AN ORDINARY HOUSE ON AN ORDINARY STREET:

A COMMUNITY-BASED ALTERNATIVE MODEL FOR

HOUSING THE AGED IN SOUTH AFRICA

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DECLARATION

I, Gaetano Anthony Mercorio, declare that the dissertation entitled AN ORDINARY HOUSE ON AN ORDINARY STREET: A COMMUNITY-BASED ALTERNATIVE MODEL FOR HOUSING THE AGED IN SOUTH AFRICA is my own work, and that the work of other authors and sources has been acknowledged by means of references.

Signed ..... **Date** .....

ABSTRACT

This study proposes an alternative model for housing and caring for the aged, without admitting them to the care of total institutions. Ordinary houses on ordinary streets are converted into neighbourhood old age homes in which a small number of elderly people live together. The home may be sponsored by any body, and, other than the cost of purchasing the house and furniture, it can be financially self-sufficient.

The study seeks to examine the difficulty of defining old age, the phenomenon of ageing populations and discrimination against the aged. It provides a brief history of old age homes. Issues in the care of the elderly are discussed, including the role of the state and the individual, and categories of the aged and housing for these groups. Some major controversies in the field, notably the question of age-segregated or age-integrated housing, institutional versus community care and the dangers of moving the aged, are described.

The study analyses the South African system of care for the elderly, and highlights the problem of the present focus on expensive institutional care. The suitability of this model of care is questioned and it is recommended that the small neighbourhood old age home model be introduced to broaden the existing continuum of care.

The Abbeyfield Society of Great Britain, which pioneered this model of housing and caring for the elderly is described. The model is examined in detail. Finally, the study explores the work of the Catholic Welfare Bureau in Cape Town, which has implemented and adapted this model in South Africa. This agency's network of neighbourhood old age homes will be extended to include care for the frail aged, and the basis of its planning proposed for this phase is examined.

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INTRODUCTION

South Africa has an ageing population. Each year the need for housing and care for the aged is growing. Care for the aged has, however, not kept pace with this increasingly elderly population. Most organised residential care for the aged has been in the form of large state-subsidised total institutions. Not only are such institutions costly to build, maintain and operate, but also their suitability for housing the relatively fit elderly has been questioned extensively in Britain and America in recent years.

This study proposes a community-based alternative model for housing the elderly in ordinary houses on ordinary streets, which are converted to group homes for small numbers of aged people. The sponsoring body provides a supportive service, while encouraging the elderly residents to remain as active as possible. The model vigorously promotes maximum possible engagement between the elderly and the surrounding community, and is based on the belief that old people are a necessary and important group in society, and that their continued life within their familiar surroundings is healthy both for them and the other age-groups living there.

This study does not seek to denigrate institutional care. It acknowledges the role institutions have to play with the elderly who are so mentally or physically weakened that they require institutionalisation. The study does promote the belief that the

fit and semi-frail aged should remain within the community for as long as possible. The neighbourhood old age home model is proposed as a feasible new option for the elderly who are either unable or unwilling to live alone. In this way the study seeks to broaden the existing South African continuum of care for the aged.

The study consists of five chapters in the following order:

Age, ageing and ageism
Housing and the aged
The aged in South Africa
The Abbeyfield model of community-based homes for the aged
An ordinary house on an ordinary street

The first chapter, "Age, ageing and ageism" explores the difficulties experienced in finding a comprehensive definition of old age, and selects a definition for the study. The phenomenon of population ageing is examined. Discrimination against the elderly, ageism, is analysed in terms of a society fascinated with youth and economic power.

"Housing and the aged", Chapter Two, places the importance of housing to the aged in context. It also debates the question of the responsibility of the government, the family and the individual in the care of the elderly. A brief history of old age homes is provided, followed by an exposition of the major different forms of housing for the aged.

This chapter also includes a brief description of some controversial debates in the field of geriatric care. Cardinal among these is the question of whether Western society does offer the elderly a significant degree of choice in their own care, or whether the social services tend to decide what is best for the old. Institutional care is viewed in relation to community-based alternatives. Age-integrated and age-segregated housing systems are discussed, together with the issue of the danger of moving the elderly.

The third chapter provides an analysis of some of the problems of the present situation facing the aged in South Africa. The fragmentation of welfare departments and services and the unequal distribution of benefits to people of different groups are seen to be unnecessary, unjust and harmful to the welfare of elderly South Africans. The state's policy of privatisation, and the relationship between the state, voluntary welfare organisations and the aged is discussed. There appears to be a contradiction between state policy and reality in that, despite an explicit policy to retain the aged in the community for as long as possible, the White population continues to have one of the highest rates of institutionalisation in the world.

The British Abbeyfield Society pioneered neighbourhood old age homes, and the history of the agency is presented briefly. This model of care and housing for old people is examined. The

location of these homes, their size and the participation of residents in the decision-making process are highlighted.

"An ordinary house on an ordinary street" is the final chapter and examines the work of the Catholic Welfare Bureau (CWB) in establishing and running neighbourhood old age homes based on the Abbeyfield model in Cape Town. The theoretical base chosen by the CWB for the expansion of this model into networks of little homes which include care for the frail and terminally ill is described.

The aged form one of the most vulnerable groups in South African society. Caring for their needs is an important role for the helping professions. This study strives to contribute to the body of knowledge available in this field in order to help the student, practitioner and, principally, the aged.

This study is limited in scope and size as a result of the requirements of the degree for which it was prepared. It consists of a literature review which indentifies some theoretical support for the community-based neighbourhood old age home, and a brief description of the Abbeyfield model and its application by the Catholic Welfare Bureau. This study is thus an introductory work, on the basis of which more detailed empirical research into the use of this model in South Africa may be conducted.

CHAPTER ONE: AGE, AGEING & AGEISM

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CHAPTER 1 : AGE, AGEING & AGEISM

1.1. THE AGED : A DIFFICULT DEFINITION

It is easier to label an individual, group or phenomenon than it is to define it concisely and unambiguously. This is indeed the case with the vast group of individuals referred to as the aged, elderly, old or even, euphemistically, as those of advanced years or senior citizens.

Tinker[1] indicates that the most commonly accepted definition of the aged is those who are of and above retirement age. While in many countries it is simple to apply this criterion, it is not without its pitfalls. Firstly in several countries, including Britain and South Africa, the official retirement age of men is 65 and that of women 60. Not only does this raise the question of why women become officially old before men, but also it creates difficulty for statistical comparisons. Tinker[2] illustrates this complication in a comparative tabulation of social surveys conducted in Britain between 1945 and 1977 which shows that much useful data cannot accurately be compared because the age taken to signify being elderly differed from 60 to 80.

Secondly, the concept of retirement is restricted principally to industrialised societies and may have little meaning for much of the population of the world, particularly those in the Third World. The use of the criterion of retirement has also the inherent weakness of the presupposition that the individual has

some form of employment from which to retire, which is not the case in parts of the globe where structural unemployment is rife.

Van Rensburg[3] adds to this debate on the definition of being aged the complicating phenomenon that people age at different rates, and that some "become aged many years before others in the same community; others retain the physical capacity to continue in productive employment for many years beyond what is normally considered the age for retirement".

The aged may thus be seen as a vast group of individuals at different levels of physical and intellectual functioning. In order to attempt some narrowing of this broad classification many authors, including the World Health Organisation[4], Tinker[5], Van Rensburg[6] and Macagnano[7], use the chronological age of 65 as the criterion to define the concept.

An additional refinement is offered by Tinker[8] and Van Rensburg[9], who distinguish between the young aged, those of 65 to 74 years of age, and the old aged, who are those of 75 years and older. This distinction is particularly important in the light of the growing increase in population longevity in the developed world which is discussed in some detail in Part 1.2.

In South Africa the age criterion for the payment of old age pensions is a useful indicator of the definition of being aged applied by policymakers. Male South Africans become eligible,

and therefore, aged, at 65, while females are pensionable, and thus deemed too old to work, at 60. Tinker[10] observes that the trend towards equality between the sexes may well lead to a change to a uniform retirement age for all.

For the purposes of this study the terms aged, elderly and old are used interchangeably to refer to people of and above the chronological age of 65, which is chosen in order to standardise the retirement age of male and females.

1.2. THE PHENOMENON OF POPULATION AGEING

During the twentieth century the population structure of the Western world has changed markedly. In no group is this more noticeable than in the aged who have increased both in actual numbers and as a proportion of the total population. This trend continues in an upward curve in future population projections.

In 1901, Tinker[11] observes, the 2,4 million elderly people in Britain represented 6% of the total population, while in 1951 there were 6,9 million aged individuals representing 14% of the total population. In 1977 this had risen to 9,6 million and 17% of the total, and the aged are projected to reach 9,9 million and 18% of the total population by 1991.

Similarly, Boekholdt and Jongenee[12] state that in the Netherlands while "in 1980 11,5% of the population was 65 and older, this will increase to 13,5% in 2000 and to 20% in 2020".

Van Rensburg[13] notes that while Europe's population was the most aged in 1975, the USA and USSR were following close behind. This phenomenon is, however, particular to the developed world and relates to a number of factors including the fertility rate, mortality rate and level of technological development of the nation. These differences between the developed and undeveloped parts of the world are observed by Vigilante[14], Burgess[15], the World Health Organisation[16], Abrams[17], Van Rensburg[18] and others.

Related to the level of technological development of countries are the advances of modern health care and effect this has had on geriatric medicine. Exton-Smith and Evans[19] note that as modern medicine has increased the potential for extending human life, it needs to change its emphasis in the field of geriatric health care from acute to chronic illness. Schuman[20], in concurring, indicates a need to develop innovative and preventative health services to the aged. A major implication of these observations is that of the cost of these services.

In his comprehensive analysis of the phenomenon of population ageing in South Africa, Van Rensburg[21] makes three vital observations about ageing populations:

* The proportion of aged people increases.
* The proportion of young people decreases.
* As a result of the above, the mean age of the population increases.

In his exposition of the ageing process in South Africa he notes that the country's "population is in a transitional stage ranging from underdeveloped to developed" and that accurate analysis is hampered by the under-registration of Black births and deaths, and to a lesser extent that of the so-called Coloured group.

Van Rensburg notes the following trends:

1.2.1. Life Expectancy at Birth

The life expectancy of the White group is 70 years and is approaching the level of Europe and the USA. The life expectancy of groups other than White is substantially lower, but is consistently rising and corresponds with that found in other developing countries. In addition to this trend is the factor of different life expectancies of men and women. This phenomenon of women living longer than men is noted world-wide in the literature on ageing, and Van Rensburg indicates that South Africa is no exception.

1.2.2 Mortality Rate (1980)

The mortality rate per one thousand of the population of the White group had decreased slowly this century to 8,3 in 1980. That of the Coloured and Asian groups had dropped rapidly in the last 40 years to 9,2 and 5,9 respectively by the same date. The Black rate was significantly higher at 12,0.

1.2.3 Birth Rate (1980)

The birth rate per one thousand of the population of the White group has declined to 16,5. The Coloured rate also dropped in the period 1960-1980, reaching 27,8 at the latter date. The Asian rate was 24,0. The Black birth rate has remained level at 40,0 since 1960.

1.2.4 Fertility Rate (1980)

The fertility rate for Whites has dropped steadily to 2,05 per 1000 which, like Europe, is below the replacement level. The White population may thus be described as an aged population. The Coloured rate has declined sharply to 3,29 and it may be classified as an ageing population. The Asian rate at 2,85 is also declining and is projected to continue in this way. The Black rate, while dropping, is still high at 5,2 and, Van Rensburg remarks, "is still in the transitional (explosive) stage, as are most developing populations".

