Co-operation between health and welfare services in Sweden and the United Kingdom

Some reflections arising from a study visit

Christine Hallett

Christine Hallett är universitetslärare i socialt arbete vid universitetet i Keele i England, ett centrum för kvalificerad forskning inom hennes ämnesområde. Hennes egna arbeten har i särskild grad gällt barnmisshandel. I anslutning därtill har hon blivit intresserad i frågor om samverkan mellan socialvård och sjukvård och hon deltar i den nu avslutade internationella studien, som redovisas på annan plats i detta nummer. Hösten 1982 genomförde hon ett studiebesök i Sverige, främst inriktad på samverkansfrågor, särskilt när det gäller äldrevården. En del intryck från detta studiebesök redovisas i denna artikel, där hon särskilt jämför svenska och engelska förhållanden.

När det gällt primärvårdens organisation förvånas hon över att man i Sverige tolererar så stora geografiska orättvisor. Också i England finns skillnader i resursfördelningen mellan olika områden men förekomsten av allmänläkare och annan primärvårdspersonal är långt jämnare spridd. I Sverige konstaterar hon en nästan total avsaknad av primärvård på vissa ställen. På andra håll har man däremot utvecklat vårdcentraler i en skala och en typ som är helt otrolig utifrån brittiska förhållanden. De omfattar inte bara läkare och sjuksköterskevård utan arbetsterapi, sjukgymnastik, dagvård, bibliotek, servicevåningar och olika typer av omsorg för äldre, långvårdsavdelningar, utrustning för en avancerad diagnostik samt på sina håll hela socialvården. Den stora omfattningen av resurser kan ge viktiga potentiella möjligheter till samverkan. Men, frågar sig Christine Hallett, kan det finnas en risk i att sjukvården får så stor dominans i sammanhanget?

När det gäller socialtjänstens villkor är hennes intryck att de brittiska socialarbetarna har en säkrare professionell organisatorisk grund än de svenska. Detta kan ha flera orsaker. Socialtjänsten i Storbritannien är organiserad i långt större enheter än i Sverige, vilket ger dem en viss styrka när det gäller att konkurrera om resurser och tala auktoritativt på socialtjänstens vägnar. Det ger också möjlighet till differentierat utbud av specialisttjänster. Möjligen ger det också socialarbetarna en mer självständig ställning eftersom politikerna inte kan i detalj reglera och kontrollera det sociala arbetet, såsom sker vid de små svenska socialdistrikten eller kommunerna. Det traditionellt långt mindre inslaget av social kontroll i England kan också spela en viss roll.

En allmänt viktig skillnad är annars resursnivån mellan de två länderna. Sverige är ännu ett mycket rikare land än England. Sverige ägnar också nio (snarare tio, redaktörens anmärkning) procent av sin bruttonationalprodukt åt hälso- och sjukvården jämfört med fem procent i England. Det kan visserligen finnas en relativ fattigdom hos grupper av äldre i Sverige. Det kan dock inte jämföras med den aktuella situationen i Storbritannien där gamla, på grund av svårigheter att betala bränslekostnader, kan lida av extrem kyla och även råka ut för undertemperaturer. Det svenska förhållandet tycks också ge ojämförligt större möjligheter att ställa olika resurser till medborgarnas förfogande. Samtidigt kan, enligt ordspråket att nöden är uppfinningarnas moder, bristen på resurser i England kanske ge möjligheter till mer nytänkande och bättre resursutnyttjande.

Så mycket är likt och så mycket är olikt mellan Sverige och Storbritannien att det kan vara intressant att följa skillnaderna när det gäller samarbete mellan hälso- och sjukvård och dess effekter.

A guide book, produced for foreigners, about local government in Stockholm begins with the warning:

"When trying to grasp the essential features of local administration in any country one important pre-requisite should be borne in mind—it is necessary to refrain from continuous and detailed comparisons with the administration structure back home".[1]

This article, which considers aspects of co-operation between health and welfare services, deliberately runs the risk of ignoring the warning quoted above. For comparisons, albeit not too 'continuous' nor inappropriately detailed, will be drawn between policies and practices in Sweden and in the United Kingdom. They will be based principally upon experience gained from a study visit to Sweden made in autumn 1982.*

The visit lasted only four weeks and raised as many (or more) questions as it proved possible to answer in a highly selective, possibly idiosyncratic, programme focussed mainly upon primary health care and the care of elderly people. Nonetheless the brief opportunity to learn about a different system in operation prompted questions and ideas as much about British as about Swedish ways of working.

