures the insured person pays approximately two-thirds of the cost.

Persons eligible for dental treatment under the Health Board scheme include those with full eligibility for health services, i.e., medical card holders and their dependants.

The latest assessment of dental services in Ireland is contained in the Dental Services Report (1979) prepared by a joint working party composed of representatives of the Department of Health, the Irish Dental Association and Health Boards. In relation to the Health Board scheme the report states that priority in the provision of treatment services is given to certain categories of patients, i.e., children, the aged, the handicapped and expectant and nursing mothers.

The Dental Services Report also points out that while there is considerable dissatisfaction with the Health Board services as a whole, the main complaints and criticisms are directed at the level of service provided for eligible adults. The Report indicated that returns from Health Boards confirm this situation. They show that the proportion of eligible persons treated in any one year is of the order of 10% which compares unfavourably with a demand rate of 25% under the Social Welfare scheme. Moreover, the treatments provided are for the most part extractions for the relief of pain and the provision of dentures.

In its assessment of the dental services the joint working party stated:

"While the services provided for children are better than those available for adults and their adolescent dependants, the overall situation is far from satisfactory and there are considerable disparities as between health board areas. It is clear that the health board dental service is not at present capable of providing an acceptable level of service for all eligible persons".4

The Council is concerned at the number of persons, in particular elderly persons, on waiting lists and the length of time that persons have to wait in order to receive treatment in parts of the country. The Council is also conscious of the fact that geographic location is an important factor in gaining access to dental servi-
ces. While recognising that a priority exists in relation to the
dental treatment of children, the Council nonetheless recom-
mends that sufficient resources be allocated to fund the adult
dental scheme especially as it affects the elderly, to ensure
that a uniform service is provided in all parts of the country.
The Council also recommends that consideration be given to
the provision of mobile dental clinics in rural areas.

6. PUBLIC HEALTH NURSING SERVICE

The public health nursing service provides a domiciliary nursing
service which includes nursing care of the aged.

At present domiciliary care of the aged is available to persons in
the following categories:—

Category I —
persons with full eligibility i.e. medical card holders

Category II —
persons other than those in category I whose annual
income in the year ended 5th April 1983 was less than
£11,000

Category III —
persons whose income is over the amount specified for
Category II but only to the extent that the nurse’s duties in
relation to persons in categories I and II permit.

The Survey of Workload of Public Health Nurses published in
1975 showed that 68% of all patients on the nurses’ current
visiting lists were aged over 65 years and occupied 38.9% of the
nurses’ home visiting time. The Survey also estimated that about
3% of the population over 65 needed intensive nursing attention.

While numbers of public health nurse posts have been increased
by about 50% over the last 7 years, there is still a shortage of
nurses. The overall national nurse/population ratio at present is
Workload of Public Health Nurses (1975) recommended an over-
all ratio of 1 : 2616. It is estimated that about 160 additional
nurses in all are required to meet this shortfall.

The Working Group also recommended that Superintendent
Public Health Nurses should ensure that an up-to-date register of
elderly persons be kept by each nurse on district duties.
Many community care areas have introduced comprehensive registers of all persons over 65 years of age, but even where these are held, there is a constant need for updating.

The Council recommends that the priority should be the keeping of a register of elderly persons at risk. The Council also recommends that there should be geriatric training for all public health nurses and specialised training for some.

The Working Party on General Nursing (1980) has made recommendations in regard to community nursing services after normal working hours and these recommendations are under consideration in the Department of Health. The Council recommends that resources be made available to allow Superintendent Public Health Nurses to arrange an acute nursing service for the terminally ill. Due regard should be had to the right of the elderly person to remain in his/her own domestic environment during the terminal phase of an illness.

Public health nurses visiting the elderly frequently have to deal with social and other miscellaneous problems not strictly related to nursing activity. Effective local voluntary activity, operating in close co-operation with the public health nursing service, could frequently cater adequately for many needs of the elderly and would reduce the nurses heavy workload in this respect. The Council recommends that a public health nurse be responsible for liaison with voluntary organisations at an operational level in each area. It should be the responsibility of the superintendent public health nurse to ensure that there is adequate liaison.