1.2.5 Projected Number of the Aged in South Africa

These four major trends compound to produce the projection that from 1980 to 2015 the number of people of 75 years and older will increase as tabulated below.

GROUP	1980	2015	% INCREASE
WHITE	108 847	248 427	128,2
COLOURED	24 767	68 107	175,0
ASIAN	4 662	28 296	506,9
BLACK	184 100	541 900	194,4

Table 1: Projected Increase of Persons of 75 years and above 1980-2015.

Source : F.A.J. Van Rensburg, The Ageing Population, Cape Town, South African National Council for the Aged, 1984.

In 1980 there were 1 081 873 aged people in South Africa, representing 3.78 per cent of the total population. It is estimated that by 2015 there will be 3 021 443 old people, representing 5,09 per cent of the total population. Of these aged people it is projected that 63,4 per cent will be Black[22].

1.2.6 Implications of an Ageing Population

A vital implication of ageing populations is noted in a report by the World Health Organisation[23] and echoed by Green et al[24]. The proportion of the elderly increases while that of young people decreases. There are thus fewer economically active individuals supporting more and more aged people at an ever growing cost. Van Rensburg[25] indicates that this situation is developing in South Africa.

In addition to there being fewer young people in the work force, there are also fewer young people in each family. The family as the basic unit of society has traditionally been the primary unit of care for the aged.

Many gerontologists like Burgess[26], Vigilante[27] and Stevenson[28] comment that one of the notable effects of industrialisation and urbanisation has been the breakdown of the extended family, which provided care for both the very young and very old. Declining birth rates add to a situation where each family has fewer young, healthy members to care for the aged. This results in the role of health and welfare organisations becoming increasingly important.

Vigilante[29] does, however, note that the extended family and its role as a traditional helping network must not be ignored. Even where family members live in nuclear family groupings, there is considerable evidence of help provided to elderly relatives

living in the same geographical area and Little[30], Gibson and Nusberg[31], Isaacs et al[32] and many others provide substantial evidence of this.

In South Africa living in the extended family situation is often the only alternative for Black and Coloured elderly people as a result of drastic housing shortages for those groups. Elk et al[33] in a study of 150 non-institutionaliszed Coloured elderly people in Cape Town did not find one living alone and ninety-six per cent lived within the extended family. Eales[34] found that urban Black elderly people in South Africa, almost without exception, lived with family members.

However, Ferreira[35] cautions that with the rapid urbanisation of the other than White groups in South Africa will come "the concomitant dissolution of the extended family unit where aged parents are cared for by adult children".

The breakdown of the traditional family helping network may indeed be gradual and uneven within the different population groups. The high percentage of White aged people in old age residential institutions reported by Prinsloo and Putterill[36], Van Zyl[37] and Martine[38] may be interpreted as an indicator of the response of the White group to old age and their aged population, a demonstration of the inability or unwillingness of the family to provide community-based care for its older members and a

growing involvement of both the state and voluntary welfare organisations.

The question of the cost of this care to the State, and thus, indirectly to the taxpayer, must be examined in relation to the number of aged persons currently in institutions, and as a projection in terms of the estimated population at the turn of the century.

South Africa has an ageing population. In order to respond adequately to this phenomenon, social planners and policymakers need to research the fullest spectrum of interventions to provide efficient, effective and life-enhancing means of housing and caring for the aged.

1.3 AN OLD BURDEN : THE STIGMA OF AGEISM

The difficulties in defining what constitutes old age highlight the differences in rates of the physical and mental ageing of human beings. In addition to this there is the demographic reality that every year there is an increasing number and proportion of aged people on the earth.

The question arises why, throughout the Western world, the aged population is viewed as a stereotype; physically frail, mentally deteriorating and increasingly, and expensively, dependent on their families and the state. This view sees the elderly as non-

contributing, obsolete and irrelevant passengers, an attitude of discrimination which has become known as ageism. It is cruelly but concisely reflected in the slang term for the old as "oxygen thieves".

Vigilante[39] observes that Western society views the aged population as a social problem caused by technological advances. He wryly comments that "for many aged people to be old is less a problem than they, or even the society, anticipated".

In advocating the discarding of this negative view of the elderly, Eales[40] notes that it is in fact only a small percentage of the elderly who become dependent as a result of becoming "frail, sick and feebleminded".

Indeed, not all old people regularly require the services of social workers, nurses, doctors and institutions for the aged. The proportion of elderly persons in a population is not reflected as the same number receiving assistance of these kinds. As Green et al[41] remark, "The basic human needs of the elderly are identical to those of any other age group".

In attempting to explain the prejudice of ageism Tinker[42], Green et al[43] and Butler[44] refer to the sociological theory of disengagement, which states that the gradual disengagement of the aged individual and society one from each other is normal and desirable. This theory, the validity of which they dispute, is

seen to affirm inactivity, passivity and the worthless expenditure of time in old age.

These negative views about ageing and aged people must have a number of causes in the societies which hold them. In attempting to define the aged in Western society, a key concept occurs in much of the literature - that of retirement from the role of worker. This role is more important than that of merely having an occupation which takes the individual to and from a place of employment for eight hours a day. Being a worker means earning money and, thus, having an intrinsic economic worth, with the concomitant power.

Hobman[45], Tinker[46] and Green et al[47] indicate that together with this loss of economic power is a loss of the employed status in societies in which the work ethic remains an important criterion of the worth of individuals.

> "Their creativity and sense of self-worth may have been seriously eroded in cultures which set greater store by the jobs which people do, by how much they earn, and what they have to show for it rather than on who they are".[48]

An additional cause of the stigma attached to being old is the near worship of the flimsy values of youth and beauty in Western society. Barrow and Smith[50] observe that the aged are rejected by "our youth-oriented society", while Green et al[51] note that

the elderly are viewed as "contributing little to a society enamored of youth". This understanding is shared by Vigilante[52] who states that the emphasis on the value of youth may actively denigrate the value of the aged.

It is ironic that Western society rejects and stigmatises the aged, as one of the few relatively certain outcomes for most individuals is the state of being aged, and a victim of the plot in which they as young people shared.

Society's view of the aged is a vital component of social policy formulation, and it is essential that ageism be attacked by proving that aged people are a valuable part of our society.

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CHAPTER TWO : HOUSING AND THE AGED

The first chapter of this study briefly placed the aged in Western society in context by providing a definition of the concept, describing the phenomenon of population ageing and observing the existence of an attitude of discrimination against the elderly.

This chapter examines the social implications of housing for the aged. Among these are the importance of housing for the elderly; the question of who is responsible for providing housing; the existence of different forms of housing for the old and some of the controversial debates in this field of social policy. The social dimension of housing the aged, while of paramount interest to this study, cannot be separated from aspects of design, geographic and topographic location.

2.1 THE IMPORTANCE OF HOUSING FOR THE AGED

A fundamental observation in examining the importance of housing for the aged is that as the majority of aged people are retired, they spend considerably more time at home than do younger people. Their homes, Schuman[1] observes, "are the centre of virtually all of their activities", and, for many physically weaker old people, Butler *et al*[2] comment that housing "constitutes the boundary of their social world". Accommodation for the aged thus constitutes more than just shelter from the elements.

Green et al[3] indicate the important additional factor that elderly people are inclined to move home considerably less than younger individuals, and that few aged people willingly relocate after the age of 65.

The result of these factors is that a number of elderly people tend to remain in what Barrow and Smith[4] term "ordinary houses in ordinary neighbourhoods". Often these homes are the same in which they lived while raising their families, and research in Britain[5] and the USA[6] indicates that approximately 50 per cent of these aged people are owner-occupiers, most of whom significantly under-occupy their homes.

Butler et al[7] indicate that the issue of under-occupation presents several potential problems. One of these is the need to release family housing to families and for the elderly to live in more appropriately sized homes. A danger of this is that the needs of the young may be regarded as more important than those of the old, who may, particularly in state or local authority-owned housing, be shunted from their familiar and beloved homes to a foreign but more "suitable" home.

Another problem is that of the cost and difficulty of maintaining large family homes. Reliance on fixed incomes is often the fate of the elderly, particularly pensioners, and the rising cost of building maintenance may make upkeep impossible.[7.8.9] The result

may be that the homes of the aged gradually become derelict, and sometimes dangerously so.

The prospects for those who privately rent housing the picture is grimmer. Schuman[10] notes that inflation has internationally affected "the housing sector more adversely than most other sectors of the economy". In South Africa this is also evident. A study of White urban social pensioners living in privately rented flats in central Johannesburg by Pringle[11] found that "nearly fifty per cent of the pension went to the payment of rent". The phasing out of rent control in this country aggravates the plight of these elderly individuals.

Faced with this barrage of difficulties it may well be asked why the aged often remain in housing which is neither suitable nor cost effective. A review of the literature indicates several important reasons. Huttman[12], Barrow and Smith[13] and Green et al[14] agree that the desire to remain independent is paramount. A second major cause is highlighted by Fox[15], Eales[16] and Struyk[17], who note that there are frequently few other alternative choices and that the aged are often not aware of existing alternatives. Finally, many old people are reluctant to leave their familiar surroundings; areas in which they know people and places, and which, Alexander et al[18] comment, acknowledge their ties with their past.

Internationally, housing for the aged has become the focus of the work of many gerontologists in recent years as a result of the effort to maintain the growing number of aged persons in their own homes in the community. Butler et al[19] state that "Good housing is seen not only as important for its own sake, but also as a kind of prophylactic against costly and discredited institutional care". The move away from institutions towards community based solutions will be discussed in detail in part 2.4.

2.2 WHOSE RESPONSIBILITY IS HOUSING FOR THE AGED?

The question of who is responsible for the provision of housing for the aged is one which strikes at the kernel of a country's social welfare policy. There is a marked contrast in the approach to the role of the state in service provision between the modern welfare state and countries which view welfare provision as primarily the responsibility of the individual.

A seminal study of the differences between these two systems is that of Wilensky and Lebeaux[20], published thirty years ago. They described the welfare state, such as Sweden and Britain, as institutional, in that the state provides social welfare benefits to all its citizens, irrespective of their means, as their unquestioned right. On the opposite pole of this continuum are states which they termed residual. These states do not, in the first instance, provide welfare services, believing this to be the role of the individual, the family and private enterprise.

Where residual systems do provide services, they do so only to provide a safety net for those individuals who fail to provide for themselves.

Little[21] refined this model to include two further stages, early institutional and maximum institutional, on the continuum. The revised continuum is illustrated below as Figure 1, and her detailed development model for specialised services for the elderly is included as Appendix A.

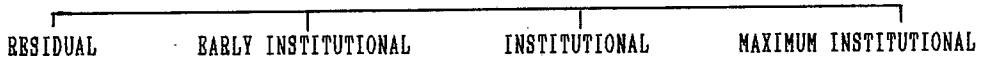

Figure 1 : Residual - Institutional Continuum

Source : Viginia C. Little, For the Elderly: An Overview of Services in Industrially Developed and Developing Countries, London, SAGE publications, 1979.

Her model is applied to twenty four countries as illustrated below in Figure 2. South Africa is inserted by the author between Hong Kong and New Zealand; closer to early institutional than institutional.