Health and welfare systems in both countries share certain characteristics. For example, they are publicly-sponsored and financed, with substantially no barriers to access through price. They are sufficiently similar to enable some comparisons to be made in areas such as territorial justice and patterns of primary care and resource levels.

Others, notably Westrin (1980)[2], have undertaken comprehensive and systematic studies of interprofessional co-operation in Sweden. No attempt is made here to replicate that work nor to take such a synoptic view. Rather, a few of the many possible themes which proved of particular interest to a visitor are selected.

Patterns of primary care

One striking contrast with the U.K. (where the health service is run by national government, although administrated by regional authorities) is the wide degree of territorial injustice accepted or at least, tolerated in Sweden both between different county councils *and* within them in the provision of primary health care. This is not to suggest that there do not exist in England substantial differences in levels of resources devoted to health care (e.g. the ratio of medical staff and of hospital beds to population) between and within the health authorities. Such differences, together with regional differences in patterns of morbidity and mortality have recently been starkly, and, following almost forty years of the national health service, disappointingly reaffirmed by the recent Black Report *Inequalities in Health*.[3] Nonetheless, perhaps because of the longer tradition of primary health care provided in England, principally by the general practitioners and a small practice team, the national coverage of primary health care is much more even. The average GP/patient ratio is 1:2,300,[4] although this figure does conceal some unevenness in distribution with, in contrast to Sweden, particular staffing difficulties in the inner cities as opposed to rural areas. But, in Sweden, the provision of primary health care is much more patchy with, in consequence, very different possibilities for co-operation from one locality to another. It was repeatedly stated that the wide discrepancies in distribution in primary care in Sweden was a transitional phase, consequent principally upon manpower shortages (especially of district doctors), and that there were active plans to remedy these. British experience in recent years shows, nonetheless, how difficult it can be to implement policy objectives of this kind and to effect a real

Brittiska erfarenheter visar hur svårt det kan vara att förändra fördelningen av resurser mellan t ex primärvård och sjukhusvård

* The visit was undertaken under the auspieces of the Research exchange Award Scheme sponsered and financed jointly by the Humanities Research Council of Sweden and the Social Science Research Council of the United Kingdom. I am pleased to record my thanks to them, to the Institute of Social Medicine, Uppsala University, which provided an institutional base and also to the people engaged in the planning and provision of health and welfare services in Sweden who generously shared their experiences and ideas with me.

17% av de engelska allmänläkarna arbetar på vårdcentraler

shift in the balance of resources devoted to primary care as opposed to hospital care.

The uneveness of Swedish provision was evident in the virtual absence of primary care in some places compared with others where it had been developed and health centres built on a scale and of a type quite unlike anything to be seen in the U.K. The main distinguishing characteristics were their size and the range of services provided. In those visited, these included the expected primary medical, nursing and receptionist services, but also occupational and physiotherapy rooms, equipment and staff; day centres; libraries; service apartments; residential care for elderly people; long-term wards; and a range of diagnostic facilities unusual in British primary care—plus, in some, extensive social welfare offices. In Britain the range of personnel and services provided and the size and equipment of the buildings does not match the scale and sophistication of these Swedish "showpieces"—a-typical though they may be. The 'typical' British pattern in primary care* is for groups of general practitioners to work together from specially adapted, but not usually purpose built, premises, with practice-attached nurses (health visitors and district nurses) and receptionists and, rarely, a social worker attached to the practice. Even where general practice is located in health centres (only about 17% of GP's in Britain operate from health centres)[6], the scale of the buildings and the range of services is much less extensive than in the large ones visited in Sweden.

The range of people and services available on one site has important *potential* consequences for co-operation between health and welfare personnel. One is that is, theoretically at least, possible to provide a variety of health and welfare services from one physical base to, for example, elderly clients. Thus primary medical and nursing care may be provided alongside occupational or physiotherapy, day service apartment care, old people's home, even long-term nursing care.