The Community Care Service should be responsible for ensuring that where there is a hospital admission it involves minimum disturbance to the well-being of an elderly person. This involves pre-admission assessment, effective liaison with hospitals and pre-discharge preparation. It should clearly be the responsibility of someone in the community care programme to perform these important functions. Public health nurses have been appointed as hospital liaison nurses in some areas. Where such nurses are operating the liaison service is generally effective. In general, however, the Council believes that stronger and more formalised links between hospital and community services need to be developed to provide for better continuity of patient care. Ideally there should be a policy of planned discharge from the time of admission and this would involve liaison with the patient’s
family. The Council recommends that hospital liaison nurses should be appointed in all areas.

7. PROFESSIONAL SOCIAL WORK SERVICE

During the past decade or so there has been a substantial increase in the number of social workers employed by Health Boards. In recent years Health Boards have drawn up areas of priority for social workers and inevitably child care tends to be the main priority. Senior social workers are conscious of the need to provide a service to the elderly. In practice, however, limitations in staff together with the fact that Health Boards have devolved their statutory responsibilities in regard to families and children at risk to social work teams has meant that social work services have largely been restricted to this area.

The Council is concerned that the social work requirements of the elderly should not go unmet. The Council recommends that a professional social work service to the elderly should be an integral part of the service provided by social work teams within the community care services of all Health Boards. This service should include help with problems of relationship, problems arising from crises due to death, change in social, medical, environmental or economic circumstances. Furthermore, professional social workers should have a role to play in planning and policy-making relative to the elderly. Social work courses should include more teaching on the process of aging and work with the elderly and more placements for students in organisations concerned with the elderly. In addition there should be post-graduate training in geriatrics for some social workers.

8. HOME HELP SERVICE

The Home Help Service became a specific, statutory health service with the coming into operation of Section 61 of the Health Act 1970. This Section reads as follows:

"(1) A Health Board may make arrangements to assist in the maintenance at home of:

(a) a sick or infirm person or a dependant of such a person;

(b) a woman availing herself of a service under Section 62 (which refers to maternity services) or receiving similar care, or a dependant of such a woman;"
(c) a person who, but for the provision of a service for him under this Section, would require to be maintained otherwise than at home, either (as the Chief Executive Officer of the Board may determine in each case) without charge or at such charge as he considers appropriate.”

It should be noted that Section 61 empowers but does not require health boards to provide a home help service.

Prior to the 1970 Act, health authorities operated informal schemes under the provisions of the former Home Assistance Code. In 1972 the home help service was formally introduced when the Minister allocated funds for the purpose to each health board. Since its inception voluntary agencies have been involved in many areas. Their knowledge of local conditions, relationships with persons in need and access to people who are willing to help make them eminently suitable to assist in the provision of this service. There are over 250 voluntary organisations providing almost 3,000 home helps. In addition, health boards directly employ a further 2,000 home helps. (See Appendix I, Table 1).

Persons Covered
There are no specific guidelines laid down by the Department of Health governing this scheme, rather the approach is to allow health boards and voluntary groups as much flexibility as possible in dealing with individual cases of need. Elderly persons, particularly those who are infirm or living alone, are regarded as a priority for attention and they constitute some 75% of the total number of beneficiaries. (See Appendix I, Table 2).

The number of elderly persons receiving a home help service represents just over 2% of the population aged 65 and over.

Cost
The expenditure on home help services by each health board, including grants to voluntary organisations providing a home help service, is given in Appendix I, Table 3.

Payment of Home Helps
Since its inception, the home help service has involved the maximum use of volunteers. Many of those involved give their time without charge, regarding their work as a friendly service to those in need.
Until recently, payments for home helps were agreed at local level. This led to variations in the amounts paid. Payments for full time home helps are now agreed at national level. The 1983 pay scale ranges from £91.00 to £99.38. Variations still exist in payments to part-time home helps who, in some areas, are paid as little as 75p per hour (December 1981 figures). There are also variations in the level of remuneration paid to home help organisers.

