Population trends in the United States highlight continuing growth in the proportion of those over age 65, mimicking the experience of Western Europe over the last four decades. Culturally congruent models of geriatric care that have developed in these countries may have particular relevance to U.S. health care planners faced with challenges associated with an aging population. A 1993 World Health Organization (WHO) Fellowship visit to long-term care facilities in four European countries to study nursing and interdisciplinary practice of high quality, restraint-free care (Evans, 1996) also provided observations about geriatric care in general. In all, 19 facilities providing long-term care for older adults were visited in Scotland, Sweden, Norway and Denmark; 10 of the facilities were similar to American nursing homes, and 9 provided inpatient psychiatric care. Observations from these visits will be used to illustrate the trends in geriatric care documented in the literature.

BACKGROUND

In the United States in 1900, only one in 25 Americans was over age 65, whereas in 1994, those over 65 represented about 12% of the population. Predictions are that between now and the year 2050 the elderly will more than double to 80 million, with as many as 1 in 5 Americans being over age 65 (U.S. Bureau of the Census, 1995). Yet some countries in Western Europe are already approaching the 20% level (Church, 1996; Nordic Statistical Secretariat, 1996; Swedish Institute, 1992). Among the countries visited, Denmark and Scotland were most similar to the United States (15% vs. 12% elderly respectively in 1994), but both Sweden (currently at 17.5%) and Scotland are expected to exceed 20% by the year 2020 (Nordic Statistical Secretariat, 1996; U.S. Bureau of the Census, 1992). Women live longer in all countries, but in Norway and Sweden, women reaching 65 in 1994 were expected to live to age 84. These trends are attributed to the successful efforts of many countries to improve standards of living and health. The experience of the European countries has been referred to as the silent revolution, where the aged are increasingly "occupying the center stage," both in terms of numbers as well as

ABSTRACT

The proportion of older adults in Western European countries, as in the United States, continues to increase rapidly. Faced with geriatric care dilemmas decades earlier, however, these countries have had more experience on which to base the development of community-based, integrated care systems for the elderly. This article provides observations from a 1993 World Health Organization Fellowship study of long-term care facilities in four European countries: Scotland, Sweden, Norway and Denmark. Several emerging trends in geriatric care documented in the literature were confirmed. These included: moratoria on institutional long-term care, emphasis on informal care and support, provision of 24-hour assistance in the home, care management to individualize care, and an expanded set of providers within integrated delivery systems.

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demands for services (Devere, as cited in Coleman, 1995, p. 456).

**OBSERVATIONS FROM THE WHO VISIT**

In Western Europe, planning for health and social services for the older segment of the population is clearly influenced by an early and strong commitment to the WHO focus on primary health care with the goal of health for all by the year 2000. Each of these countries incorporated the WHO goals into health care reform legislation, and all have moved rapidly toward their achievement. In each country there can be seen a congruence between sociocultural values and the health care system (Evans, 1996).

**Scotland**

Scotland’s 50-year-old National Health Service (NHS) has been influenced by several important legislative changes in the past 8 years. In 1989, an initiative entitled Working with People (Scottish Office, 1991) resulted in a set of charters in which the NHS pledged to partner with people in communities to improve health, and the people assumed responsibility for changing personal health care behaviors. The Community Care Act of 1990 emphasizes community-based primary health care as opposed to institutional care and provides for the broad use of care managers (primarily social workers) to coordinate care for the frailest people (Bronthon, 1995). Collaboration between social services, health services and the general practitioner is a requirement. Additional themes in health care reform in Scotland include the decentralization of control to the local authorities (e.g., governance of NHS hospitals by a local Trust) and privatization (e.g., outsourcing for hospital services, for-profit nursing homes, private group homes for dementia patients).