No British examples are known to the author of the provision of services such as day care, occupational or physiotherapy or long-term residential care from a primary care base. This reflects and important organisational and, possibly, ideological difference between the systems in the two countries. Crudely and with some danger of oversimplification, the problems of frail elderly people (outside hospital) have been defined in Britain as *social* and responsibility in the public sector largerly given to the organisationally separate social welfare departments, run by units of local government and known as social services departments. It is these organisations (together with voluntary and private social welfare agencies) which provide the bulk of day care and residential accommodation for elderly people. Their structural separation from the national health service, coupled with the reluctance of some GP's to concern themselves with the care of their elderly patients,[7] leads to a situation where the social services play a vital role in community-based care of elderly people with quite inadequate input from the full range of health care professionals. There is, of course, medical and nursing care from general practitioners, distric nurses and from health visitors for people in their own homes, but the virtual absence of physiotherapists from social services departments (and from general practices and health centres—the great majority of physiotherapists are employed in hospitals) mean that their services are restricted to in-patients or those attending hospital as out-patients. In Sweden, it was possible to see physiotherapists working from bases in hospital or health centre, in day and residential care, and even

I Storbritannien är det mycket ovanligt att sjuksköterskor i primärvården medverkar i den dagvård eller övrig service som organiseras av socialtjänsten

* It is not the case as is stated in the Swedish Ministry of Health and Social Affairs publication "*Primary Health Care Today*"[5] (e.g. p. 14) that in Great Britain 'one-doctor practices with a nurse prevail'.

Stora svenska vårdcentraler ger en möjlighet för gemensamma bidrag till äldrevård, som inte existerar i Storbritannien

in instructing home-helps in simple exercises and techniques to use with clients in their own homes. A second example, was the 'outreach' of district nurses from health centres to municipality old peoples homes offering supervision and advice to care assistants caring for the 'iller' residents. In Britain, it is most unusual for nurses from a primary health care base to make a health care contribution to the day or residential care services provided by social services departments, despite the physical and mental frailty of many of those who receive such services. Where the large Swedish health centres existed, there was an opportunity for potential contributions from a common base from a wider range of professionals than exists in Britain.

It was suggested above that the separation of health and welfare services in Britain is not simply organisational but also serves a symbolic function in stressing that social difficulties are separable from health problems or, to take the case of elderly people as an example, that ageing is a normal process and not a disease. One possible consequence of the large health centre complex which combines primary medical care services with e.g. day centres, service apartments and residential homes for elderly people is that the daily living environment of the residents, whatever attempts are made at softening the interior design, is unequivocally *medical*. This may matter less if, in the long term, primary *health* care were to develop with an emphasis on health prevention and maintenance and on the place of social and environmental as well as physical factors in health. At the moment, however, the operational realitites in primary care are medically based and illness oriented. People visit the health centre when they are sick. It would be interesting to know whether close proximity to this environment has an effect on the self-image of the residents in, for example, service apartments or residential homes on health-centre sites.

Social welfare

Such considerations are also relevant to the broader relationships between health and welfare personnel and to the status of social welfare. A few health centres were visited in which the whole of the local municipality social welfare office was located, not simply a social worker on attachment (as sometimes occurs in Britain). There was no local organisational base for social welfare separate from the health centre complex. In centres where this pattern existed, social welfare staff interviewed were extremely enthusiastic. They referred to closer and easier collaboration with health personnel and to the beneficial side-effects in terms of accessibility, status and image of social welfare of being carried along on the more respectable coattails of primary health care. None questioned the possible disadvantages of this arrangement. This confirmed an impression gained, although it was challenged by some in discussion, that social welfare may have a more secure professional and organisational base in the U.K. than it enjoys in Sweden. These are complex and subtle matters and may seem paradoxical. It cannot be denied that, despite vast increases in staffing and resources in the early 1970's, social work in Britain has its own difficulties, including being publicly held to account for failing to prevent deaths through child abuse. Its uncertain public image is reflected in the Government's decision in 1980 to set up an inquiry into the roles and tasks of social workers–the Barclay Committee.[8] There are differences, however, in the position of social work in Britain and in Sweden. First, in Britain social workers are less often and clearly identified as agents of social control. The phrase 'social control' is, as Higgins (1980)[9] has noted, used loosely in respect of much social work activity. In a variety of ways, besides exercising compulsory measures of control, social workers acts as controllers, for example reinforcing dominant assumptions about fam-

På vårdcentraler med samlokalisering av medicinsk och social vård var socialarbetarna ytterligt entusiastiska över samarbetet

ily life and patterns of behaviour and in their powers to grant access to resources, e.g. residential care or financial aid. In Sweden, however, greater emphasis than in the U.K. is placed upon social workers as controllers, stemming principally from their responsibilities in social assistance and the treatment of alcohol abusers.