The Council considers that the home help service is a vital form of support for elderly persons living in the community and that it needs to be developed. Variations in the organisation and operation of the service between and even within health board areas, however, is a matter of concern. So great is the variation that the Council recommends that the Department of Health undertake a review of this important service.

9. BOARDING-OUT

In some parts of the country the boarding-out of elderly persons, mainly from institutions, is organised as part of the home help service. The boarding-out of elderly persons can be of considerable benefit in enabling them to obtain the care they need in the community. The Council therefore recommends that the boarding-out of elderly persons in a suitable environment should be encouraged, and that there is adequate supervision of such arrangements by the community geriatric team (see Section VI).

10. FUEL SCHEMES

While there are a number of schemes which are designed to help elderly persons and others meet their heating costs, the two main schemes considered here are the cheap fuel scheme and the national fuel scheme.

Cheap Fuel Scheme
This scheme was introduced in 1942 as an emergency measure to ensure a supply of fuel to the less well-off. In particular, the scheme was designed to protect the poor in urban areas against blackmarket prices for fuel. The scheme operates in seventeen
towns and cities which were designated in 1942, as "non-turf" areas but the list of towns has remained substantially the same since 1942. In general, the scheme has been changed very little since its inception.

Under the scheme, which runs from October to April each year, eligible persons receive a fuel allowance (voucher or cheque) which is currently worth £4 per week or £120 for the 30 week period of the scheme. Vouchers may be used to pay almost any kind of heating bill whether ESB, gas, heating oil or solid fuel. Prior to 1979/80 the fuel vouchers could only be used in exchange for turf or timber. A feature of the Cheap Fuel Scheme is that people who qualify do so, by and large, as of right and not at the discretion of the various local authorities who administer the scheme. Those eligible are persons receiving any of the following payments: Supplementary Welfare Allowance (as a basic payment), Non-Contributory Old Age Pension, Widow’s Pension (Contributory and Non-Contributory) and Unemployment Assistance (provided the recipient has dependants). These categories of eligible people were decided upon in 1942 and there has not been any addition to the list since then. The actual dispensing of vouchers or cheques is done in different ways in different places but usually involves either the local Community Welfare Office, the Post Office, the Employment Exchange or the local Town Hall.

**National Fuel Scheme**
This scheme was introduced in the 1980/81 winter and applies to the entire country, including the 17 urban areas covered by the Cheap Fuel Scheme. People who qualify under this scheme get a weekly fuel voucher to the value of £4 which, like its counterpart in the Cheap Fuel Scheme, may be used to pay for almost any kind of heating bill. In many parts of the country the vouchers are issued in either two or three instalments rather than weekly. In a few places vouchers are not used at all, instead an equivalent cash payment is made to people who qualify.

Unlike the Cheap Fuel Scheme there is no entitlement as of right under the National Scheme. The health boards, who administer the National Scheme, have been instructed by the Department of Social Welfare that eligible people are those "who are unable to provide for their heating needs from their own resources". The Department then elaborates on this by stating that beneficiaries
will usually be recipients of a long-term social welfare payment or health board payment, though receipt of such a payment does not necessarily qualify a person. In fact, the Community Welfare Officer is meant to investigate the means and family situation of each applicant before reaching a decision. In practice, the people who qualify are people on a long-term welfare payment who have no other income and who are either living alone or with another welfare recipient or with dependants (spouse and/or children). The Department’s directive as to who should qualify is open to interpretation and it seems inevitable that it will be interpreted in different ways by different health boards.

The National Fuel Scheme has no specific statutory basis though it is generally seen as an extension of the kind of provision which may be made under the Supplementary Welfare Allowance scheme.

