INSTITUTIONAL CARE OF THE ELDERLY: A COMPARISON OF THE CITIES OF NEW YORK, LONDON AND MANNHEIM


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INTRODUCTION

Most developed countries can expect to have increasing numbers of elderly (over 65) in their population in the next decades. Optimal provision of care for the elderly, no longer capable of totally independent living, remains a major challenge. For many elderly, some form of institutional care will always be necessary. Each country has already developed a system of such care and a cross-national comparison of systems may illuminate possibilities of institutional care and the advantages and disadvantages of the alternatives.

The US-UK studies of the elderly (Mann, 1980) have focussed on the institutional provision for the elderly in the cities of New York and London (Gurland et al., 1979). The two city comparison has been extended to include the city of Mannheim, West Germany. A summary of the data from the three cities comparing the system of institutional care and the health status of a random sample of residents is presented here. A random sample of Care Staff was also interviewed in each city.

The two European cities have a somewhat larger proportion of elderly citizens but the age and sex distribution between the three cities appear similar. The number of institutional places per 100 elderly of the population and the proportion of places in
institutions providing a medico-nursing type of care versus residential care are shown in Table 1. It can be seen that despite having a smaller proportion of elderly amongst its population, New York provides a larger proportion of places than the European cities. **Nursing Places:** New York: skilled nursing facilities. London: Psychiatric or Geriatric Hospital wards. Mannheim: Altenpflegelheim. **Residential Places:** (personal day-to-day assistance, nursing and medical help not available in situ). New York: Health Related and Domiciliary Care facility. London: Residential Homes. Mannheim: Altenheim. (Special housing available in London and Mannheim is not included in this study).

Table 1 also compares the financing of institutional care in the three cities. In New York the majority are in private ownership, in London in public ownership and in Mannheim the majority are owned by voluntary organisations.

**METHOD**

A long-term care facility for this study was defined as a place where 4 or more unrelated elderly can live together for more than 6 months and take communal meals.

In New York and London a random sample (n = 24) of institutions was drawn from a list of all facilities meeting the above definition. Patients were selected at random to give a 0.5% sample of all in care. In Mannheim all institutions with more than 50 residents were selected for study, a 1/7 sample of females being studied. (To make a comparison, the males in the samples in London and New York have been omitted in this three city study.)

All selected residents were assessed by semi-structured interview (CARE. Gurland et al., 1977). Assessment methods have been described in full elsewhere (Gurland et al., 1979). In Mannheim an abbreviated version was used. Patient comparison is presented for (1) dementia (responses to the Organic Brain Syndrome Scale, 11 item, score \( \geq 8 \) = severe dementia). (2) depression (abbreviated depression scale, 6 item, score \( \geq 2 \) = depressive symptoms and (3) ADL Scale (0-41 point scale indicating impairment of activities of daily living). Depression items were only scored for subjects scoring \(< 8\) on the OBS scale. A random sample of Care Staff working in the institutions chosen for the resident study was also assessed using a semi-structured interview, The Nurses Aid Interview (Godlove et al., 1980).