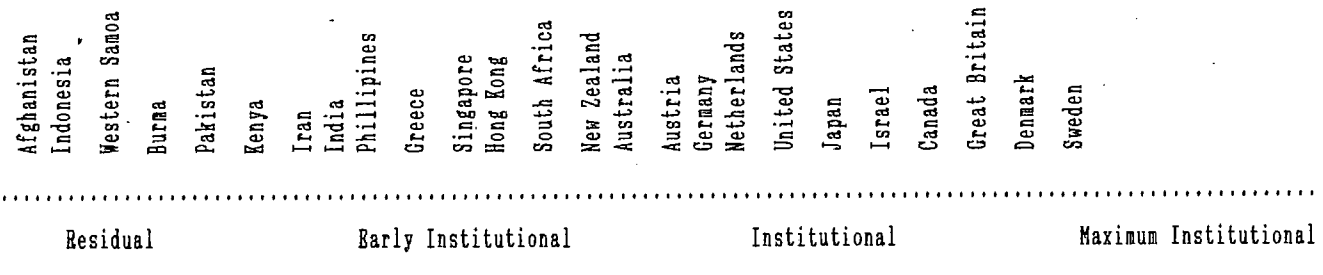

Figure 2 : The Residual - Institutional Continuum of Elderly Services

Source : Virginia C. Little, For the Elderly: An Overview of Services in Industrially Developed and Developing Countries, London, SAGE publications, 1979.

The South African welfare system is inserted at this point because while the state's policy is predominantly residual, it does provide some aid to those who fail to be self-reliant, and who qualify in terms of a stringent means test. This policy is neatly described by Ferreira[22] in her study on pensions for the aged in South Africa :

> ... the primary responsibility for making provision for old age is that of the individual and his family. When people are unable to help themselves, the State provides some financial assistance. However, this is done by using a principle of 'exclusion' rather than 'inclusion', whereby a pension is viewed as a privilege and not a right, and a means test determines a person's eligibility for assistance.

Eales[23], in her study of the Black urban aged in South Africa, states that in this country, after the individual and the family, "the major responsibility for the care of the aged lies with the private sector and voluntary organisations".

The relationship between the state, voluntary organisations, private enterprise and family with regard to providing housing for the elderly has been debated extensively in the USA in recent years, as a result of what Struyk[24] describes as the "dramatic reductions in the level of resources,the country believes it can allocate to federally supported programs".

Several years earlier, shortly after President Reagan had been elected, Nelson[25] had cautioned that "a large segment of the public is now calling for limits on the cost of government and the role of government in the lives of individuals". He concluded that if the government was to do less, then individuals and their families would have to do more.

He was however in agreement with many authors in the field of gerontology, including Gibson and Nusberg[26], Tinker[27], Little[28] and Stevenson[29], that even in strongly institutional states family networks provide significant levels of social, economic, emotional and physical assistance to their elderly relatives.

Olsen[30], reacting to increasing pressure on voluntary organisations in Britain in recent years, wrote that "there is no doubt that we must resist the promotion of voluntary effort simply as a response to current fiscal constraints", but added that the use of social support networks and, consequently the utilisation of formal and informal care for the elderly was most desirable.

However, Specht[31] warns of the dangers of the state relying too heavily on social networks as having "huge untapped resources that can and should be harnessed to meet social needs".

Within the South African context this point is particularly germane. By allocating to the aged individual and his family the responsibility for his welfare there is the intrinsic difficulty of asking the poor, those who have the least, to do the most for themselves.

2.3 HOMES FOR THE AGED : A BRIEF HISTORY

An excellent history of the emergence of institutional homes for the aged is provided by Townsend in his authoritative study entitled The Last Refuge[32]. This section of the study draws heavily on his work.

The development of institutional homes for the aged is an ancient practice rooted in the Christian belief in the virtue of caring for the vulnerable - the old, the sick, the poor and disabled. As early as the third and fourth century gerontochia were established by the Christian Church in Eastern Europe.

Western Europe was slower to institute care for the aged, but by Medieval times infirmary almshouses and houses of pity were established by the church in Britain. For centuries the sick, the abandoned and poor of all ages were cared for in one building.

This situation continued under the Poor Relief Act of 1601 which established poor houses, which became known as the workhouse, in England and Scotland. Differenciated housing for the aged was

not introduced in terms of the Poor Law Amendment Act of 1834, and the mixed workhouse continued to exist until the Royal Commission on the Poor Laws in 1909 recommended that separate institutions for the aged be introduced. This introduction was a slow one, and it was not until after the Second World War that the National Assistance Act of 1948 made local authorities responsible for providing homes for the elderly in need of care.

It was recommended that the optimum size of homes for the aged was 25 to 30 people, but shortages of funds prevented the closure of the large old institutions. It was only after Townsend's The Last Refuge[33] was published in the early nineteen-sixties, that the negative effects of large-scale institutionalisation were acknowledged. The size of new old age homes was reduced, and a range of community-based domiciliary care services were introduced in an attempt to keep the aged in the community for as long as possible. This movement also led to the development of sheltered housing for the elderly which will be described more fully in part 2.4 of this study.

Van Zyl's study of White South Africans' attitudes towards old age homes[34] provides a useful history of institutions for the aged in South Africa.

The earliest forms of institution for the old were established at the old Somerset Hospital and the Slave Lodge in Cape Town in the early nineteenth century. The first true home for the aged was

the Ladies Christian Home which was opened in Cape Town in 1876. Other church groups followed suit.

The establishment of old age homes was one of the tasks of the Department of Social Welfare which was established in 1937. A per capita subsidy for needy residents of homes, who were subjected to a means test, was introduced in 1942. Already at this stage, Van Zyl[35] notes, "the State adopted the principle that the erection and maintenance of old age homes was the task of private welfare initiative".

While this policy has continued, the number of homes for the aged, particularly for the White group, has increased substantially. In 1977 there were 276 subsidised homes for the aged, caring for 15 621 sub-economic and 2 702 economic residents[36]. By 1985 the state was subsidising 378 White old age homes, caring for 21 715 sub-economic and 3 952 economic aged individuals[37].

Growing concern about the high proportion of elderly persons in institutions for the aged in South Africa will be detailed in Chapter 3.

2.4 CATEGORIES OF HOUSING FOR THE AGED

2.4.1 Ordinary Community Housing

Most elderly people live in ordinary housing units located within the wider community. This may be in the form of houses, cottages or flats. There are also aged individuals residing in accomodation in boarding houses, hotels and similar age integrated settings in communities.

Old people who dwell in ordinary community housing may be single, live alone with a spouse, with other family members or together with non-related friends. Domestic arrangements range from living alone to residing within a multi-generational extended family situation.

Aged people residing in ordinary housing on ordinary streets may be owner occupiers, live in housing owned by family members, rent other privately owned dwellings, or be tenants of the state or local authorities.

The sharing of ordinary community housing by elderly people who are not relatives has recently come under the spotlight in the gerontological literature. Schreter and Turner[38] note that the term shared housing is, however, only a new classification for "a modernized version of an historic living arrangement - boarding and lodging in private homes".

Soldo et al[39], who studied the community living arrangements of aged unmarried women, found that shared housing was one of "several adaptive responses the informal support network can make". It can be noted from the above studies that this type of domestic arrangement presents an alternative to institutionalisation, that it adds to the range of housing choice available to the aged, and that it is also a form of self-help.

2.4.2 Sheltered or Supportive Care Housing

Sheltered or supportive care housing is defined as that which provides independent living accomodation for the elderly together with access to a system of support which may be utilised if and when it is required.

Sheltered housing for the aged, may take a number of forms ranging from self-contained flatlets attached to ordinary domestic family houses within the community to purpose-built age-homogenous grouped housing schemes erected and run by private welfare organisations and subsidised by the state or local authority.

On the one end of this continuum of supportive care housing is the self-contained apartment built adjoining an ordinary family home. These are known in Britain as granny annexes or flats, and in the USA as accessory apartments. Tinker[40] notes that "the idea is that the elderly person will be able to live independently yet be able to give and receive help from their

family next door". In this form of housing the elderly individual remains a resident of an ordinary street in an ordinary suburb with its full range of persons of different religions, ages, sexes, and, in most countries, races.

On the opposite extreme of this continuum are institutional congregate housing complexes, built and run by welfare agencies. They provide sheltered care in the form of specially designed self-contained flatlets or cottages for the fit elderly. These units on this extreme end of the continuum are linked to non-self-contained rooms within a conventional old age home, and a nursing section for the very frail elderly, and all three sections are part of the same complex of what be termed a total geriatric care facility. Several other models of sheltered or supportive care housing may be located between the two extreme points on this continuum.

Closest to the granny flat concept is that of the conversion of existing domestic houses by a welfare organisation to accommodate a group of elderly persons within the community, Tinker[41] describes this model as providing "shared rather than self-contained accommodation". In this type of housing residents may lead completely independent lives, cooking and cleaning for themselves, or they may live as a community which shares common meals and other tasks. A live-in warden, supervisor or housekeeper may or may not be provided. Nursing and social work services are provided by the sponsoring agency if and when they

should be required. These houses may be described as agency-sponsored group homes.

This model was pioneered by the British Abbeyfield Society and is described by Wotton[42]. Housing the elderly in the Abbeyfield manner will be described fully in Chapter 4.

Further along the continuum towards the supportive care component of the total geriatric care facility, are grouped self-contained flatlets or cottages either located among ordinary community housing or segregated in the form of retirement villages or schemes. These sheltered housing schemes are linked to a warden or supervisor, but do not provide services to the frail who are unable to live independently. They may provide a service centre offering meals and other personal services together with recreation and other group leisure activities for both aged residents and non-residents. State subsidy is utilised for these services.

The continuum of sheltered or supportive care housing for the aged is illustrated in Figure 3. Little's[43] stages on the Residual-Institutional Continuum are included in brackets, as there is a clear congruence between these classifications.

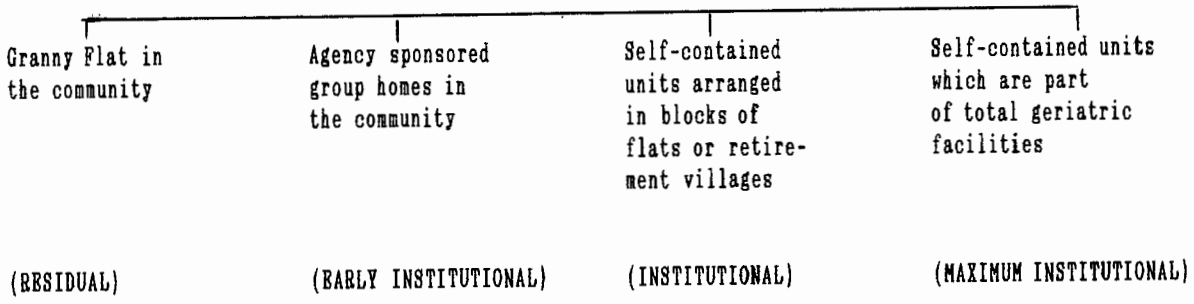

Figure 3 : Continuum of Sheltered or Supportive Care Housing for the aged.

The granny flat attached to an ordinary house on an ordinary street may be seen as residual in that responsibility for the aged is taken by the old person and his family without aid from the state or a voluntary welfare organisation.

The agency-sponsored group home is early-institutional in that the voluntary sector is involved and a level of supervision support is provided. The institutional stage is represented by self-contained grouped dwellings which are state subsidised specialised housing. The self-contained units which are included in a total geriatric care facility can be seen to be the maximum institutional point on this continuum of sheltered housing in that they are clearly part of a total institution for the aged.

2.4.3 Very Sheltered or Extra-Care Housing

Very sheltered or extra-care housing is a logical subsequent step from sheltered or supportive care housing. Where the latter provides accomodation for the reasonably fit, independent elderly, extra-care is intended to maximise the independence of the elderly who are infirm, rather than frail, and who require practical assistance with many of the tasks of daily life.

Typically the very sheltered or extra-care model provides meals, housekeeping services, such as cleaning and laundry, as well as personal services which may range from help with bathing and dressing to assistance in drawing pensions or transport to medical services. There may also be help with the administration of medicine and drugs[44].