Comment
The Council considers that the two schemes outlined above have some very unsatisfactory features. The Cheap Fuel Scheme was designed to deal with an emergency situation in 1942 and the reasons for confining the scheme to 17 urban areas would appear to have little relevance forty years later. Anomalies arise from this situation. For example, large segments of the Dublin city area lie within Dublin County Council’s jurisdiction and so are not covered by the scheme. This gives rise to a situation where one person qualifies for fuel vouchers simply by virtue of where he/she lives while another person of similar status does not qualify because he lives outside the designated areas. Another problem with the scheme is that some people qualify as of right for a voucher even though they may be well able to look after their own heating costs. This applies in particular to a woman in receipt of the contributory widow’s pension. The automatic entitlement for the widow is discriminatory since outside of the 17 urban centres people with much lower incomes may not qualify under the National Fuel Scheme.

The main problem with the National Fuel Scheme is that nobody is entitled as of right under it. People living in most of the country, which only has the National Scheme in operation, are therefore discriminated against, relative to those covered by the Cheap Fuel Scheme.
The Council recommends that a **uniform national fuel scheme be adopted** which would ensure that elderly persons in similar economic circumstances be entitled to fuel vouchers. In making this recommendation the Council recognises that questions of cost and entitlement have to be borne in mind. If a uniform national scheme is adopted it is recognised that either the cost could be much greater than at present and/or that certain categories of persons which benefit under the present schemes could lose eligibility. Various options for a uniform national fuel scheme are set out in Appendix II.

The Council welcomes the commitment made by the Minister for Health and Social Welfare in the Dail in February 1983 to have the fuel schemes reviewed with the intention of combining both schemes to provide a single scheme based on uniform criteria of eligibility. Before it is finalised the Council wishes to be consulted on an alternative scheme.

The present scheme commences in October and ends in April but the heating needs of elderly persons do not necessarily coincide with this period. **The Council therefore recommends that a fuel allowance be given during the summer months but at half the value of the allowance of the winter months.** The availability of vouchers during the summer months would also enable elderly persons to stockpile some fuel before the onset of winter and would ensure that they had sufficient fuel during cold spells outside of winter.

### III The Role of Voluntary Organisations

Voluntary bodies in Ireland have long been involved in providing community services for the elderly. Indeed, before the “community care” idea was taken up by the statutory bodies their voluntary counterparts were already applying the principle in their work. Several of the more important community care services provided now by the health boards such as home nursing, home helps and fuel schemes were, in fact, pioneered by voluntary organisations.

Prior to the mid-1960s much of the voluntary work undertaken on behalf of the elderly was linked to the church-related orga-
sations. Since that time there has been a very considerable expansion of services provided by more broadly-based community groups. In particular, the publication in 1968 of the Inter-Departmental Committee Report, *The Care of the Aged*, did much to stimulate the development of social service councils and similar bodies serving the needs of the aged. The impetus created by the 1968 Report has waned somewhat since about 1974 but the legacy of that period remains.

One can only guess as to the full extent of voluntary services in Ireland since detailed, accurate information is not available. An indication as to the number of organisations involved may be had from the fact that the *Directory of Social Service Organisations* (published by the National Social Service Council in 1980) lists more than 250 local voluntary organisations, most of which provide services for the elderly. These include social service councils and care of the aged committees and other community care organisations. In addition there are a number of organisations operating at national level which are concerned with the welfare of the elderly e.g. Society of St. Vincent de Paul, Friends of the Elderly and Alone. Information as to the number of people involved in voluntary work with the elderly is difficult to establish but it seems reasonable to assume that a very substantial number of volunteers are so involved. In fact voluntary service to the elderly constitutes the single largest area of voluntary activity in Ireland.

It is, however, clear that voluntary organisations provide a wide range of community services for the elderly. One major contribution is in the area of maintaining social contact through, for example, visitation, organising parties, outings and holidays, and through day centres. Another major area of activity is the provision of direct material assistance through, for example, fuel, laundry services, transport services, meals-on-wheels, provision of housing and house repairs. Voluntary bodies are also involved, though to a lesser extent, in paramedical services such as chiropody, occupational therapy and physiotherapy.

