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Institutional Care for Older People in Developing Countries: Repressing Rights or Promoting Autonomy? The Case of Buenos Aires, Argentina

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Abstract[1]

Population ageing is an established trend in almost all developing countries, including rapid increases in the oldest age groups. At the same time, processes of social, economic and cultural change call into question the extent to which older people with care needs can rely on kinship networks to provide this support. As a result, most developing countries have seen a major expansion in the demand for and provision of institutional care for older people in developing countries. Despite this, the quality of services offered by the growing number of care homes has scarcely been studied. This paper assesses whether privately-run old age homes offer their residents a dignified life, respecting their rights and promoting their social inclusion, or whether these homes lead to segregation and undermine personal autonomy. The paper draws on a survey of 101 old age homes conducted in Buenos Aires, Argentina during 2004 and 2005. This case study is prefaced by a brief review of key issues for long-term care across the developing world. The Argentine survey reveals considerable diversity in the performance of care homes, with most falling a long way short of internationally recognised best practice in care provision.

Introduction

The growing role of long-term care in developing countries

Although many older people are able to enjoy relatively independent and active lifestyles, the probability of experiencing disability and reduced functioning increases through old age (Woodrow 2002). Consequently, increases in the number of older people, especially those in the oldest age categories, creates additional demand for long-term care of one kind or another. In richer countries, this growth in long-term care needs is well-documented and has become the subject of intense discussion among academics and policy-makers (Brodsky et al. 2003a; Howse 2007). By contrast, in most developing countries these issues continue to receive minimal attention (Brodsky et al. 2003b; Lloyd-Sherlock 2002).

There are a number of reasons for this worrying neglect. First, some policy-makers have been slow to recognise the rapid growth of very old populations, and greater priority is still given to younger age groups. Second, policy is dominated by concerns about formal pension programmes, including contributory schemes and social pensions. Third, there is a tendency to assume that informal support networks continue to function relatively well in most developing countries, reducing the need for specific policies and interventions. This is based on the observation that older people in developing countries are less likely to live alone than is the case in richer countries (United Nations 2005). However, it should not be assumed that co-

[1] The authors are indebted to Janet Seeley for her helpful comments on an earlier draft of this paper. Nevertheless, they take full responsibility for any errors or flaws in this paper.

residence with other adults is a guarantee of effective informal care. Also, there are indications that living arrangements in many developing countries are rapidly shifting towards patterns found in the North (Palloni 2000).

Table 1. Population aged 80 and above, 1950-2025.

Regions	Years	1950	1975	2000	2025*
Less developed regions	% of total	0.3	0.4	0.7	1.3
Less developed regions		5,278,000	12,072,000	34,057,000	87,333,000
Argentina	% of total	0.5	0.9	1.7	2.8
Argentina		86,000	234,000	630,000	1,321,000
	Years	1947	1980	2001	2015*
Buenos Aires city (Federal Capital)	% of total	0.6	2,5	4,5	4.8
Buenos Aires city (Federal Capital		17,604	74,257	125,742	147,185

* Median variant projection.
Sources: UN (2002); National Censuses of Population 1947, 1980 and 2001. Provinces' Population Projections 2001-2015 INDEC, Argentina.

Despite this complacency, there is considerable indirect evidence that most developing countries are facing a very rapid expansion in demand for long-term care. Established population ageing is increasingly reflected in the growth of the very oldest age groups. Although the population aged 80 and over still only represents a small share of the total population of developing regions, in absolute terms it almost trebled between 1975 and 2000 (Table 1). At the same time, various trends, including greater female participation in salaried labour and increased levels of migration, may be reducing the capacity of informal networks to provide care. Studies from a wide range of developing countries indicate important shifts in inter-generational relations, whereby older generations are becoming less confident about receiving care and support from younger family members (Bhat and Dhrubarajan 2001; Aboderin 2004; Jelín 2005). There is also evidence that residential institutions are becoming an increasingly acceptable alternative to family care. For example surveys of attitudes about caring for older people in India found a substantial shift over time. In 1984, 91 per cent of adult children surveyed said it was their duty to care for older parents; by 1994 this had fallen to 77 per cent (Jamuna 2003). The 1984 study found no children who supported the idea of sending older people to care homes, but by 1994 23 per cent did.