In all very sheltered or extra-care housing a full-time warden supervisor or housekeeper is provided for both day and night. The warden's role is to assist with practical, rather than nursing, tasks and to arrange the services of a doctor, nurse or social worker when required.

Butler et al[45] indicate that like sheltered housing, very sheltered or extra-care housing is an attempt to optimise the independent living of aged persons within the community rather than in total institutions.

However, extra-care schemes also range in style from the British Abbeyfield Society's converted ordinary domestic housing on ordinary suburban streets to purpose-built intercom-linked flatlets which form part of a total geriatric care facility as described in part 2.4.4. The danger inherent in the latter type of very sheltered housing is described by Butler[46], who comments that a scheme "with three wardens and thirty-five tenants, or 'residents', very quickly begins to resemble an institution".

Extra-care housing differs from the frail section of a conventional institution for the aged, and from nursing homes or geriatric hospital wards in that it does not provide a full-time nursing service for the chronically ill. The role of the warden is to assist the residents in the same common sense way that a daughter would care for her aged mother in her own home. This allows for the provision of practical care during an acute, and temporary illness, just as the family would nurse an elderly relative at home in consultation with the doctor and the district nurse.

In many cases the elderly may thus be kept within the extra-care house until death as often elderly people suffer from conditions which do not require "professional nursing care or active medical treatment"[47].

2.4.4 Institutions for the Aged

Institutions for the aged differ from family homes, sheltered or very sheltered housing in that they can be classified as total institutions specifically designed and operated for the residential care of the elderly. Goffman[48] provides a lengthy discourse on the nature of total institutions in his 1961 work Asylums. They may be classified in this way when all elements of life occur in one place and under the control of the sponsoring body. The life of the total institution is rigidly organised and serves the needs and desires of the total institution rather than the individual served by it.

Such institutions are isolated from, rather than integrated with, the normative community, and the resident group is age-homogeneous. In total institutions for the aged the only non-old people are the staff and visitors.

This classification of housing for the aged includes conventional old age homes, long-stay nursing homes for the elderly and geriatric chronic wards in hospitals.

Typically institutions for the aged stress the physiological health and nursing needs of residents. They may be seen to be predicated on the medical-model of care, which tends to be rigid and hierarchical. Bowker[49] compared medical-model dominance, institutional totality and levels of resident humanisation in four old age homes in the USA. He found that the greater the

degree of medical-model dominance, the lower the degree of resident humanisation.

Among the recommendations of his study entitled Humanizing Institutions for the Aged were the need to involve residents in the decisions which affect their lives, to allow them to bring as many personal effects as possible on admission and to modify the physical structure of total institutions to resemble as much as possible the ordinary family home. The debate of institutional versus community care will be describd in more detail in part 2.6.2. It is not, however, the purpose of this study to denigrate institutions, but to propose the inclusion of other non-institutional models in the South African continuum of care for the elderly.

2.5 CLASSIFICATIONS OF THE AGED AND HOUSING FOR THE AGED IN SOUTH AFRICA.

In South Africa the aged are officially classified into three groups by the Department of Health Services and Welfare[50]. This classification is also used in other South African gerontological literature, including works by Prinsloo and Putterill[51] and Eales[52].

Group One: is called the Normal Aged. It comprises elderly people who are healthy and independent, and who need little or no assistance in caring for themselves.

Group Two: is that of the Infirm Aged. These are elderly people who are still healthy, but are unable to care for themselves without regular assistance.

Group Three: consists of the Extremely Infirm Aged. Individuals in this group are either physically or intellectually so frail that they require constant assistance and supervision.

The categorisation of housing for the elderly is congruent with these classes of old people.

Category A: accommodation consists of self-contained units for individuals or couples who are able to care for themselves (Group I).

Category B: accommodation consists of single and double rooms for elderly people who are normally healthy, but are not but are not able to manage by themselves (Group II).

Category C: accommodation is of the ward or sickroom design for those aged infirm people who need constant care (Group III)[53].

2.6 MAJOR DEBATES IN THE HOUSING OF THE AGED

2.6.1 The Aged, Housing and the Question of Choice

Schuman[54] remarks that "perhaps the most characteristic aspect of aging is that of loss". Together with the loss of relatives and

friends through death come the many losses which result from retirement. The elderly person on retirement loses the status of being a worker, economic power, colleagues and, most vitally, "active participation in society"[55]. Integrally connected with these changes is the distressing phenomenon that all too often, in society's view, being old means the loss of the right to self-determination and thus that of choice.

Butler et al note that the elderly are frequently viewed very paternalistically, and it is believed "that we should - we have a right - to intervene in other people's lives, to 'do them good'"[56]. The result of this widely held view is that social planners have tended to provide for the level of need described in Bradshaw's Taxonomy of Need[57] as normative, or the type of house it is commonly believed an aged person ought to have.

The result of this is well documented in the gerontological literature. Barrow and Smith[58], Butler et al[59], Fox[60], Huttman[61], and Eales[62] all indicate that the aged require a far greater range of housing alternatives from which to choose. These should include a variety of non-institutional and institutional residential arrangements. In recommending ways of dealing with the international crisis of the multiple needs of the elderly, the World Health Organisation recommends that services for the aged be developed "with the close participation of those using the services"[63].

In examining the inappropriate number of White South Africans in institutions for the aged, Eales concluded that among the causes of this phenomenon "most important is the lack of alternatives"[64]. Expanding the range of housing options for the elderly in South Africa holds the inherent challenge of enlarging the continuum of care for the aged.

2.6.2 Institutional versus Community Care

During the last four decades there has been a growing international concern that institutionalisation of the aged has at least as many negative as positvie outcomes. Barton[65] coined the useful term institutional neurosis to describe the cumulative negative effects of total institutions. Townsend[66], Bowker[67], Knight and Walker[68] and many others argue that institutions for the aged deny the individuality, privacy and dignity of the elderly and propose that "care for the elderly should be shifted from institutional to community setting"[69].

Exton-Smith and Evans remark that "many, if not most, of the 'problems' we associate with older people may lie in our institutional arrangements, not in older people"[70]. In advocating community care Knight and Walker note that "the principle of provision of treatment in the least restrictive setting possible has been a cornerstone of the community mental health movement"[71].

The response to this debate has been considerable, particularly in Britain and the USA, which have seen a marked increase in sheltered and very sheltered housing schemes, relaxation of town planning codes to allow the erection of granny flats, service centres for the aged and the wide range of domiciliary services to old people.

Intrinsic to the argument for community care is a point noted by Butler et al who believe that "the ability of elderly people to live in the community can depend as much on the accommodation they occupy and its location, as the support services they receive"[72].

These services include on the one hand those provided by the formal sector, the state and local authority, and, on the other, those of the informal sector consisting of voluntary welfare organisations and the family and friends, who constitute an informal helping network.

2.6.3 Age Integration versus Age Segregation

One of the most controversial debates in the sphere of housing policy for the aged is the choice between integration, or heterogenity of the aged in the community, and segregation, or homogenity, of groups of elderly people

A fundamental aspect of this debate is described by both Tinker[73] and Alexander et al[74] who stress that historically it is assumed

that the aged were fully integrated in the community as a result of the extended family structure, which may have spanned as many as four genereations within one household. This assumption is dubious and difficult to prove, owing both to a lack of reliable data and to the fact that, relative to today, people did not live as long.

Alexander et al[75] find in Isaacs et al[76] supporters of the argument that social integration of the aged is impossible before social and urban planners provide suitably integrated housing for the elderly within the normative community.

The major explanations of the desirability of age-segregated or homogeneous housing for the elderly suggest that it facilitates friendship, social exchange and that older people tend to congregate together, as Barrow and Smith state, because of "the difficulty in old people's finding acceptance in our youth-orientated society"[77]. This in turn may lead to the finding of Alexander et al that "when these elderly communities are too isolated or too large, they damage old and young alike"[78]. Both studies indicate that this leads to a vicious cycle; the aged are alienated and become progressively remote from the young, who grow to view them with the suspicion and horror, and who fail to benefit from their undoubted potential contribution to the wholeness of the community. This in turn perpetuates the discrimatory phenomenon of ageism because, as Barrow and Smith

note, "If young people never get to know old people, prejudice and discrimination against the elderly will continue"[79].

One of the most prolific researchers of this phenomenon is Sherman[80,81,82] whose findings indicated that while age-segregation or homogenity facilitated helping contact between aged residents, this assistance never grew to the level of significance of the assistance provided by family members and long-standing friends outside the age-integrated complex. These findings were supported by Stephens and Bernstein[83] who confirmed that interpersonal relations within age-segregated complexes were more centred on "social and psychological resources such as conversation and advice" rather than practical and material help, which was drawn from interpesonal networks on the outside of the centre. Poulin[84] found a similar phenomenon in which the significant support came from interpersonal networks established over a lifetime rather than in the relatively brief sojourn in age-integrated housing.

Goodman[85] and Pynoos et al[86] recommend from their studies of reciprocity among residents in age-segregated complexes that a more productive informal support network might be established within the intergenerational or age-integrated setting, particularly as younger people tend to have both greater physical and material resources with which to provide help than older, weaker (although often willing) aged individuals.

Siegel's comparison between homogeneous and heterogeneous areas for the elderly concurred with these findings, concluding that the aged who live in segregated communities and who "become disabled, or who have diminishing financial resources may have to move closer to their kin"[87].

The literature in this debate has one central finding - that the continued involvement of family members and old friends, remains of great importance to the well-being of the elderly, and, incdeed, to the whole community.

Alexander et al provide a masterful summary of a feasible solution to convert to action this conclusion:

> "We therefore need a way of taking care of the elderly which provides for the full range of their needs:
>
> 1. It must allow them to stay in the neighbourhood they know best - hence some old people in every neighbourhood.
>
> 2. It must allow old people to be together, yet in groups small enough not to isolate them from the younger people in the neighbourhood.
>
> 3. It must allow these old people who are independent to live independently, without losing the benefits of community.

4. It must allow those who need care or prepared meals, to get it without having to go to nursing homes far from the neighbourhood"[88].

This model, which is being established in Woodstock in Cape Town by the Catholic Welfare Bureau, will be described further in part 4.3.

2.6.4 The Question Of Moving The Elderly

"The move will kill her" is an oft-quoted response to the all too common problem of "What shall we do with Granny?" The elderly person in these cases may be living within the extended family, alone in her own home or in a mismanaged or unsuitable residential institution or other housing deemed inappropriate or even dangerous by her family.

The gerontological literature is split on the controversial issue of moving the elderly from one form of housing to another. On the one hand there are the positive findings of authors like Wittels and Botwinick[89], Storandt and Wittels[90], Brearley[91], and Schulz and Brenner[92] which have several important conclusions in common.

The first concerns the degree of voluntarism with which the aged individual moves from one form of non-institutional housing to another. The higher the degree of voluntary choice in moving, the less negative the effect on quality of life and longevity.

Secondly, their studies have in common the conclusion that where the environmental change between the old and new unit is fairly small, negative outcomes are significantly reduced. The first three of the above studies also found that where the quality of the new environment was an improvement on the previous one, positive outcomes were experienced.

However, moves from non-institutional to institutional settings were found by Brearley[93] and Schulz and Brenner[94] to have more distinctly negative outcomes. This finding was corroborated by Tobin and Lieberman's study of the implications of institutionalisation. In assessing "what institutions do to the old" ...they concluded that... "only the most intact survive the first year after admission"[95] from a previous non-institutional home.