Ideally, it is generally agreed; elderly persons fare best where they are provided for by their own families and immediate neighbours, rather than by organised services whether voluntary or statutory. The Council believes that this informal caring should be supported and encouraged. The development of organised services for the elderly should not undermine the informal care
provided by neighbours and friends. Services provided by voluntary bodies have a number of distinguishing characteristics:—

(a) Voluntary services provide welcome diversity and, in some cases, an element of choice.

(b) Some services are more appropriately provided by volunteers than by statutory personnel e.g. all of the “social contact” services mentioned above.

(c) Voluntary organisations are sometimes innovative in a way which one cannot normally expect of statutory bodies.

(d) Most voluntary bodies are free from the bureaucratic procedures and narrow accountability which often characterise statutory bodies.

On a broader level, people’s involvement in voluntary services, whether for the elderly or other groups, does much to promote social cohesion and community development. In this case voluntary service has a significance far beyond the level of helping the elderly.

While the importance of the voluntary contribution to meeting the needs of the elderly is not in dispute, it would be wrong to deny the existence of certain problems. The effectiveness of community care services, as they have developed since the establishment of the health boards, has not yet been adequately evaluated. Neither has there been any thorough evaluation of the voluntary component within the overall community care services.

A feature of voluntary activity is that it takes different forms in different parts of the country. This variation is, in itself, welcome. But this also means that the spread of voluntary services around the country is uneven and that the level of development and sophistication is equally uneven. In some parts of rural Ireland especially, there is a low availability of voluntary services for the elderly precisely where such services are most needed (see Section V).

The question of funding voluntary services for the elderly is also a cause for concern. To a larger degree voluntary bodies rely on grants from the health boards (under S.65 of the Health Act, 1953) as their primary source of funding. These grants are not
confined to groups working with the elderly; they may be paid to any organisation which provides a service which is "similar or ancillary" to a service which the health board may provide. A number of difficulties arise in this context. Firstly, there is no agreed definition of what is meant by "similar or ancillary". Secondly, S.65 grants are discretionary and there is no obligation on any health board to fund any particular voluntary service. There seems to be great variation in practice from one area to another as to which kinds of voluntary bodies are grant-aided by the health boards. Organisations working with the elderly are competing for S.65 grants with all kinds of other bodies (e.g. handicapped, child care) on an annual basis. It would be particularly helpful if groups working with the elderly could rely on continuing availability of funds without the annual competition from other voluntary organisations. One possible solution might be to revive the practice of each health board having a specific allocation for grant-aiding care of the aged activities. This was the practice for a number of years up to 1974 when, apparently, this specific allocation was merged with the general S.65 grants. The Council endorses a recommendation made by the National Social Service Board for "a clarification and rationalisation of the procedures whereby voluntary bodies are grant-aided by health boards".6

Perhaps the greatest constraint experienced by voluntary groups concerned with the elderly (in common with other groups) is the fact that they are operating in a policy vacuum, i.e., there is no overall policy framework for the development of the personal social services in Ireland. In the absence of such a policy framework an integrated approach to service delivery is impossible to achieve. For voluntary groups working with the elderly the consequence of this policy vacuum is that their efforts and those of the statutory bodies very often do not properly mesh together to achieve their common purpose.

Action on this issue is vital in the interests of achieving the best possible level of community services for the elderly. The Council recommends that all Health Boards be obliged to provide community organisers to work with voluntary groups. The main task of these organisers would be to give a full-time back up to voluntary workers and to deal with areas such as assessment of needs, reviewing and improving services, motivating others to become involved and liaising between voluntary and statutory
bodies. The Council also recommends that there should be a representative from the voluntary sector as of right on each health board.

Because of the important role of voluntary activity in the care of the elderly, the Council proposes to prepare a separate report on this subject.

IV Repairs to dwellings of elderly persons.