Table 2. Long-term care options for older people.

Intensive institutional care	Long-term hospitalisation
	Nursing homes
Less intensive institutional care	Residential homes
	Short stay or respite care
	Sheltered housing
Community services	Day centres
	Nurse visits
Family support	Home help
	Cash benefits for carers
	Support groups for carers

The range of possible policies and interventions to support long-term care for groups such as older people is very broad. Some of the approaches most commonly adopted in developed countries are summarised in Table 2. Rather than an "*all or nothing*" distinction between family care and full residential institutionalisation, it is more helpful to think in terms of a spectrum of alternatives. In most developing countries the extent and range of government involvement in most of the interventions listed in Table 2 is effectively minimal (Brodsky et al. 2003b). As a result, there are anecdotal indications that a largely unregulated private sector is emerging to meet this unmet need, primarily in the form of small residential old age homes.[2]

Residential care for older people in Argentina

All of the above trends contributing to growing demand for care are clearly apparent in the city of Buenos Aires in Argentina. In 2001 4.5 per cent of people living there were aged 80 years old or more, compared to 3.6 per cent in 1990 (INDEC 2001). This high rate of population ageing resulted from Argentina's early experience of fertility transition, which in turn was a consequence of the country's historically advanced development and relative prosperity (Della Paolera and Taylor 2003).

Estimates for the degree of dependency faced by older people in Buenos Aires vary. Drawing on survey data about older peoples' health status and functioning, a recent study found that 22 per cent of people aged 60 or more in 2001 experienced some form of dependency (Monteverde et al. 2008). Of these, the great majority experienced either "*high*" or "*severe*" levels of dependency. There was a clear gender

[2] For example, according to a recent BBC News report about China, "Starting up an old people's home is a guaranteed way of doing good business in China… So, many schools are changing into old people's homes" (Reynolds 2007).

gap, with older men experiencing less dependency (14 per cent) than older women (25 per cent). The study estimated the average number of years people aged 60 could expect to experience dependency during their remaining lifetimes: 5.5 years for women and 2.5 years for men. A separate study of older people's functioning in Buenos Aires conducted in 2001 found that 29 per cent of those aged 75 and over reported difficulty in performing at least one basic activity of daily living (ADL), such as dressing or walking (Table 3).[3]

Table 3. Percentage of persons aged 60 years old or more by number of limitations in basic ADLs, 2001.

	0 60-74	0 75+	1 – 2 60-74	1 – 2 75+	3+ 60-74	3+ 75+
Bridgetown	90	76	2	7	7	14
Buenos Aires	***87***	***70***	***9***	***20***	***4***	***9***
Mexico, D.F.	85	63	10	20	4	16
Montevideo	86	73	11	20	2	6
Santiago	80	61	13	21	6	16
Sao Paulo	85	67	12	19	4	14

Source: PAHO (2001).

At the same time, data for female employment and older people's living arrangements all indicate reduced family care capacity. Between 2001 and 2005 the rate of female economic activity in Argentina rose sharply, from 43 to 56 per cent, probably as a result of the country's severe economic crisis.[4] In 2001, 19 per cent of Argentines aged 65 or more lived alone and 27 per cent lived in nuclear families without children. In Buenos Aires city, the respective figures were as high as 27 and 32 per cent.[5]

Direct government support for long-term care in Argentina remains very limited. Key welfare agencies responsible for services for older people, such as the *Programa de Atención Médica Integral* (Integrated Health Programme for Pensioners; PAMI)

[3] It should be noted that the concept of "limitations" in basic ADLs is different from "dependency". The former refers to the difficulty of carrying out specific activities, such as walking, dressing and bathing. The latter refers to the need for a third party provider of daily care (Redondo 2008).

[4] These figures are calculated in different ways and therefore may not be entirely comparable. However, a range of other indicators and measurements show a similar sharp increase (Cristini and Bermudez 2007).