Barrow and Smith[96] offer an explanation for this phenomenon. They found that the attitude of the elderly towards moving was affected by whether the change led to an increase or decrease in dependency. Living in the community was viewed as the most independent and most positive, and in an institution as the most dependent, and thus the most negative.

A dissenting view is offered by Ferraro[97], on the other hand. He found that aged people moving within heterogeneous, age-integrated settings did experience negative outcomes, and that

those moving from community-based housing to age-segregated accomodation complexes fared better as a result of the physical support and social links offered by housing of this type.

Tinker provides a balanced and succinct comment on this debate.

> "...the elderly are not a homogeneous group and may not gain from being treated as if they were .... Some want independence with privacy. Others want to live with other people. Some like quiet and to be able to associate mainly with people of their own generation. Others prefer the company of younger people.... It is more sensible to make varied provision, so that for example the elderly can choose to live either in mixed communities or in special schemes for their age group alone"[98].

This view adds substance to the aim of this study, which is to enrich the South African range of options for the care of the elderly. Broadening the existing continuum of care provides more alternative models of accommodation from which the elderly may choose, ranging from the small community-based converted family house, to the highly sophisticated purpose-built geriatric ward in a general hospital.

Group Two: is that of the Infirm Aged. These are elderly people who are still healthy, but are unable to care for themselves without regular assistance.

Group Three: consists of the Extremely Infirm Aged. Individuals in this group are either physically or intellectually so frail that they require constant assistance and supervision.

The categorisation of housing for the elderly is congruent with these classes of old people.

Category A: accommodation consists of self-contained units for individuals or couples who are able to care for themselves (Group I).

Category B: accommodation consists of single and double rooms for elderly people who are normally healthy, but are not but are not able to manage by themselves (Group II).

Category C: accommodation is of the ward or sickroom design for those aged infirm people who need constant care (Group III)[53].

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CHAPTER THREE : THE AGED IN SOUTH AFRICA

3.1 THE PRESENT SITUATION

3.1.1 A Multitude of Welfare Departments

The South African government has instituted a policy of separate development for the race groups it identifies as White, Coloured, Indian and Black. In implementing this policy, separate welfare departments have been created to plan, control and provide welfare services to each of these groups.

In addition to this, the government has granted a controversial form of "independence" to the parts of South Africa known as Transkei, Ciskei, Bophuthatswana and Venda in terms of its policy of developing ethnically-separate independent homelands for Black South Africans. Each of them also has its own department of welfare.

A number of negative implications for the aged are inherent in these policies. Most basic of these is that in South Africa the policy of separate development has been unequal, with the Whites, Coloureds, Indians and Blacks enjoying welfare services different in both quality and quantity.

A cursory examination of the amounts of social pensions paid in 1987 to the elderly of different groups illustrates this point:

White social pensioners receive	R198.00 per month
Coloured social pensioners receive	R147.00 per month
Black social pensioners receive	R 97.00 per month

Service provisions to the elderly of different groups is also discriminatory. Prinsloo and Putterill[1] found in their 1986 study of residential institutions for the aged in the northern suburbs of Cape Town, 2 212 beds in 24 homes for White elderly persons and 579 beds in 6 homes for aged Coloured individuals. In the whole of Cape Town there are only two old age homes for Black persons, one in Nyanga and one on Langa. Together they provide fewer than 100 beds. Eales[2] noted in her 1980 study of the urban black aged in South Africa that "only two of the 160 organisations affiliated to the South African National Council for the Aged offer services to Black aged".

By the creation of separate welfare departments for each race group in South Africa, and also for each of the so-called independent states, the planning, provision and control of welfare services has become fragmented. This fragmentation and the lack of effective co-ordination may be seen to have contributed to one of most the difficult problems facing the aged in South Africa. This problem is the lack of a national policy for the welfare of the aged.

Eales[3] comments that one of the most vital tasks which could be achieved under an all-inclusive national policy for the aged is "the co-ordinated and sustained development of facilities and services". A national policy could also institutionalise the provision of equal service provision for all race groups.

A noteworthy negative effect of the policy of independent homeland development is that the so-called independent areas are omitted from the South African population census. This serves to aggravate the already serious problem of the inaccuracy of Black census data, and denies policymakers easy access to a clear and comprehensive demographic picture of the whole country, on which they could base rational planning for the aged and other groups.

In addition to this is the fact that accurate statistical information from the so-called independent states is particularly important in that they are underdeveloped rural areas. Planners and policymakers need to study in depth the differences between the demographic characteristics and needs of rural and urban populations. The urban-rural dichotomy is of great importance in the field of gerontology, especially in this period of rapid urbanisation of Black people and the social changes which this transition is bringing about. Among these are the effects on the extended family, the Black urban housing crisis and structural unemployment - all of which will significantly affect the burgeoning number of aged Black South Africans.

3.1.2 The Relationship between the State, Voluntary Welfare Organisations and the Aged

Part 2.2 of this study examined the question of who is responsible for the welfare of the aged. It emerged that the social policy of the South African state places the responsibility of providing for old age primarily on the individual and the family. The state only provides assistance in instances where this primary group has failed.

The state also promotes the policy of privatisation, in terms of which it subsidises the private sector in the form of voluntary welfare organisations, to provide services to the aged. These services are principally concerned with housing, although in recent years greater emphasis has been placed on service centres which assist aged individuals living in the community[4]. These activities of private welfare organisations are co-ordinated by the South African National Council for the Aged[5].

The nature of the relationship between the state and voluntary organisations is described by Eales[6] as a partnership, in which the private sector initiates and establishes services, while the state provides subsidies and also policy directives which determine the nature of welfare services which it is prepared to assist.

There are two important implications of this relationship. The first is that private welfare organisations have become utterly

dependent on the subsidies provided by the government. During 1984/1985 financial year for example, the state funded 378 White old age homes to the extent of R54 924 000 "in terms of subsidies for running costs, while R614 000 was spent on the purchasing of furnishings"[7]. This amount represents an average subsidy of R145 301,58 for each of these 378 homes. Clearly these institutions would be in a serious position if the state were unable for any reason to continue subsidising them.

A second implication of the relationship between the state and voluntary welfare organisations concerns the process of subsidy allocation. The onus is on the welfare organisation to prove to the appropriate Regional Welfare Board, as the local representative of the welfare department concerned, that a need for a particular service exists. Once this is approved, a subsidy may be provided.

The principal actors in this process are the two partners in the welfare relationship, who together provide for what Bradshaw[8] termed normative need - those services which society (represented here by the state and the welfare organisations) believe the client "ought" to have.

Where do aged clients fit into this process? Is their glaringly conspicuous absence not the confirmation of the observation of part 2.6.1; that on their retirement elderly people lose their rights to choose, to be heard or to participate? Would it not be

more appropriate if, as the World Health Organisation[9] recommends, the aged as service consumers, be meaningfully consulted by the service providers?

The current subsidy policy does not promote an active debate between the elderly and those organisations which serve them. If the aged were purposefully drawn into this debate they could formulate their service requirements in terms of expressed need. In order to do this, the aged will require active and significant levels of participation in the decision-making processes of planning social policy.

How can this be achieved? Oriol[10] notes that simply in terms of their numbers, the aged in Western society have become a major political force. Chapter 1 of this study indicated that this holds true for South Africa. In Britain and the U.S.A advocacy groups of elderly people such as Age Concern and the American Association of Retired Persons have been able to influence social policies affecting the aged significantly[11]. The development of advocacy groups of aged persons in South Africa may add a new and enriching dimension to the relationship between the state and voluntary welfare organisations.

3.1.3 The Emphasis on Institutional Homes for the Aged

Welfare departments in South Africa have, in accordance with social policy throughout the Western world, the principle of keeping "aged persons in the community for as long as

possible"[12]. Despite this explicit principle, a recent study by Prinsloo and Putterill[13] indicated that there is an inappropriately high number of healthy White persons over the age of 65 in institutional homes for the aged. Van Zyl[14] and Eales[15] found that the White aged population of South Africa has one of the highest rates of institutionalisation in the world.

It may be asked why this principle is so clearly being contradicted. The answer to this pressing question is remarkably simple. The emphasis on housing for the aged in South Africa has been on institutional old age homes, rather than on a broad spectrum of alternative forms of accommodation like granny flats, shared or sheltered housing. As Eales[16] notes, these are solutions which prevent "premature admission of many old people to expensive old age homes". In addition to fulfilling the aim of the principle of maintaining the elderly in the community for as long as possible, alternative forms of housing will reduce the pressure on institutions, which should concentrate, as Prinsloo and Putterill[17] point out, on "the admission of frail aged and crisis cases", who require the constant medical and nursing care which can be provided in total geriatric institutions.

3.2 THE ROCKY ROAD AHEAD

Institutional homes for the aged are expensive to build and operate. Their survival has been shown to be dependent on state subsidies.

The institutional housing of the aged in South Africa has concentrated on providing for the needs of the White group, and, to a lesser extent, those of the Coloured population.

South Africa has an increasing number of aged citizens. Van Rensburg[18] estimates that by the year "2015, 63,4% of the aged population will be Blacks". He cautions that as there has been little done to provide services fo this group until now, the task of housing and caring for an increasing number of elderly Black people is not to be underestimated. Clearly South Africa cannot afford to provide old age institutions for all its elderly citizens, quite apart from the fact that they have been shown to have negative effects on the aged.

What is required is an inexpensive non-institutional alternative model for housing and caring for old people.

South Africa is in a critical stage of its political development. The promotion of an appropriate non-institutional model of housing holds an implicit political danger. Will Black South Africans, who have suffered the devastating effects of apartheid for many years, approve of these new models, or will they interpret them as yet another second-best solution which is inferior to the total institutions for the aged which the White population clearly values so highly?

The dependency of existing institutional old age homes on state subsidies also holds an obvious danger. What will happen to their aged residents if the country can no longer afford to subsidise them, or if the government refuses to provide subsidies to one group or another?

This study proposes a model which offers one answer to both of these questions. The Abbeyfield model of housing small groups of elderly people in ordinary houses on ordinary streets can be introduced rapidly and inexpensively in all communities in South Africa. Abbeyfield houses keep the aged in the community, have no need for subsidies for running costs and can be run by the aged for the aged. This model is described in detail in Chapter 4.

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CHAPTER 4 : THE ABBEYFIELD MODEL OF COMMUNITY-BASED HOMES FOR THE AGED

4.1 THE BASIC PHILOSOPHY

The Abbeyfield Society has developed a simple, inexpensive and non-institutional model for providing housing and care for the aged in ordinary houses on ordinary streets. The model is based on the principle of helping elderly people to remain in the community within a system of support which is family-sized and intimate, yet which allows the resident privacy and independence.

Abbeyfield houses are ordinary family homes which are converted to house groups of seven to ten old people "where the kind of building reminds them of home and not an institution"[1] Houses are acquired in as many different suburbs as possible, so that the aged who move into this form of agency-sponsored group home can retain the important social networks they have established during their lives. While within the supportive care of a sheltered housing system, they remain close to family members, old friends, their place of worship and familiar shops and services.

A resident housekeeper, shops and cooks two meals per day and cleans the communal areas of the house. Residents provide their own furniture and are encouraged to look after their own bed-sitting rooms.