Essential Repairs Scheme
An essential repairs grant which was introduced in 1962, is available for houses in rural areas which cannot be made fit for human habitation at a reasonable cost and where the repairs being undertaken are necessary to make the house habitable for the lifetime of the present occupiers (usually elderly persons). Grants can be given only if the repairs cost less than £2,000. However this does not mean that a grant of £2,000 is payable. The maximum amount of the grant is £600. The grant is paid by the local authority which then recoups half the amount from the Department of the Environment. The local authority can carry out the work itself and its contribution may be both in cash and in kind, e.g. materials. In some areas local authorities have carried out repairs by direct labour and this has proved satisfactory. The Council recommends that local authorities should make arrangements to carry out the necessary work under this scheme. The Council also recommends that local authorities be allowed discretion to carry out work which is not of a structural nature e.g. provision of a solid fuel cooker or rewiring.

Task Force
In April 1982 the Government established a special Task Force to deal with improving the housing conditions of elderly persons. The Task Force is composed of representatives of Government Departments, local authorities and voluntary organisations.

The Task Force’s initial budget of £1 million was allocated to health board areas. Those benefitting under the scheme are old
people living alone in unsanitary or unfit conditions and who are not in a position to carry out work necessary to bring their living conditions up to an acceptable standard.

The types of work which qualify under the scheme include the provision of water and sanitary facilities; necessary repairs to make dwellings habitable “for the life time of the occupant”; refurbishing; cleaning; redecoration; fire place installation and the provision of food storage facilities. Various voluntary organisations working with the elderly are asked to identify individual cases which would benefit under the scheme.

Since satisfactory housing conditions are a prerequisite for enabling elderly persons to live in their own community the Council welcomes the decision of the Government in establishing the Task Force and notes with satisfaction that a further £1 m. was made available in 1983. The Council recommends that the scheme be continued for as long as is necessary. Furthermore, in the operation of the scheme it is essential that priority be given to elderly persons living in the worst housing accommodation.

V The Elderly in Rural Areas

Proportionately more elderly persons live in rural areas than in urban areas. In general, counties in the west of Ireland, the least urbanised region in the country, have proportionately more elderly persons. In 1979 for example, 17.3% of the population in County Leitrim was aged 65 and over. This was the highest figure. The corresponding figure for County Kildare was 7%, the lowest of any county in the country. In all of the counties in the west of Ireland the proportion of the population aged 65 and over was higher than the national average.

Apart from having relatively high proportions of elderly persons, many rural areas are characterised by a low density of population. Once again, areas in the west of Ireland have the lowest density of population. This poses problems in providing services and the cost of providing services is an important factor in areas outside of towns and villages.

Transport

Since most of the services are located in urban areas it is important that elderly persons have reasonable access to these servi-
ices. Some members of the rural population live at a considerable distance from services. In 1980, for example, two-fifths (40%) of the medical card population in the Western Health Board area lived more than five miles from their doctor. The corresponding figures in the Eastern Health Board area was one-twentieth (5%).

Ironically, elderly persons living in some rural areas who are entitled to free travel are unable to avail themselves regularly of this facility either because the public transport system is non-existent or inadequate or because they reside at a considerable distance from the main thoroughfares.

The lack of access to transport may reduce access to a range of services such as shopping, religious services, health services, available in towns.

Health Boards can provide transport facilities to bring patients (both out-patient and in-patient) to Health Board institutions or to centres where they can avail themselves of various health services. Health Boards may use their own vehicles or hire privately-owned vehicles for patients. The costs incurred in providing transport is relatively high.

The Council recognises that the whole question of transport for the elderly requires further detailed examination. However, it recommends that, **some form of subsidy should be provided for transport in rural areas for elderly persons where public transport is inadequate.**

**Other Problems**
Elderly persons living in urban areas are likely to have greater access to services provided by statutory and voluntary agencies than the elderly living in rural areas. The vast majority of voluntary organisations are based in urban areas and while some may cater for the immediate hinterland it is the population of the urban area itself which receives most attention. Less time is spent by voluntary workers in travelling to the aid of elderly persons in urban centres and consequently it is possible to deal with problems more promptly. In urban areas the general welfare of elderly persons can be monitored by voluntary workers more closely and more frequently. Home helps, home visitation, domiciliary and out-patient services can be provided more speedily in an urban setting. Furthermore, voluntary workers (who are normally based in urban areas) while prepared to work in an urban
area may be less inclined to travel into the countryside to tend to elderly persons living wide distances apart, often in remote locations.