[5] It should not be assumed that older people living with unemployed adult children are guaranteed access to good family care. With reference to a poor district of Buenos Aires, Lloyd-Sherlock and Locke (2008) find that co-resident children can be as much a cause of vulnerability for older people as a source of support.

collapsed during the 1990s due to a combination of massive corruption and reduced state funding (Lloyd-Sherlock 2003). Among other services, PAMI had supported a programme of day care centres for older people, numbering several hundred in Buenos Aires alone. PAMI had also contracted out residential care services to a network of private care homes, which it was responsible for regulating. As a result of PAMI's collapse, many care homes were forced out of business and the quality of day care centres also suffered. Older people lacking a state pension (mainly those from the poorer and more vulnerable sectors) were not permitted access to PAMI services, and were left to resort to a parallel scheme with minimal resources. Over the past five years PAMI's financial situation has improved, and it has begun to develop a new network of care homes. To date, this has been on a much more limited basis than before its collapse, partly because private care homes no longer trust PAMI to honour its financial commitments. As such, the great majority of institutional care is provided by a completely independent private sector, with the full costs borne by the residents (or their families) rather than through a social insurance programme.

According to the 2001 Census, two per cent of Argentines aged 65 and over, and five per cent of people aged 80 and over were living in residential homes, almost all of which operated on a private for-profit basis. For Buenos Aires, the rates were significantly higher: four per cent of people aged 65 and over and nine per cent aged 80 or more.

The following section analyses the finding of the first comprehensive survey of care homes in Buenos Aires. We pay particular attention to whether these care homes promote the rights of older people or whether institutional living is tantamount to neglect and abuse. These two different perspectives are provided in the wider literature on residential care for older people. With reference to Europe, Castel (2004) argues that, traditionally, the practices of institutional care were shaped by strategies of containment and control. Similarly, Donzelot (1979) observes that residents were often policed through strict regulatory regimes. These powerful critiques led to new rights-based approaches to long-term care, which have become increasingly influential in the developed world (Kagan and Burton 2004; Wilson 2000). In developing regions, it is unclear whether more traditional and repressive approaches continue to prevail or whether these have been superseded by more "enlightened" models. The Pan American Health Organisation (PAHO) recently set out a framework for what it considers best practice in care homes:

"*attention in geriatric homes implies the recognition of values, respect for preferences and support for the development of a variety of models. The adoption of this philosophical approach entails a commitment not only to promote values such as freedom of choice, independence, individuality, privacy and dignity in everyday activities, but also to encourage*

its use in the preparation of assistance models for geriatric homes and supervise the quality of those surroundings" (PAHO 2004: 17).

As a first step to promote this framework, a comparative survey of care homes was conducted in Argentina, Chile and Uruguay, with funding from the Inter-American Development Bank and technical support from PAHO. The following case-study is taken from this wider, international project[6].

Methodological approach

The study applied both quantitative and qualitative social research methods. Quantitative techniques were used to conduct a survey of a random sample from the Metropolitan Area of the City of Buenos Aires (MABA). The sample was selected based on the framework provided by the National Population and Housing Census of 2001 (ARGENTINA/INDEC), which for the first time identified and surveyed geriatric homes. Random phased procedures (districts/neighborhoods, census radius, establishments) were applied to determine a sample of 101 establishments from various districts across Buenos Aires. Additionally, establishments for the internment of dependent young persons were added to the sample, with a random selection of 10 per cent of institutions identified by the National Ministry of Health.

The sample of residents was selected by applying random techniques within each of the establishments where interviews were conducted. The size of the sample was set at 10 per cent of the residents in each establishment. However, in order to obtain a balanced representative sample, a minimum of two and a maximum of four residents from each establishment were included. In the event of a refusal, random replacement procedures were used. Family members responsible for the selected residents were interviewed in the case of older people who could not answer the cognitive test properly. Argentine law prohibits care homes from providing details about the relatives of residents with cognitive problems, which reduced the number of interviews which could be conducted with this category. Consequently, the sample is biased towards physically impaired residents who did not display cognitive impairments.