A second difference which may be of considerable importance in the relationship between health and welfare, is that in Britain, social welfare is organised in larger organisational units than in Sweden. The 116 units of local government (county councils and metropolitan boroughs) which provide social welfare through social services departments serve populations ranging in size from 174,000 to over one million.

This reflects deliberate policy decisions made in the late 1960's and early 1970's[10] to create unified social services departments in units of a size which enabled them to provide the required range of specialist services, and gave them an organisational base of sufficient strength to compete successfully for resources and to speak authoritatively on behalf of social welfare. The next tier of local government—the district councils (closer in population size to the Swedish municipalities) was rejected as too small for these purposes.

An important and related theme in these reforms was the establishment of an organisational and professional base independent from medicine, in close relationship with which social work had earlier developed. This thinking was also reflected in the decision implemented in 1974 to transfer all social workers in hospitals from the employment of the national health service to the local authority social services departments. Many remained doing exactly the same jobs as before but their formal employment by welfare agencies rather than the health service was seen to be important in itself. These debates seemed somehow less pressing in the Swedish context where social workers accepted a close alliance between health and welfare without seeming as sensitive about preserving a separate organisational base and identity.

De stora socialvårdsenheterna i England har kritiserats bland annat för sin byråkratiska och hierarkiska struktur och sin stelhet

The British decision to establish large departments of social services should not be presented uncritically. The departments have been criticised, amongst other things, for their bureaucratic and hierarchical structures, their inflexibility, and remoteness from the populations served, despite widespread efforts to decentralised services and establish sub-offices in various parts of the areas covered. Indeed one of the most important current developments in British social work is the trend towards much greater decentralisation of services in "patch" or community based social work inforced by the Barclay Report.[11]

Nonetheless in comparing the British and Swedish frameworks within which co-operation takes place, this difference in scale is very important. While in some towns or villages, health and welfare staff may share health centre premises in Britain, as they do in Sweden, it would simply not be possible for the *whole* local social services department to operate from a health centre in any locality. The enterprise is on a much larger scale of organisation.

The greater average size of British social services departments contributes to, but perhaps does not wholly explain, the third significant difference noted between the position of social workers in the two countries. It concerns the amount of discretion in decision-making accorded to social workers. As in many of the matters discussed here, there are evident dangers in generalising. In Britain[12] as in Sweden[13] there is considerable local variation in these matters with different policies and practices reflecting differences in the role relationships between elected representatives and professionals. Nonetheless, it appears to be the case that the larger size of the British departments—which itself poses practical limitations on the extent and frequency with which local politicians can intervene in decision-making especially concerning individual cases—as well as perhaps different traditions of 'professionalism' in British local government have resulted in British social workers now having rela-

Skillnaderna mellan Sverige och Storbritannien omfattar bland annat skillnader i deltagandet i de lokala kommunala valen – 90% deltagande i Sverige mot omkring 40% i Storbritannien

tively greater freedom of powers of decision. This difference does not only apply to financial matters, as Lewis (1982) notes.[14] The difference may be accentuated by the moves in Sweden to decentralise further and devolve responsibilitites to sub-units within the municipalities.

It is not the intention here to appraise the advantages and disadvantages of the two systems in this respect. Important differences in the national contexts make such a task difficult. They include differing participation rates in local elections (over 90% in Sweden compared with some 40% in the U.K)– which affects the 'representativeness' and 'legitimacy' of elected local politicians–and the much greater degree of consensus on social and other issues in Swedish politics. In the context of interprofessional work, however, two interesting issues arise. The first is, does the extent to which local politicians can influence/control the decisions of social workers affect the social workers capacity to co-operate as equals with health care workers and are they accepted as such by health care professionals? The second is rather different. It has been suggested by Westrin (1980)[15] with reference to Sweden and by Weiss (1981)[16] with reference to the USA, that politicians may have a greater commitment to co-ordination and co-operation than the professionals themselves. There exists the possibility in the Swedish system that the close involvement of the politicians in welfare (and indeed in health) may place them in a better position to press for implementation of the political objectives of co-operation.