The Scottish model of primary care is a well-developed and important cornerstone for health care. The general practitioner (GP) serves in the gatekeeper capacity, with support available from nurse health visitors, community health workers and district health nurses. A recent law requires the GP to provide a minimum of one health review annually for all patients over age 75. The GP can prescribe other services (e.g., social services, domiciliary or respite care, hospital at home [Iliffe, & Gould, 1995]) and also refer for specialist care. Geriatric specialists (geriatricians) are assigned to a geographic “catchment area,” work with an interdisciplinary geriatric team, and control access to specialized geriatric services. These include inpatient geriatric units in community hospitals, psychogeriatric units in psychiatric hospitals, day hospitals (which fill the gap between acute and community-based care for the more frail), geriatric outpatient services, specialized home care, domiciliary care, and continuing care (nursing home) facilities. Thus, the more complicated needs of older high-risk patients can be better managed.

A strong emphasis has been placed on improving the knowledge and skill of the GP in care of the elderly, with a recent focus on recognition, diagnosis and management of dementia, including assistance to families. At the University of Stirling, a national effort has been launched, using techniques similar to those of pharmaceutical companies wishing to influence physicians’ prescribing patterns, to help clinicians to incorporate assessment and care management strategies into their practices (Alzheimer's Disease Society, 1993).

The concept of a “respite flat” (apartment) offers an example of how families are supported in caring for frail elders. In this program, it is possible for a family to take a holiday together, at the shore, for example, with personal care and health services being provided by onsite staff. This enables the entire family to remain together while the primary caregiver benefits from a respite from care tasks. Although there is renewed emphasis in Scotland on community-based care, the charter for people in continuing care nursing homes (Directors, 1993) is supportive of high quality institutional care. Entitled “Helping people to feel at home,” it promises residents choices in daily living, promotion of independence, respect for personal identity and privacy, a “named nurse” or “key worker” (similar to the concept of primary nurse or nursing assistant), emphasis on quality of life, and a comfortable death with dignity.
Scandinavia

In the Scandinavian countries, a highly developed social welfare system has been in place for many years to provide cradle-to-grave health and social services. There are many similarities with the Scottish system. The values in Scandinavian health care include continuity, self-determination, and community living (Cates, 1993).

Sweden. In Sweden, health care legislation passed in the 1980s specified a requirement for “individualized care” for every long-term care resident. Observations in nursing homes demonstrated how this goal is being carried out. The environment is very homelike, incorporating furnishings and artifacts that would be found in the homes of the elders now residing there. Personal choice is provided in all aspects of daily living, including time of rising and going to bed, dressing, bathing, eating, artwork and music selection and so on. Staff pay special attention to each resident’s usual patterns and desires, incorporating these into the daily life and care for the person. Recognizing that nursing homes have a tendency to create rather than prevent dependency, individualized care respects the older person’s need to continue to be responsible for personal space and clothing with assistance from a nursing assistant (“helper”).

Increasingly, 24-hour home care and housing alternatives are being developed as a way to decrease overuse of institutional care. Intermittent care programs make use of the continuing care (nursing home) environment for short-term admissions of patients from the community; in-depth assessments and treatments are provided during the brief (e.g., 2-week) admission while families are provided a planned period of respite (Berthold, Landahl, Larsson, & Svanborg, 1989). Such a program supports the ability of families to continue to care at home. During the periods at home, support and continuing rehabilitation services are offered. When the person requires increasingly intensive continuing care, long-term admission is possible if desired; knowledge of the person and continuity of care is assured since the person is admitted to the same facility with the same staff that has provided intermittent care all along.

Norway. In Norway, one nurse’s statement reflects the deep cultural respect for patients’ freedom of choice, autonomy and ability to negotiate risk-taking in living as unrestricted a life as possible. He said, “We have to take a lot of chances when we care for elderly.” Schools of nursing have based their curricula on a philosophy of caring. Efforts are underway to reduce fragmentation of care, improve continuity and quality of community-based care as decentralization to the level of municipalities occurs (Cates, 1995). In Oslo, an example of interdisciplinary collaboration between psychogeriatric and geriatric nurses was observed, in which the nurse from the psychogeriatric unit visited the nursing home to provide consultation to the staff regarding care of elders with dementia and depression.