The survey was conducted between December 2005 and February 2006 and included three separate questionnaires for care home managers, residents and family carers. The questionnaires mainly consisted of closed pre-coded items, along with a small number of open questions. All questionnaires were conducted through personal

[6] The survey in Argentina was conducted by Nélida Redondo, from the Research Department of ISALUD University.

interviews in the care establishments. In total, the survey covered 101 home managers, 300 residents and four family carers (responding on behalf of residents).

There was a high refusal rate among care homes: around 50 per cent. These were substituted on a randomised basis. This high rate of refusal is typical of other surveys of commercial enterprises in Argentina and elsewhere in Latin America, and may reflect a high proportion of informal, semi-legalised businesses. Due to delays in homes signing consent forms or in managers being available for interviews, it was necessary to replace a further 25 per cent of the original sample. There was no obvious difference between those homes which particiated in the survey and those which were not prepared to, in terms of their official status or location within Buenos Aires. Nevertheless, the substitution of homes initially selected with ones which were prepared to participate in the survey may mean that the sample is heavily biased towards establishments which conform to legal requirements and which offer an above average quality of care.

The survey also included a theoretical, non-probabilistic sample of 10 residents, who were selected according to their age, sex and length of stay in the establishments. These informants had all indicated that they were happy to relate their personal experiences of being admitted and of life in the care homes when they were interviewed for the questionnaire. These interviews provided a more in-depth analysis of residents' experiences, including life before admission. They also provide a source of direct quotations which illustrate more generalised experiences. All these indepth interviews were conducted in private rooms in the care homes. The interviews broadly drew upon life history methods, focussing on those events seen as most important by the informants themselves, with particular emphasis on their admission to the care home. The length of these interviews varied between one and two hours, depending on the willingness and capacity of each informant.

Data on the care homes

The survey consisted of a random sample of 101 privately-owned care homes, operating on both a profit and not-for-profit basis. There are only a few government managed care homes in Buenos Aires, and these are mainly very large and located in the outskirts of town. It is striking that none of these government homes admits older persons with high levels of dependency for everyday activities. As such, older people with limited mobility or suffering from problems like incontinence or dementia –the very groups most in need of residential care- are automatically excluded from government provision.[7] Since one of the selection criteria for the survey was that homes should contain at least 25 per cent of residents with high levels of

[7] Similar practices have been reported in other developing countries, such as India (Patel and Prince 2001).

dependency, the govenment homes did not qualify. Almost 95 per cent of the private establishments in the sample operated on a for-profit basis, which is representative of the wider set of care homes in the city. The typical (median case) private establishment had an approximate capacity of thirty-two beds distributed over an average of 11 bedrooms, almost all of them shared by two to three residents. Table 4 shows the distribution of the establishments interviewed by number of residents.

Table 4. Total number of establishments by age of residents and population size.

Number of residents in the establishment	Less than 20 residents	21 to 30 residents	31 to 50 residents	More than 50 residents	Total
Total	26	29	29	17	101

Source: authors

Our analysis of the survey data begins with a review of the institutions themselves, before focussing more specifically on the experiences of their residents.

The survey found that all the care homes were subject to a high degree of regulation and routine. The keeping of clinical records and professional controls was required by the local and provincial government authorities responsible for supervising care homes. Consequently, in virtually all the homes managers reported that careful files for all residents were maintained by staff, as well as by visiting health-care professionals. In over three-quarters of homes, nutritionists were involved in the preparation of menus, and nearly half organised regular group activities for residents. All of the establishments were visited regularly and systematically by a medical doctor, who was responsible for keeping clinical records, examining residents at least once a month and issuing/updating medical prescriptions. Close to 60 per cent of establishments had internal operating regulations, although only 45 per cent provided formal service contracts for residents.

Other features of the internal dynamics of institutional life and health care services for residents were more varied across the care homes. Two key factors affecting these variations were the number of residents in each establishment and the value of the monthly fee. It is difficult to separate these two effects, since larger establishments tended to charge higher fees.