Resources

The level of resources available in health and welfare in Sweden and the possible consequences for interprofessional co-operation proved to be of considerable interest. It has been both fashionable and necessary in recent years to argue that resource shortages can afford opportunitites, perhaps long over-due, to reexamine taken-for-granted assumptions and working practices and to devise more effective methods. It is neatly summarised by the English phrase "necessity is the mother of invention" and there is clearly some truth in the saying.

Beyond a certain point however, it is likely that severe and consistent resource shortages will affect the nature and quality of co-operation, and this point may now have been reached in British health and welfare services. Much interprofessional co-operation has its basis in exchange theory–professionals seek help from each other because they perceive others to have goods (skills, resources, time, powers, influence) which they lack. If certain or all of the groups involved know that they must refuse more often than they can give, they are likely to try to avoid those contacts with clients and with other professionals which emphasise this fact. They will also be trying to protect their own hard-pressed budgets against further claims. It was clear that in Sweden, despite the current economic position, the basic pressure on resources was less severe. This was not, of course, unexpected. Sweden's economic performance in recent years has been superior to that of the U.K. Furthermore, even allowing for the considerable difficulties in making international comparisons in the field of health economics, it is beyond doubt that Sweden, in devoting 9% of its GDP in health compared with a British figure of about 5%,[17] has one of the most highly developed and resourced health care systems in the World. Does this affect practice at field level? There *seemed* to be less tension field level over resources amongst and between the different professions than, it is suggested, would be common in the U.K. This can be illustrated with reference to the care of

Om vissa yrkesgrupper vet att de oftare måste vägra än de kan erbjuda samarbete kommer de att undvika kontakter med andra yrkesgrupper

elderly people. It should, perhaps be stressed that in some places visited acute shortages (e.g. of beds in longterm care) were emphasised but a vivid, and possibly at typical memory, is of one health centre team of medical and welfare personnel reporting on their regular meetings to decide the appropriate mix of health and welfare provision for their elderly patients/clients in the context of *vacancies* in service apartments, old people's homes, long-term care, beds for the elderly mentally confused and spare capacity in the home-help and home nursing services.

In such circumstances, it is more possible to contemplate schemes such as one visited (operating from a hospital base) in which individual cases are discussed by health and welfare personnel and costs allocated between the budgets in varying proportions (e.g. one third health care, two thirds 'social' care) depending on the circumstances.

Another impression gained may relate as much to differences between Britain and Sweden in *styles* of care as to differences in levels of resources. Without having undertaken comprehensive and standardised assessments (including of mental confusion) it is not possible to offer 'hard' evidence to substantiate an *impression* that the placement of elderly people was roughly on level "higher" in Sweden than in the U.K. That is to say, the populations in facilities such as service apartments, old people's homes and long-term care wards *appeared* to be more mobile, alert and independent and less incapacitated than might have been expected of their British counterparts in similar types of care. This is not a simple matter and two facts should immediately be stated. First, there is evidence that, in Britain, there is a worrying lack of coherence in the allocation of elderly people between various types of care—in particular, some people in 'higher' levels of care are considered to be less in need than some of those in lower levels.[18] Furthermore, there is now clear evi-

Man får ett intryck att äldre människor placeras på grovt sett en vårdnivå högre i Sverige än i Storbritannien

Vården ute i samhället på grund av bristresurser leder i Storbritannien till ekonomiska, psykologiska och sociala kostnader för familjen, särskilt kvinnorna, på ett sätt som kan beskrivas som skamlöst och exploaterande

dence[19] that the acute shortage of public (and private) provision leads to the care of some people in the community at costs to their careers (usually the women in the family) in economic, psychological and social terms which some would argue are quite scandalously and exploitatively high in a so-called welfare state.*

It is *possible* that the relative availability of resources, in some areas at least in Sweden, has led to a greater readiness to provide. The Sundsvall study[20] suggests that some people could have been cared for on a lower level although if concluded that most of the people studied were on the right level of care. Nonetheless, the ratio of hospital beds to population (15–16 per 1 000 in Sweden compared with less than half that number in the U.K.[21]), is of interest here. It would appear that in Britain "elderly people and those chronically sick are more often cared for by relatives or given medical care in the home."[22]

This is not to suggest that such a position might not pose its own difficulties in inter-professional co-operation if traditional and entrenched patterns of providing care were to offer resistance attempts to develop more flexible patterns of community-based provision.