4.2. ORIGIN AND DEVELOPMENT OF THE ABBEYFIELD SOCIETY

The Abbeyfield Society was established in 1956 by a retired officer in the Coldstream Guards, Major Richard Carr-Gomm, as a response to the neglect and loneliness he found among fiercely independent old people in the poor dockland suburb of London, Bermondsey. While they refused to enter institutional care, they were neither happy nor able to manage on their own. Carr-Gomm formulated the Abbeyfield concept in a house in the street of the same name, where he "conceived the idea of bringing together a group of four to seven lonely people to form an unrelated 'family unit' ..... Residents would receive the gentle support they needed, yet their own bed-sitting room would be their own home within a house".[2]

The success of this first neighbourhood home for the aged led to the establishment of more and more houses. Local Abbeyfield Societies were formed throughout England, Scotland, Wales and Northern Ireland to start and run homes based on this model. In early 1987 the Abbeyfield Society opened its one thousandth house in Britain.[3]

The Society has also pioneered the development of extra-care or very sheltered care houses, which are designed to accomodate the frail elderly within the ordinary house on the ordinary street. Extra-care Abbeyfield houses absorb residents of the Society's supportive care houses as well as from the wider community. There are presently 33 extra-care houses in Britain.

An attempt has also been made to spread the Abbeyfield concept internationally. National societies, affiliated to the British Abbeyfield Society, have been established in South Africa, Australia and Canada, and are being formed in Ireland, France and the Netherlands.[4]

4.3. THE ABBEYFIELD MODEL

4.3.1. Location of Houses within the Community

A cornerstone of the Abbeyfield model of housing the elderly is the belief that it is vital to keep the aged within ordinary communities, and preferably in areas where they have lived much of their lives. By remaining within familiar surroundings elderly people are able to continue using and developing their social networks, ranging from friends and family members to well-known shops and services, health facilities and other amenities.

Alexander, the renowned architect, notes in his extensive treatise on the structure of cities, A Pattern Language, that "when neighbourhoods are properly formed they give the people there a cross section of ages and stages of development".[5]

He notes that there is a tendency for old people to gather together, but that when these clusters grow too big, the young are denied contact with the old, who become isolated. He concludes that large age-segregated housing schemes are a

reaction to the phenomenon of ageism, and are damaging because "old people need old people, but they also need the young, and young people need contact with the old".[6]

The Abbeyfield model is designed to achieve this integration of the aged within the community, in homes which are similar to those of their neighbours, and which are clearly not total institutions. The social network of each resident is, actively drawn into the day-to-day life of the house in several ways.

Firstly, neighbourhood residents are encouraged to form a local Abbeyfield Society to control and maintain the Abbeyfield home in their area, and to establish other supportive homes and an extra-care house if it should be needed. In this way the houses in a particular area come to become part of the local option of that area. They are the places where elderly people from that area belong and control of the homes is vested in the people who live in those areas. This emphasis on the voluntary involvement of neighbours has been tremendously successful in Britain, where there are an estimated 10,000 regular volunteers who plan, establish and maintain Abbeyfield houses.

A second way in which the community-based location of Abbeyfield houses utilises the social networks of residents is by encouraging the friends and family of each resident to participate in the direct care of residents. This ranges from helping the aged friend or relative with personal tasks, such as

hair-washing or pedicure, to attending to business matters such as pensions and wills, to taking them out on outings or providing transport to medical facilities. In this way the social networks of residents are encouraged, unlike in total institutions predicated on the medical-model where friends and family of the "patient" are generally excluded from their care.

The Abbeyfield model allows the children of aged residents to work or engage in other activities such as child-rearing with the knowledge that not only are their parents safe and comfortable, but also that they are near enough to permit a daily visit. Grandchildren who go to school in the neighbourhood are able to visit grandparents on their way home from school, and there is even the possibility of the Abbeyfield resident providing after-school care for grandchildren.

Alexander supports this model of housing the aged by observing the need to provide a system which fulfills the following conditions:

"1. It must allow them to stay in the neighbourhood they know best - hence some old people in every neighbourhood.

2. It must allow old people to be together, yet in groups small enough not to isolate them from the younger people in the neighbourhood.

3. It must allow those old people who are independent to live independently, without losing the benefits of communality.

4. It must allow those who need nursing care or prepared meals to get it, without having to go to nursing homes far from the neighbourhood".[7]

4.3.2. The Size Of Abbeyfield Houses

The Abbeyfield model attempts to create an "unrelated family unit"[8] of 7 to 10 people who develop a system of mutual support and care, and are yet able to retain their independence and privacy. The limitation of size of supportive houses is an attempt to retain intimate relationships between the aged themselves, between residents and their caregivers, and between the aged and the wider community. They are designed as the antithesis of large, clinical institutions for the aged in which the individuality of each old person is denied by the economy of the large scale and the necessity of conforming to institutional rules and regulations. In small homes it is possible to cater to individual tastes, personalities and subtle, but important, individual differences in lifestyle.

The location and size of Abbeyfield houses both relate to the society's belief that old people need independence and privacy in a system of supportive care which facilitates maximum engagement with the community at large. A British institutional nursing

home matron, a respondent in Blythe's journalistic documentation of the ageing process, commented:

> "The best kind of old people's home is the little, discreetly controlled unit such as an Abbeyfield house with its half-dozen residents and supervisor, where one has a latchkey and a roomful of one's own furniture".[9]

The issue of size is debated at length in social work literature. Among those authors who support smaller non-institutional alternatives is Schumacher[10], whose Small is Beautiful argues for a social and economic system designed "as if people mattered".

On a South African level, Macagnano supports both the concepts of community location of old age homes and the restriction of size, advocating "a return to small things, to warm feelings, to an atmosphere typical of the village, where, once, the burdens of life were 'simply' shared....".[11]

4.3.3. Resident Participation in Decision-Making

The Abbeyfield model draws residents into the process of controlling their own home. Each resident is automatically a member of the Residents Committee, which participates actively in a democratic process of decision-making which affects the daily running of the house. Together with the Residents Committee, the housekeeper and the House Committee, which is drawn from

interested people in the neighbourhood, jointly control and maintain the home.

The locus of control is thus vested in the level of the residents, as well as being shared by the staff and voluntary management. Lemke and Moos[12] and Hitch and Simpson[13] found that participation in decision-making enhanced feelings of well-being and self-respect among residents, and also that it was easier to allow residents to participate in smaller homes.

4.3.4. Emphasis on Activity

Together with greater autonomy than in total institutions, the Abbeyfield model of supportive housing also requires considerable activity on the part of residents. They are expected to keep their own rooms tidy and clean, attend to their personal laundry and are encouraged to assist the housekeeper to maintain the communal areas and prepare and serve meals.

The residents are thus engaged in some basic purposeful tasks of which they themselves are the beneficiaries, unlike the passive patient in a total institution whose life consists of waiting - waiting to be served a meal, to be washed, and, ultimately, to die.

Wotton observes that the Abbeyfield Society has found that when the major responsibilities of daily life are taken care of, the elderly "remain active for longer than they would otherwise have

done, and, in the majority of cases, health either improves or a deterioration of health is arrested".[14]

4.3.5. Flexibility

The Abbeyfield model is extremely flexible and can be used for groups of elderly people of "any income or national group".[15] The form of the house can be adapted to the particular lifestyles of groups. Some groups may prefer purpose-built modern houses, while others may favour the conversion of gracious old-fashioned homes.

The Australian Abbeyfield Society has highlighted this flexibility of the model, and Dunster notes that "there is no reason why houses cannot be established for various groups of people with common interests or backgrounds, for example, ethnic groups, pensioners with very limited assets, or those with considerable assets".[16]

Within one city there may thus be a highly luxurious house in an expensive residential area, as well as others in middle and lower income-groups. In England the Society has recently established two houses for Polish-speaking elderly people who immigrated to the country late in life and have not been able to master the English language. Wotton notes that the Polish-speaking houses were started in order to counter the fact that the barrier of language had led to the residents being "in greater danger of

becoming isolated in old age than their contemporaries who speak fluent English".[17]

The advantage of the flexibility of this model for South Africa is obvious. Houses may be established for the rich and for the poor, for those who wish to integrate with people of different groups and for those who are more comfortable living with those of their own group. The model is intended to provide the aged with a choice of lifestyle, rather than to dictate a particular mix of residents.

4.4. THE ABBEYFIELD SOCIETY IN SOUTH AFRICA

The Abbeyfield Society of South Africa was established in 1985, although the Abbeyfield model has been used by the Catholic Welfare Bureau in Cape Town since 1981. The Abbeyfield concept is seen as introducing a further option to the South African continuum of care for the aged.

The model is suitable for South African conditions for a number of reasons. The issues of location within the community, size, participation in decision-making, the emphasis on activity and the flexibility of application have been described in part 4.1. De Tolly, the Director of Planning of the Cape Town City Council, indicates that a vital consideration is that the model "emphasizes affordability, regardless of income or race".[18]

The Abbeyfield supportive house does not depend on state subsidies for operating costs. The only finance required is the capital cost of purchsing and converting old houses or building new houses. The cost of maintaining the property, service and utility charges is covered by the rental paid by residents.

In addition, the model may be used by all manner of voluntary and service organisations, church bodies and other community groups. As this falls conveniently within the present government's policy of privatisation of welfare services, a case may be made for the funding of capital cost by the state. Alternatively, local authorities such as town and city councils own large tracts of housing stock, and may be approached to lease houses to the Society at a nominal cost. Town and city councils may also be approached for rates exemptions and the support of its health services in providing domiciliary services.

The South African Abbeyfield Society established its first house in Claremont in Cape Town in February 1987. The house, which will eventually provide a home for eight people, presently houses three elderly women and a housekeeper. This initial home is aimed at providing housing and care to people with an income of between R450 and R600. This fledgeling Society is too young to contribute significantly to this study. The work of the Catholic

Welfare Bureau in adapting this model to South African conditions has been conducted over a period of six years, and provides a number of insights which are described in Chapter 5.

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CHAPTER FIVE : AN ORDINARY HOUSE ON AN ORDINARY STREET: THE CATHOLIC WELFARE BUREAU HOMES FOR THE AGED PROGRAMME

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CHAPTER 5: AN ORDINARY HOUSE ON AN ORDINARY STREET : THE CATHOLIC WELFARE BUREAU HOMES FOR THE AGED PROGRAMME

5.1. SUPPORTIVE CARE HOUSES

5.1.1. Early Days

The problems of the urban elderly poor were selected as the focus of the work of the Catholic Welfare Bureau (CWB) for 1980. This year-long project led to the choice of the Abbeyfield model of community-based care and housing for the aged and the purchase of the CWB's first neighbourhood old age home, Gill House, at 43 Greatmore Street in Woodstock.

The house is located approximately 200 metres from the Main Road, which offers a large range of shops and services. The terrain in which it is sited is also flat, and suitable for the elderly. The Catholic parish church of St Agnes is situated about 250 metres from the house, providing easy access to church services and activities. The house is within a kilometre of Woodstock Hospital and 2 kilometres from Groote Schuur Hospital, both of which are on the bus route.

The accommodation originally offered by the house comprised four double bedrooms, one single bedroom, two bathrooms a lounge, a separate visitors lounge, a large kitchen and a granny flatlet for the housekeeper. The decision to provide a live-in housekeeper was based on the Abbeyfield model. Her role was to clean the communal areas of the house and to assist the residents

where necessary, although they were required to keep their own rooms clean and tidy, do their own laundry and provide their own meals.

Admission to the nine available places in Gill house was limited to so-called Coloured social pensioners. When the house opened in 1981 residents were charged an all-inclusive monthly fee of R25. Most of the residents were referred by the local parish priest. The total fees covered the costs of the electricity, water and approximately one third of the housekeeper's salary. The balance of her salary, the maintenance of the property and any other costs had to be subsidised by the CWB.

The house was purchased and furnished on a cash basis as a result of a fundraising drive. The Cape Town City Council exempted the Bureau from the payment of rates, except for charges for refuse removal.

The first year of operation brought a number of factors clearly into focus. The most important lesson was that the model could work in an urban South African context. There was a very small turnover of residents, with only two leaving during the initial year. Both had been unable to settle down and left voluntarily to live with relatives.