Particular problems can arise in relation to the provision of meals-on-wheels in rural areas. Thus, for example, transport costs can be high due to the distance between the centres where meals are prepared and the dwellings of recipients. In fact the transport costs can exceed the cost of the meals. The Council recommends that Health Boards explore the possibility of having meals provided on a one-to-one basis by neighbours in rural areas where it is not possible to provide a meals-on-wheels service.

VI Organisation Recommendations

To achieve greater co-ordination in the planning and delivery of services at local level, the Council recommends that Health Boards should have a statutory obligation to provide community geriatric services similar to the obligation to provide child health services. The Director of Community Care should have an obligation to develop multi-disciplinary teams to be known as Community Geriatric Teams, in each district covering a population of 25,000 to 30,000. This team would consist of a public health nurse (with special training in geriatrics), an area medical officer, a community physiotherapist and an occupational therapist. The key person on the team would be the public health nurse who would be involved full-time with the elderly. Other members of the Team would not be exclusively concerned with the elderly but would be available as the occasion demanded.

There may be difficulties in providing physiotherapists and occupational therapists as recommended since the majority work in hospitals. The Council therefore recommends that physiotherapists and occupational therapists be appointed to community care services by Health Boards either on a full-time basis or on a shared basis with hospitals. The Team would maintain liaison with other relevant personnel and would be expected to acquire expertise in the same way as Child Care Teams.
The Team should have responsibility for the following functions within its district:

1. Be involved in an overall plan for the elderly within the Health Board area and to be responsible for implementing a local geriatric plan. This local plan would take into account geographic distribution of elderly persons and the changing demographic situation. The local plan would also have regard to the entire range of facilities available to the elderly. As part of this plan, for example, the Team could be involved, in conjunction with local authorities, in identifying sites for special category housing.


3. Be involved in pre-admission assessment of all routine admissions to long-stay institutions and Welfare Homes.

4. Establish close liaison between the hospital/nursing home including the community hospital where it exists and the home of the patient.

5. Be involved in the boarding-out of elderly persons.

6. Be consulted on the allocation of tenancies of local authority dwellings for elderly persons.

7. Establish and maintain liaison through the Director of Community Care with local authorities with a view to having necessary repairs carried out on dwellings of elderly persons.

8. Work closely with voluntary organisations in the district.

The Housing and Institutional Care Committee of the Council is examining the desirability of having a broader-based team covering three or four districts with a total population of 75,000-100,000 whose function would be the integration of all services (hospital, community and housing) at this level. The Council is giving consideration to this matter and will make a recommendation in a later report.
### TABLE 1

**NUMBER OF HOME HELPS EMPLOYED***

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<tr>
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<td>F/T</td>
<td>P/T</td>
<td>F/T</td>
<td>P/T</td>
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<td>-</td>
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<td>6</td>
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<td>-</td>
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*The statistics given above include home helps employed directly by the relevant Health Boards and those employed by voluntary agencies, which receive grants from Health Boards to provide a home help service. The figures represent the position as at 31st December of each year.*
### TABLE 2

**BENEFICIARIES OF HOME HELP SERVICES**

(a) = Total number of beneficiaries  
(b) aged beneficiaries

<table>
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<td>231</td>
<td>270</td>
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<td>321</td>
<td>359</td>
<td>882</td>
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<td>(b)</td>
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<td>293</td>
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<td>503</td>
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<td>545</td>
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</table>