A final observation about resources concerns the economic situation of the Swedish population and thus of clients of health and welfare services with possible consequences for inter-professional co-operation. Major difficulties are posed for health and welfare personnel in the U.K. by the poverty facing many of their elderly (and indeed other) clients/

* The levels of stress which may be experienced are indicated by a growing awareness among health and welfare professionals of the problem of physical abuse of some elderly people by those who care for them.

patients. It is, of course, recognised that poverty is to an important degree a relative concept and that the experience of deprivation is real and harsh for the poorest sections of Swedish society. Nonetheless, it is clear that income levels, for excample, in old age in Sweden[23] are such as to avoid the situation which is not uncommon in the U.K. of elderly householders suffering from extreme cold and even hypothermia through sheer lack of resources to pay winter fuel bills.[24]

Interprofessional co-operation in Sweden, therefore, starts from a resource base in the public health and welfare services and amongst the community as a whole which is generally less dire than the one currently facing their British counterparts. It would be interesting to monitor the differences in the nature and frequency of co-operative working which may result. In conclusion, it is important to stress that in this article certain attributes of the context in which interprofessional co-operation takes place have been selected and their impact upon a British visitor described. The discussion has been necessarily both speculative and tentative and it may have only limited applicability to the general situation in Sweden. No doubt, putting pen to paper on the basis of limited experience is both dangerous and provocative, but it is hoped that it may also offer food for thought.

REFERENCES

1. Stockholm Information and Consumer Office (1979) Local Self-Government in Stockholm p. 3
2. *Westrin, C-G:* (1980) Primary Health Care: Co-operation between health and welfare personnel in Sweden
3. Department of Health and Social Security (1980) Inequalities in Health, London
   cf. also
   Townsend P & Davidson N: (1982) Inequalities in Health, Harmondsworth: Penguin
4. Cmnd. 7615 (1959) Royal Commission on the National Health Service, London: HMSO p 75
5. The Swedish Ministry of Health and Social Affairs (1981) Primary Health Care Today
6. Cmnd 7615 (1979) op cit p 86
7. see, for example,
   Isaacs B and Neville Y: (1976) The Measurement of Need in Old People Scottish Health Service Studies No 34 Edinburgh: Scottish Home and Health Department.
8. National Institute for Social Work Training (1982) Social Workers Their role and tasks (Barclay Report) London: Bedford Square Press
9. *Higgins J:* (1980) Social Control Theories of Social Policy Journal of Social Policy Vol 9 No 1 pp 1–23
10. see, for example,
    Cmnd 3703 (1968) Report of the Committee on Local Authority and Allied Personal Social Service Authorities London: HMSO
11. National Institute for Social Work Training (1982) op cit
12. see, for example,
    Hallett, C (1982) The Personal Social Services in Local Government London: George Allen and Unwin
13. *Lundblad H:* (1979) Delegerad beslutanderätt inom kommunal socialvård (Stockholm: Liber)
    quoted in
    Lewis M R: (1982) 'The roles of elected local government officials in planning and implementing health and social services in Sweden and the United States' mimeo. University of Houston, Graduate School of Social Work, Texas, USA
14. *Lewis M R:* (1982) op cit
15. *Westrin C-G:* (1980) op cit
16. *Weiss J* (1981) Substance vs symbol in administrative reform: the case of human services co-ordination Policy Analysis pp 21–45
17. Swedish Ministry of Health and Social Affairs (1982) Health in Sweden p 65
18. see, for example,
    Plank D: (1977) Caring for the Elderly: A Report of a study of various means of caring for dependent elderly people in 8 London Boroughs (London: Greater London Council)
19. see, for example,
    Finch J and Groves D: (1980) Community Care and the family: a case for equal opportunities Journal of Social Policy Vol 9 Part 44 pp 487–451
    and (ed) *Walker A* (1982) Community Care Oxford: Basil Blackwell and Martin Robertson
20. Moving elderly people to service and care institutions and facilities. Sundsval 1980 (English summary)
21. The Swedish Ministry of Health and Social Affairs (1982) op cit p 76
22. Ibid p 76
23. The National Commission on Aging (1982) Just Another Age: A Swedish Report to the World Assembly on Aging, Stockholm p 36
24. *Wicks M:* (1978) Old and Cold London: Heinemann