Larger care homes were more likely to keep records completed by external medical professionals and other hired service providers. They were also more likely to keep record books completed by people in charge of recreational activities, functional assessment scales, and to prepare food rich in protein. Larger homes had a wider variety of equipment and materials, and usually contained a qualified clinician as technical director. Less positively, larger homes were more likely to physically restrain residents to avoid falls and other mobility problems, and to make greater use

of sedatives to overcome behavioral disorders and mental confusion (Table 5). These issues are especially significant in terms of the rights framework discussed above. It is widely known that, in line with current generally accepted ethical practice in long-term geriatric institutions, the use of physical restraints and sedation of residents are questioned methods and are only considered suitable when they form part of a specific and limited treatment (Gastmans and Milisen 2006).

Table 5. Number of care homes that made use of physical restraints, by the number of residents in each homes.

	Less than 21 residents	from 21 to 30 residents	from 31 to 50 residents	More than 50 residents	Total
Residents subject to restraining means	5	10	13	10	38
No restraining means used	21	19	16	7	63
Total	26	29	29	17	101

Source: authors

The survey found that internal protocols and regulations were widely seen as a tool for controling and organizing residents through medical-sanitary practices. For example, although 96 per cent of establishments claimed to offer personal health care programs for residents, only 15 per cent reported that these plans were prepared with the residents' involvement. In a further 21 per cent of cases, the plans were agreed with the involvement of residents´ relatives. As such, residents and relatives were excluded from the majority of personal health care plans. If these health care programs were mainly of a therapeutic nature, it would be an essential requirement to obtain the agreement, commitment and involvement of the recipient or their relatives. In the larger homes, levels of resident involvement tended to be lower. Many home managers referred to "emotional support" provided to residents, but more careful analysis revealed that this "support" was implemented through procedures that "adapted" individual behavior to the collective sphere of the residence, with set timetables and scheduled recreational activities. Models accommodating multiple styles, interests or individual lifestyles for residents were not common.

Homes that were larger and more expensive than average offered greater diversity in terms of special dietary needs, had more equipment and materials, and organised a wider range of recreational, rehabilitation and cultural activities. However, these larger homes also tended to be more rigidly regulated. Although smaller establishments possesed fewer resources, they were managed less rigidly and contained fewer internal regulations. To a limited extent, this may have increased their scope for moving away from traditional approaches. Predictably, the most expensive care homes offered the best of both worlds: sophisticated and varied services, as well as operating dynamics in line with progressive thinking. Typically,

the most expensive homes offered personal contracts with residents and health care programs drawn up with the involvement of the residents and their relatives. These homes made little or no use of sedation or physical restraints.

Data on the residents

Table 6 provides summary data on the care home residents. According to the survey, a "*typical*" resident (median score) was aged 82, was most likely a woman (70 per cent) and to be widowed (almost 60 per cent). More than 95 per cent of residents had been living with relatives and they had an average of seven years of schooling. We will now analyse the experiences of these residents, taking into account a number of key characteristics: the circumstances of admission; their level of dependency, sex, age and length of stay.

Table 6. Residents by sex and age group.

Sex	Less than 65 years old	65 to 79 years old	80 to 84 years old	85 to 89 years old	90 years and over	Total
Female	28	42	59	45	46	220
Male	32	20	17	7	8	84
Total	60	62	76	52	54	304

Source: authors

Immediately before being admitted, 80 per cent of respondents had been living in their own homes, mostly in one-person households. The average length of stay was two years, although more than 15 per cent of residents admitted within the last two years had come from another care home. Almost 70 per cent of residents reported that their health was "*good*" or "*better than good*". Over 80 per cent reported that they had been examined routinely by a medical doctor belonging to the establishment during the previous month. Despite their good self-reported health status, over 60 per cent claimed to have some type of illness. The illnesses most frequently reported were arthritis and motor dysfunctions. Strikingly, 90 per cent of residents said they were taking some type of medication, most commonly psychotropic drugs, followed by medication for hypertension.