The second positive factor was the confirmation of CWB's hope that it was unnecessary to provide any meals. Each resident was

allocated a section of kitchen cupboards and ready access to the stove and refrigerator. Several residents elected to cook their meals together on a rota basis, while others preferred to cook for themselves alone. A social worker visisted the house three times each week for an hour per session.

Thirdly, it became apparent that a housekeeper was redundant in a house occupied by seven female and two male pensioners, all of whom were relatively healthy. Her caring services were not even required by the men, as they had their food cooked by the women pensioners. Not only did the housekeeper not have enough to occupy her time, but also the cost of her salary prevented the house from being self-financing.

It was decided to experiment with a house without a housekeeper. Galvin House, located at 72 Gemsbok Avenue in Lotus River, was opened in 1982. The house provided accommodation for six elderly pensioners in three double bedrooms. A kitchen, bathroom and livingroom constituted the communal area. Once again, only fit social pensioners of the so-called Coloured group were admitted. The residents were given the responsibility of keeping the entire house clean and tidy, and a house committee was formed. A CWB social worker attended a weekly house committee meeting at which matters of general concern relating to the running of the house between residents were discussed.

After one year the Galvin House experiment was evaluated and compared with the Gill House experience, which was then at the end of its second year. Two major issues emerged. The first was that Galvin House had been totally financially independent. The small surplus was enough to start a modest maintenance fund. In contrast, Gill House had continued to require a monthly subsidy from CWB, although, if the housekeeper's salary was deducted from the financial statement, it also reflected a small surplus. Maintenance costs of Gill House, a rambling Victorian villa, were predictably higher than those of Galvin House, a solidly built house erected in the nineteen-seventies. It was decided to maintain the housekeeper for a further year as two of the residents were becoming frail and would need more assistance.

A second factor also related to the presence of the housekeeper at Gill House, where the residents refused to assist the housekeeper clean the communal areas, claiming that such work was the reason for her being employed. Residents of Galvin House, however, efficiently kept the house immaculately clean and reported that they enjoyed the housework.

In both houses the role of the social worker was an important one. She selected residents from the referrals made principally through parish priests, Catholic institutions, as well as from the CWB's own casework service. She was responsible for arranging the move to the house, together with all the necessary documentation. Ensuring the general well-being of the residents

was also her role. While house committee meetings were run on a non-therapeutic basis, and principally concerned day-to-day operating issues, occasionally group work methods were used for the resolution of conflict. In isolated cases residents with problems engaged in a private therapeutic relationship with the social worker.

The issue of the role of the housekeeper became clear during Gill House's third year of existence. The two residents who appeared to have been becoming frail deteriorated rapidly, both with terminal cancer. The first, a man of 74 with no living relatives prepared to assist in his care, required only a daily visit from the district nurse and basic home nursing. It was not necessary to hospitalise him, and he was nursed at home for two months by the housekeeper, who was assisted by three of the female residents. He died peacefully in his own bed at Gill House.

The second frail resident was nursed at the house by the housekeeper for six months until her condition became so medically complex that, on the recommendation of the doctor, she was admitted to the frail section of a state-subsidised old age home, where she died within five weeks of admission.

In both cases it was the housekeeper who became the pivotal caregiver, providing what Wotton[1] terms "the standard of care that a loving daughter would give to an elderly parent". Support was provided by the social worker and the residents, and

specialised medical care was provided daily by the district nursing sister.

During this third operating year of the Homes for the Aged Programme the CWB had established two further houses, Kelly House in Elsies River and Huis Frederica in Parow, the former housing six so-called Coloured people and the latter three White pensioners. Two further houses were planned to open in 1986, one in Rondebosch-East and one in Schotsche Kloof.

It was resolved that the Gill House housekeeper be retained and that if and when residents of other houses became frail they could be transferred to Woodstock to be cared for by her.

5.1.2. A Growing Frail Population

During 1986 supportive care houses were opened in Rondebosch East for six White pensioners and in Schotsche Kloof for seven so-called Coloured elderly people. The CWB acquired the adjoining semi-detached cottage to Huis Frederica, which, when the two were joined, could then accommodate seven residents in five single rooms and one double room. In the so-called Coloured houses the fees were raised to R30 per month, while White pensioners paid R50 monthly.

A potential problem in these neighbourhood old age homes began to emerge in late 1986. The entire programme displayed a negligible turnover of residents. Once settled they did not move away, and

with the passage of the years it became clear that the CWB would soon be faced with an increasing frail population, to whom there existed a moral obligation to provide care until the end of their lives.

Acting on this evidence the CWB turned to the British Abbeyfield Society, which had pioneered a system of extra-care or very sheltered housing for the frail elderly. This model, which is described in detail in the manual Abbeyfield Extra Care[2], is different from supportive care houses in that the following services are provided to residents:

* All meals and between-meal beverages, including breakfast in their rooms.
* Help with bathing, dressing and undressing.
* Bedmaking, laundry and cleaning of room.
* Night attendance.
* Custody and administration of medicines.
* Help with personal affairs when required, e.g. pensions, shopping etc.
* Accompaniment to hospital, chiropodist, dentist etc when required.[3]

Clearly this represented a need for much more sophisticated physical infrastructure as well as more staff who would require

training in order to provide this level of care. It was during the preliminary search for appropriate buildings to be converted or for land on which to erect a purpose-built extra-care house, that the CWB decided that it was necessary first to formulate a clear theoretically based model for the relationship between the community, supportive care houses and extra-care neighbourhood homes for the aged. The model selected is described in part 5.2.

5.2. A NETWORK OF SUPPORTIVE AND EXTRA-CARE HOMES FOR THE AGED

The Catholic Welfare Bureau's application of the Abbeyfield Society's model of providing supportive care to small groups of relatively healthy social pensioners in ordinary family houses on ordinary suburban streets indicated the feasibility of this form of agency-sponsored group home. The extensive literature on the Abbeyfield Society's model of extra-care accommodation for the frail elderly appeared to present a similarly acceptable and workable model with which CWB could initiate this form of care. The problem facing the agency during its planning phase for the introduction of the first extra-care house was the nature of the relationship between supportive and extra-care houses, and between the houses and the community in which they were located.

A model which is congruent with the Abbeyfield model of housing the elderly was formulated by Alexander[4]. He proposed that every community should house a proportion of elderly people, who would live in a number of cottages arranged discretely through the community, interspersed with residents of all ages. At the

centre of this network would be a core house, in which the frailest people would live and where they would receive nursing and other care. Those less frail, but who still require cooked meals, personal care, medical help or merely company, would live in groups in cottages within a few hundred metres of the core houses. Fitter elderly people could live in cottages still further away from the core, but still within easy walking distance of it. This model is graphically represented in Appendix B.

The combination of Alexander's model and that of the Abbeyfield supportive and extra-care houses produces a neighbourhood network which provides total care for all but the acutely-ill aged, without the need of total institutions and without establishing large homogenous colonies of elderly people.

Using the combination of these models the Catholic Welfare Bureau has planned two neighbourhood networks of care, both of which will be established during 1987.

The Woodstock network has Gill House in Greatmore Street as an existing supportive care house. Within 250 metres in Dublin Street, CWB has acquired three large semi-detached cottages which are being converted to provide a core house consisting of:

* a supervisor's flat, with private kitchen and bathroom.
* five double bedrooms for frail pensioners.
* two specialised bathrooms for the frail.

* a catering kitchen.
* a community centre for neighbourhood elderly people.
* a small lounge.
* a social work office.
* toilets.

The Dublin Street core house is directly opposite the Catholic Church of St Agnes and the St Agnes Primary School. It is located within the heart of Woodstock, on flat terrain and within easy walking distance of all shop and amenities. The layout of the house is depicted in Appendix C.

The topographical relationship between the Dublin Street core, Gill House and the community of Woodstock is illustrated in Appendix D.

A registered geriatric nursing sister has been appointed to plan and implement a recruitment and training programme for staff and to implement the programme in conjunction with the CWB senior social workers.

An additional network is planned for Khayelitsha, where five houses have been purchased in Village 1 of Town 1. The layout of the 60m^2 houses is shown in Appendix E. A housemother and her family will live in the centre house, and six elderly pensioners in each of the remaining four houses. The frailest residents will live directly next door to the housemother, while those less

frail will live further away, interspersed with the ordinary community.

At the pre-implementation phase of these networks it appears that CWB will have to charge a fee equal to seven-eighths of the social pensions of the residents in order that each network will not require outside subsidy, other than the capital cost of purchasing, furnishing and equipping the homes.

The Woodstock network will accommodate persons of all groups, but it is predicted that residents will predominantly be of the so-called Coloured group. The following amounts represent the monthly fees payable by pensioners of each group:

White	:	R173	of a total pension of R198
Coloured:		R138	of a total pension of R147
Black	:	R85	of a total pension of R 97

The Khayelitsha network will provide care and housing exclusively for Black pensioners.

The Catholic Welfare Bureau will fund the salary of the nursing sister and a part-time social worker, as well as their vehicle expenses.

The extra-care component of the networks will be introduced on an experimental basis and will be evaluated after one year of operation. This new programme clearly indicates a rich field for empirical research.

5.3. MAJOR FAILING OF THE CWB PROGRAMME

While the CWB Homes for the Aged Programme demonstrates a number of successes, there is one important sphere in which it fails to follow the Abbeyfield model. This is on the issue of the involvement of the community in initiating, establishing and running these neighbourhood old age homes.

Sporadic efforts were made to involve parishes in the life of their own little homes for the aged, but these attempts failed to draw the level of voluntary support enjoyed by the Abbeyfield Society. This area will form part of the focus on community in the planning of the Woodstock and Khayelitsha networks, as the CWB believes that without community control, the homes belong to the agency rather than to the community in which they are located.

The present highly-centralised system of controlling the programme vests control in the hands of the agency and the residents alone. By failing to draw the community into the running of the home, the important resources of the residents'

and the neighbourhood's social networks are not harnessed. In addition, the agency has to expend considerable human and material resources, which could more profitably be used in propagating this model of geriatric care in other areas.

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CONCLUSION

Housing and care for the ever-growing numbers of South African elderly are issues which increasingly confront the state, religious institutions, families and individuals. The cost of existing geriatric institutions is already enormous, and waiting lists for admission are burgeoning. The Black and so-called Coloured elderly, have few institutions for the elderly compared with their White counterparts.

What is required is a broadening of the continuum of care for the elderly in South Africa to include as many non-institutional alternatives as possible. These alternatives range from increased levels of domiciliary care to the amendment of town planning regulations to allow the erection of granny flats, fostering an elderly person and to small neighbourhood houses where a few elderly people can live in the security of a group, and yet maintain their privacy, independence and links with the familiar community around them.

The last-mentioned alternative is proposed by this study as eminently suitable for South African conditions. Not only is it not dependent on state subsidisation for running costs, but also it is flexible enough to be introduced in any community, rich or poor, racially integrated or segregrated.

Among its important features are the location of the houses right in the very heart of the community where the aged belong; the

intimate, homelike qualities of the homes; their limited size; and the emphasis on involving both residents and the community in the process of making the decisions required to plan, establish and operate homes in their neighbourhood for the aged of that area.

Intrinsic to the construction of this model, and, indeed, to this study, is the belief that the aged have significant contribution to make to the health and well-being of each and every community.

This study indicated several areas which could profitably be examined by other researchers.

The first is the need for an extensive empirical study to compare appropriate indices of well-being of residents of total institutions, neighbourhood old age homes, and other forms of care.