Denmark. In each Nordic country visited, use of Orem’s self-care deficit theory was prominent; the theory fits well with the philosophy and values of these countries, e.g., respect for autonomy and decision-making and assistance provided at the level of compensation needed. At Skaevinge municipality near Copenhagen, Denmark, a former nursing home was converted to a health care center, with sheltered apartments (a mix between independent and assisted living), guest apartments (similar to subacute beds in American nursing homes, but for short-term use by community-dwelling elders who require assistance with recovery), and a day health center open to all citizens irrespective of age (Cates, 1994; Coleman, 1995; Wagner, 1992). Consistent with the self-care model, residents were viewed as adult pensioners with the right to self-determination and personal decision-making. Interdisciplinary primary teams of home helpers, nurses, and nursing assistants provided care within a small geographic “neighborhood,” including patients living in the sheltered apartments as well as those in the community. Each patient had a specific “named helper” (primary nurse or aide); a central triage system facilitated the work of the “night patrols,” those nursing staff who provided personal care or more emergent services during the evening and night. While Denmark has a moratorium on new long-term care beds (Hennessy, 1993), relation-
ships and normalcy in the environment are also stressed in the remaining nursing homes.

COMMON TRENDS
IN EUROPEAN ELDER CARE

Several trends common to care of elderly were observed across all four countries (Coleman, 1995):

- Institutional long-term care beds have been capped and/or reduced, with renewed emphasis on repairing and upgrading existing housing to accommodate those with disabilities and providing housing alternatives, including assisted living, group homes, foster homes, and so on, so that people can continue to live in the communities to which they are accustomed (Cates, 1993). A central policy issue is to what extent should there be publicly financed institutional long-term care. While there is no evidence that community-based care is any less costly, there is nonetheless both cultural and policy support for home-based care in all three Scandinavian countries as well as in Scotland (Cates, 1993). Twenty-four-hour home health services, providing the full range of personal care and skilled nursing, are available for persons in all types of residences.

- Informal care from family members and neighbors is emphasized and supported. For example, family care leave has long been in existence (Cates, 1994). Family members who leave the work force to provide care for frail elderly at home may be eligible for subsidy or actually be employed to provide this care. Extensive respite services and caregiver information and training programs, both from social and health services sectors, support families in their caregiving roles.

In each Nordic country visited, use of Orem’s self-care deficit theory was prominent...

- Care management to individualize care in the home or institutional setting is an important component. The concept of the “named nurse” (primary nurse or caregiver) provides for accountability and enhances continuity, individualization and quality of care and patient satisfaction.
- Responsibility for design, implementation, management and payment for health care is decentralized to local governments (county councils and municipalities). This permits the development of services that are more sensitive to the needs of particular communities, as well as a sense of ownership.
- The typical “provider system” has been expanded to include other services not normally included such as “night patrol” and 24-hour care at home, volunteer services, and emergency services. Social and health care systems are increasingly well-integrated to include private and public sector services, with institutions assuming new roles in providing community-based services; thus, much of the problem of care fragmentation and so on is diminished. Home care programs use the concept of the neighborhood-based team extensively, provide for coordinated, integrated services, provide 24-hour care and home alarms to those who need them.

As might be surmised, local governments face tremendous fiscal and budgetary pressures (Stallknecht & Jespersen, 1996). There continue to be enormous cost increases in institutional care even though more care is being provided in the community; this relates to the fact that those remaining in institutions are much more frail and that quality of care and staffing have also been improved (Cates, 1993). Competition at the local level over limited funds raises public policy concerns regarding whether communities can really be trusted to “do what is right,” especially for the frail elderly.

Communities and states in the U.S. have already begun to face many of these same challenges. Since a common goal is shared, that of providing the best possible care to an aging population, knowledge of the European experience could inform decision-making as U.S. health care undergoes reform.

REFERENCES


KEYPOINTS

1. Since Western European countries have been confronting the dilemmas associated with caring for a burgeoning older population for several decades, models developing in Europe may have relevance for the United States as it faces unprecedented growth in its aged.

2. Scotland and Scandinavia have already begun to implement structures to respond to the increasing need for services to older adults.

3. A cornerstone of all care models is an emphasis on community-based as opposed to institutional care, on individualized care management by a primary nurse or caregiver, a decentralization of responsibility for services to the level of the local government, public-private partnership in provision of integrated services, and support of informal caregiving.


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