Residents' experiences of admission to the homes

Research from developed countries shows that the great majority of older people prefer to remain in their own homes as long as they can, and consider institutional living as a last resort (Wilson 2000). This survey found a number of worrying aspects of the decision process of admitting people into care homes, and these had an important effect on experiences after admission. Many residents had clearly been

very reluctant to come to the care home, and may have experienced elements of coercion. The following testimony is quite typical:

> Interviewer: Why did you need to be admitted?
> "I needed to because I couldn't walk anymore. I started to get arthritis. I had two operations and then my children told me I should come here, get admitted. I cried a lot. I didn't want to go. They didn't make me do it…they let me do what I wanted…And so I started to think about things, turn them over in my mind. I asked myself what would be best…Because they [children] are out at work the whole day and, more importantly, they've got their own lives. And it makes sense that I had been able to live my life, and so they should be allowed theirs too. So I agreed to it [admission]."
> [82 year old woman, admitted four years previously].

In this case and many others, the extent to which residents had been permitted to make an independent decision about admission was often questionable. This decision was important, both in terms of respecting the right of older people to choose their long-term care option, and because it had a large bearing on their experiences after admission. The questionnaire found strong associations between the extent to which older people were involved in the admission decision and their general perceptions, behaviour and wellbeing in the care homes. Slightly over half of residents (67 per cent) reported that they were involved to some extent in the decision to be admitted, and that admission was usually due to increased care needs. Of these, however, 58 per cent said they had not been dependent on a third party carer before their institutionalisation.[8] This suggests that frail or chronically-ill older people who did not experience particularly high levels of dependency in everyday activities lacked the suitable home-care to allow them to continue living independently at home. The following is typical of many residents' experiences:

> " I used to live on my own. Until my legs started to go funny…they got covered with blisters…there was nobody who could help out….my life had changed a lot"
> Interviewer: You didn't have any relatives who could help?
> "My nephews and nieces"
> Interviewer: "So didn't they come to help?"
> "No. They just took me here. Two years ago. Before that I was in my own flat. I'd lived there from 1972 until 2004. I still own it, you know…"
> [92 year old woman, admitted two years previously]

[8] Another 10 per cent were unable to recall if they had been dependent on a carer before their admission to a care home.

Although care needs were the most common motive for admission, over 10 per cent of interviewees claimed they had been admitted because of poverty, a lack of housing or family support, or due to abandonment. A similar proportion (11 percent) reported that they had been placed in homes by local government or PAMI social workers, since they had no relatives who were prepared to care for them. Many of the latter cases had previously been hospitalised for unnecessarily long periods due to a lack of home support, and had been transferred directly from hospital to a care home, as this man describes:

> Interviewer: And when you came here, what happened?
> "I broke my hip. I was in Moron Hospital for six weeks. I was separated from my wife by then, and so I just spent some time living there in the hospital. Then they told me we would have to sort things out, that we'd send a letter to the mayor's office. 'You just sign there'. And so I did what I was told to. They told me the day they would pack me off…and then they brought me here.
> Interviewer: So you couldn't stay with your children?
> "No, I couldn't.
> Interviewer: And what do you do here during the daytime?
> "Nothing".
> [63 year old man, admitted one year previously].

Taking together those residents who were admitted for reasons of poverty, a lack of housing or abandonment, and those who were placed in homes by social workers, 21 per cent reported that their institutionalization had been due to what might be termed "social reasons". People admitted into care homes for these reasons were mostly aged under 65 and had mostly lived in care for at least six years. They were more likely to report that they had not been not involved in the admission decision. Residents reporting they had been admitted for social reasons were generally less satisfied with the food provided in the homes and were more likely to feel abandoned by family and friends, receiving infrequent visits.

Respondents who claimed they had not been involved in the decision of becoming institutionalized were more likely to be in low spirits. In many cases, they said they did not wish to live in a care home. This group of residents was more inclined to consider that they had lost independence within the establishment and to complain that they could not find places to be alone (Table 7). The following account is typical of this group's experience:

> Interviewer: So what do you do during the day?
> "What? I don't do anything. I just drink maté tea with them [she points towards some younger residents]….It's all my brother's fault.

> He made us sell off the house. Now I have to live somewhere I don't like, eating food I don't like, and I don't have the money to buy my own food, so I just have to eat spaghetti bolognese, with the spaghetti all tangled up. The other thing is that I want to loose some weight, because when I came here –I was always slim, but here I just sit around and started to eat like a horse"
> [49 year old woman, admitted four years previously].