The second area for research is a longitudinal study of the physical health, emotional well-being, and levels of activity of residents of neighbourhood old age homes. Thirdly, it might be useful to compare neighbourhood homes established in communities which differ in socio-economic, racial or religious groups.

From the perspective of social planning and administration there are a number of other areas for research. Among these is the need for an examination of the financial implications of this

model including cost-benefit analysis and a calculation of an exact unit establishment and running cost per bed per home. This in turn may be compared with the cost of establishing and operating each bed in a total institution.

Research is also required in the area of extra-care or very sheltered housing for the aged. Not only do the financial implications require analysis, but also evaluative research of the pilot projects run by the Catholic Welfare Bureau in Woodstock and Khayelitsha may yield useful information for others who wish to experiment with this model.

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APPENDIX A

SPECIALIZED SERVICES FOR THE ELDERLY: STAGE OF DEVELOPMENT MODEL

RESIDUAL: Characterized by:

(1) family and mutual aid only; some volunteers;

(2) some private homes for the aged;

(3) no public funding of facilities for the aged;

(4) lack of training programs;

(5) lack of home help or other domiciliary services.

EARLY INSTITUTIONAL: Characterized by:

(1) organized social services, including volunteer organizations;

(2) attempt at supervision/regulation of private homes;

(3) some public funding of institutions for the aged;

(4) professional training programs with an aging component;

(5) demonstration home help domiciliary services.

INSTITUTIONAL: Characterized by:

(1) specialized medical facilities, such as geriatric hospitals, chronic care and attention homes;

(2) licensing and regulation of private homes by a public agency;

(3) public funding extended to special housing, community centers, and other facilities;

(4) substantial development of professional training programs;

(5) substantial development of a range of domiciliary services, including home help, meals on wheels, laundry, transportation, and the like.

MAXIMUM INSTITUTIONAL: Characterized by:

(1) a range of specialized facilities, including day care centers and hospitals, halfway houses;

(2) participation/leadership in regional/international programs for establishing and enforcing standards;

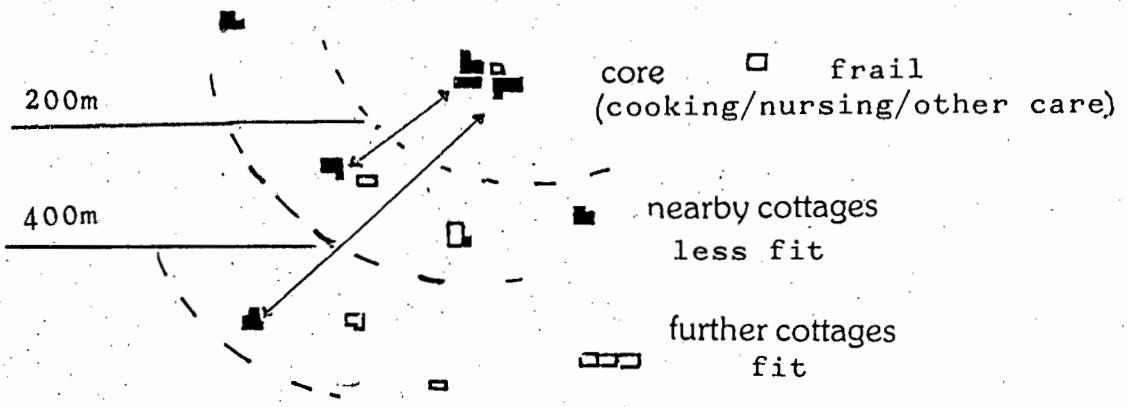
(3) active organizations of the aging, political and otherwise;

(4) regional centers for research, training and community service in gerontology;

(5) a cluster of domiciliary services, co-ordinated with other health and welfare sub-systems.

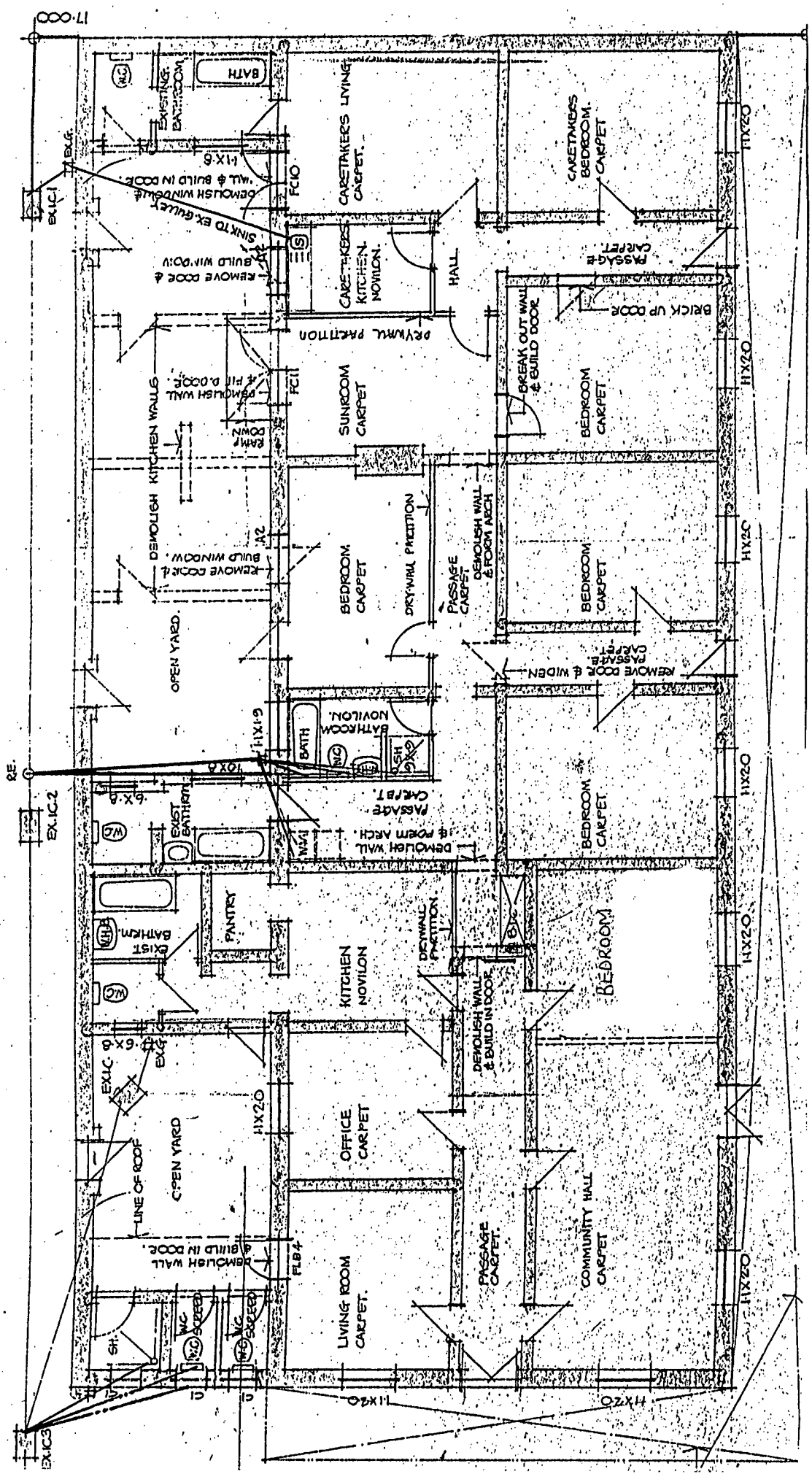
APPENDIX B

a system of neighbourhood old age homes



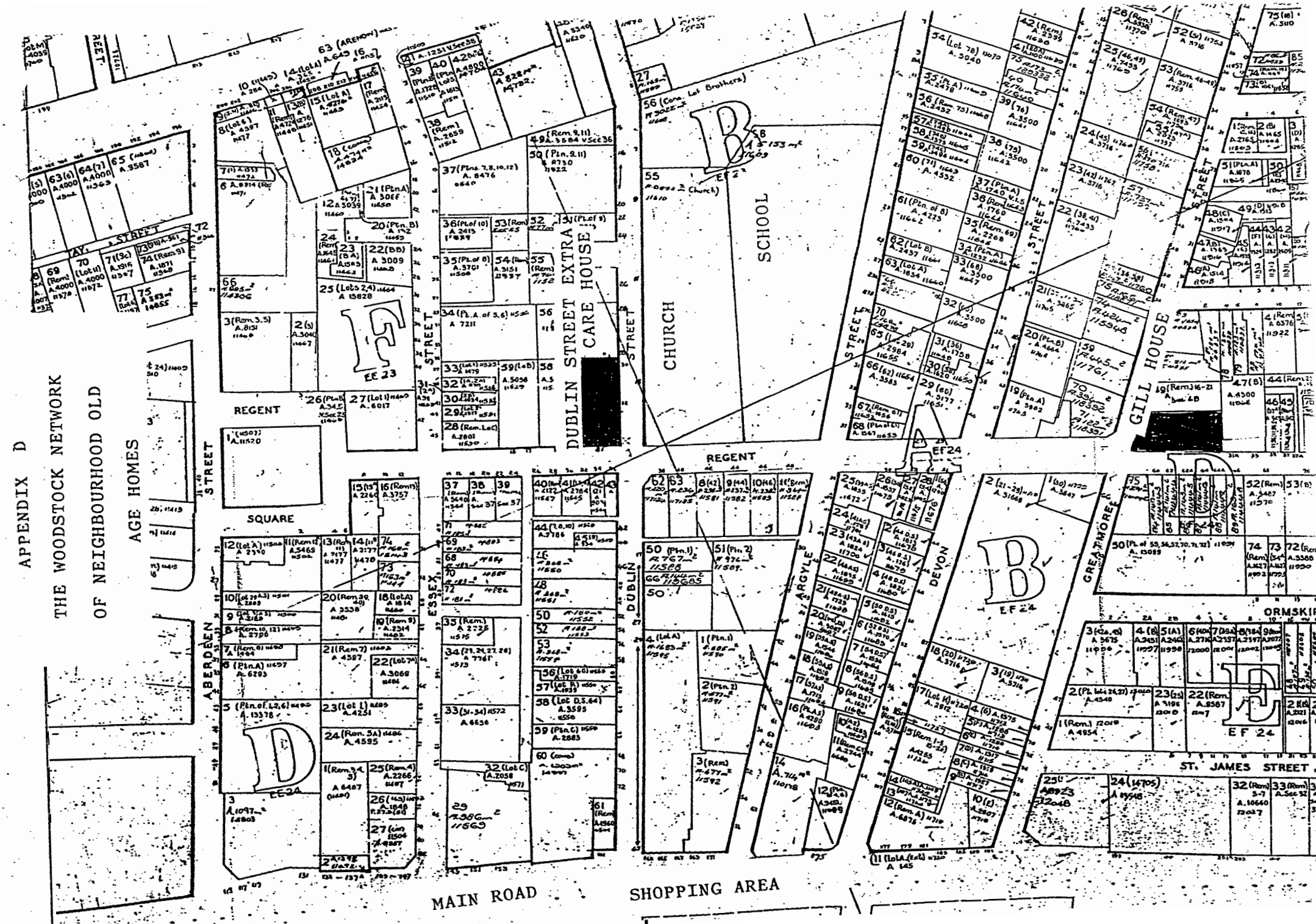
APPENDIX C

THE DUBLIN STREET EXTRA CARE HOUSE



APPENDIX D

THE WOODSTOCK NETWORK OF NEIGHBOURHOOD OLD AGE HOMES



APPENDIX E

NETWORK OF KHAYELITSHA COTTAGES FOR COMMUNITY-BASED CARE OF THE AGED