The statistics given above include beneficiaries of home help services provided by the relevant health boards and those provided by voluntary organisations funded by health boards. The figures for 1974—1979 represent the position at 31 December of each year. The total number of beneficiaries in any year would be higher. The 1980 and 1981 figures represent the average over the year.
# Appendix I

## Table 3

**Expenditure on Home Help Services**

<table>
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<tr>
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<td>305,845</td>
<td>342,000</td>
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<td>South Eastern</td>
<td>44,000</td>
<td>76,993</td>
<td>98,766</td>
<td>N/A</td>
<td>126,878</td>
<td>171,229</td>
<td>246,250</td>
<td>213,074</td>
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<td>Southern</td>
<td>64,645</td>
<td>125,709</td>
<td>160,340</td>
<td>N/A</td>
<td>247,895</td>
<td>320,207</td>
<td>384,000</td>
<td>563,469</td>
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<tr>
<td>Western</td>
<td>174,175</td>
<td>271,705</td>
<td>140,156</td>
<td>N/A</td>
<td>400,000</td>
<td>455,564</td>
<td>630,425</td>
<td>644,287</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>627,588</strong></td>
<td><strong>1,132,289</strong></td>
<td><strong>1,114,490</strong></td>
<td><strong>1,565,000</strong></td>
<td><strong>1,872,423</strong></td>
<td><strong>2,489,315</strong></td>
<td><strong>3,357,761</strong></td>
<td><strong>N/A</strong></td>
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*The figures given include expenditure by the Health Boards for home help services provided directly by the Boards and expenditure by way of subsidy to Voluntary Bodies providing home help services on behalf of the Health Boards.*

**The Figures for 1974 relate to the nine month period ending 31st December 1974.*
APPENDIX II

SOME OPTIONS FOR A UNIFORM NATIONAL FUEL SCHEME

At present there are approximately 55,000 recipients of fuel vouchers under the Urban or Cheap Fuel Scheme and 88,000 under the National Fuel Scheme. The total cost (excluding administration) is £17.16 million.

The following are some options which might be considered in introducing a uniform National Scheme.

1. Cheap Fuel Scheme Only
   This would involve an extension of the existing Cheap Fuel Scheme (Urban Scheme) to the rest of the country. This would involve considerable extra cost since eligibility would be extended to all recipients of Unemployment Assistance with dependants and to all recipients of Widows Contributory Pension. On the other hand recipients of Deserted Wives Allowance, Unmarried Mothers Allowance, Invalidity Pensions, Disability Benefit and Deserted Wives Benefit are not included in the Cheap Fuel Scheme but may benefit from the existing National Fuel Scheme.

2. National Fuel Scheme Only
   This would involve the abolition of the existing Cheap Fuel Scheme. It would also involve removing eligibility from some recipients of Widows Contributory Pension and all recipients of Unemployment Assistance with dependants. The main disadvantages would be that the Scheme is administratively cumbersome and there is not entitlement as of right.

3. Free Electricity Allowance as Guideline
   The electricity allowance is largely confined to elderly persons living alone or with dependants. The number of beneficiaries is 144,000. Many of the existing categories (e.g. recipients of Unemployment Assistance) who benefit under both the existing Cheap Fuel and National Scheme would lose eligibility. The cost of the winter scheme would be £17.28 million and an all-year scheme would cost £23.62 million. The main advantage of using the free electricity allowance as a guideline is that it would be easy to administer.
4. Elderly persons with Social Welfare Payment

This would apply to all persons over 66 who are in receipt of a Social Welfare Payment (whether old age pension, retirement pension, widows pension and others). The number of persons involved is 277,000. The cost of the winter scheme would be £33.24 million and an all-year scheme would cost £45.43 million. The scheme could be administered by the Department of Social Welfare. Some savings would be effected by confining the benefit to one recipient per household but this would involve extra administrative work.

REFERENCES


National Council for the Aged Publications

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<th>Title</th>
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<tbody>
<tr>
<td>1. Day Hospital Care</td>
<td>April 1982</td>
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<td></td>
<td>A Discussion Document</td>
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