Table 7. Responses of residents who were and were not involved in the admission decision (per cent).

	Involved in admission decision	Not involved in admission decision
Low spirits	4	14
Lost independence since admission	20	31
Lost privacy since admission	17	27
No longer able to performn enjoyable activities	11	21

Source: authors

Overall, the survey shows that the perception of having been involved in the decision of becoming institutionalized is a key factor for the subjective wellbeing of people interned in long-term establishments. The finding that a third of residents felt they had no involvement in this decision is, therefore, a matter of concern.

Residents and dependency on third parties.

Dependency on third persons at the time of the interview arose as another highly significant variable associated with attitudes, motivation and behavior in the care homes.[9] While 22 per cent of non-dependent residents claimed to be very happy and felt very well, only 13 per cent of those that were dependent felt the same. Dependent residents were more likely to report that they did not feel in good health or in good spirits. Furthermore, dependent persons were relatively more worried about their health status, family and affective wellbeing than non-dependent residents were. To some extent, the negative experiences of dependent residents may be more a reflection of their experience of being dependent, rather than specific failings in the homes. Conceivably, these older people may have also reported negative experiences had they remained at home receiving care from family members. Nevertheless, there is evidence that institutions in the survey were not always successful in dealing with the specific challenges of caring for dependent individuals.

[9] It should be noted that all the dependent people interviewed were mentally lucid: their impairments were essentially physical/motor in nature.

Predictably, dependent older people were more likely to encounter difficulties moving around the establishment or leaving it. As a result, they left the establishment less frequently: 24 per cent said they preferred to stay inside and another 20 per cent said they enjoyed going out but could not walk properly. The general opinion of dependent residents was that care homes were not good at promoting their social integration or cognitive and emotional stimulation. For example, dependent persons were less likely to participate in recreational group activities than was the case for other residents and 72 per cent said they could not go on organised outings. As a result, most spent the vast majority of their time seated in the common areas of the establishments. According to one resident:

> Interviewer: Are you comfortable here in the home?
> "Yes, very comfortable".
> Interviewer: Is there anything you dislike about being here?
> "It's not that I dislike things…but many things here make me very sad…seeing these people who are in such a bad state, who can't move or do anything. At least I can still move around and walk. These people are just paralised all the time and it really makes me so sad. I've always been a very emotional person, really emotional…Anything can make me start to cry".
> [92 year old woman, admitted five years previously].

At the same time, the majority of this group (54 per cent) reported that they did not know of places within the care home where they could enjoy some privacy, compared to only 30 per cent of other residents. Also, a higher proportion of dependent residents said that people working in the homes did not knock on the door before entering their rooms than was the case with non-dependent ones (50 and 46 per cent, respectively). The following account was typical of many residents' responses:

> Interviewer: Is there anything that you miss at the moment?
> "My own independence and privacy. Places where you can get some privacy are very expensive…here nobody has any independence, everything has to be shared, even the towels we use…but I still like to have my own things, I can't get used to sharing. They tell me that it could be because I'm stuck up, but it's not that…I have always liked to be on my own"
> [92 year old woman , admitted two years previously].

Most of the dependent residents did not know if they were allowed to decorate their own rooms, mainly since they had never asked. Predictably, their social networks were also limited: 35 per cent of this group referred to a lack of friends within the establishment, compared to only 19 per cent of other residents.

Despite these restrictions, dependent residents did report a number of more positive experiences. Most importantly, 81 per cent of dependent persons said that there was a person in their establishment who was specifically responsible for helping them. In theory, this should enable these residents to develop a closer relationship with their carer than in situations where the responsibility is shared across a number of workers. Despite their lack of social contacts and mobility, dependent residents were more likely to receive visits from family and friends than were other residents. Among this group, 62 per cent reported that relatives were allowed to visit the establishment to take care of them whenever they liked, without any restriction to timetables.

Finally, almost per cent 44 per cent of dependent residents claimed their income was not large enough to cover their expenses, compared to only 30 per cent of non-dependent residents. There is some objective basis for these perceptions. Specific needs stemming from dependency on third parties were almost exclusively paid out of pocket, without the aid of private health schemes or state services. Since the costs of internment in long-stay establishments were usually covered privately, personal income was sometimes stretched. For example:

> Interviewer: And if you want to buy something?
> "Because my sister is very supportive, she pays for this place. She pays before the month starts. But she's also got problems with her legs and so the man here –do you know him? – He offered to go to my sister's for the payment. Then I just buy what I need with whatever is left over."
> Interviewer: And your sister helps you out a bit?
> "I get more help from my grandchildren, who are comfortably off…If I need something, they will get it for me."
> [91 year-old woman, admitted 11 years previously).

In summary: the evidence indicates that a dependent status limited the range of activities carried out on a daily basis. It also limited relationships with other people and the outside world, as well as privacy within the collective areas of the establishments. Dependency had a negative impact on individuals' general outlook and perceived economic wellbeing. While it might be unrealistic to expect that dependent older people would report the same level of general wellbeing as other older people, there were various indications that their particular needs were not effectively catered for in the homes.

The sex of residents

The sex of residents was also statistically associated with various dimensions of everyday life in the institutions. Female residents were significantly more likely than men to consume psychotropic drugs, such as antidepressants, sedatives and anxiolytics (33 per cent versus 19 per cent, respectively). Several female residents admitted to taking sedatives and anxiolytics routinely, and these were requested continually from attending medical doctors. These would then be provided with the necessary prescriptions. Various gender studies show a greater tendency among women to suffer symptoms of anxiety, anguish and depression after middle-age, when their adult offspring become independent (Burín 1990). Data from this research shows that this tendency continues throughout old-age, at least for women living in long-term stay institutions.

Men and women also displayed significant differences in terms of worries, everyday activities, personal hygiene and appearance. Men were more likely to report concerns about sexual activity (although the survey did not ask about the underlying causes of these worries), and were more likely to report worries over money matters. Women were more inclined to tidy their own rooms, do handicrafts, participate in gymnastic exercises and attend religious activities and workshops. For their part, men were more inclined to visit friends and family. The questionnaire required interviewers to give their opinions regarding the general hygiene of respondents. In this regard, they indicated that the women interviewed were more inclined to display good personal hygiene, including clothing and general appearance, than was the case for the men.

Age and length of stay

Predictably, some associations were observed between length of stay, chronological age and certain key attitudes. Residents who had lived more than six years in the same establishment were less prone to report a loss of privacy upon joining the institution. This could indicate adaptation to institutionalization, which was not apparent among those residents who had spent less time there or who had come from another establishment. On a more positive note, people who had joined more recently were more likely to have signed a service contract with the institution. A greater proportion of people aged less than 65 reported that they had been interned for "*social reasons*" than for the other age groups interviewed. Among this younger age group, 45 per cent claimed they were not visited by friends or family, compared to only 10 per cent of residents aged over 85. On the other hand, 86 per cent of residents aged less than 65 could leave the establishment regularly, while only 60 per cent of those aged over 85 were able to make regular outings. Furthermore, younger residents were more likely to want to carry out other activities, mainly work.

There was a positive correlation between chronological age and the availability of monetary income. Almost all of the oldest residents had sufficient monetary resources, but more than 35 per cent of thoses aged less than 65 claimed that they did

not. One major reason for this was that more than half of the residents aged less than 65 did not receive retirement or pension benefits, while almost all those in the older categories did.[10] By contrast, the younger residents were more likely to cover the care homes' fees through health insurance schemes (mainly PAMI) or government assistance programmes: 33 per cent of those aged younger than 65 paid this way, compared to only two per cent of those 85 and over. This would appear to be further evidence that PAMI and state programmes focus on the institutional care needs of poorer social groups who are relatively young, rather than people who are older, frailer and more dependent. It may also be the case that the care homes prefer to take in less "demanding" cases.

General experiences of residents

There was a general consensus among residents that establishments tended to be "depressing". Most residents claimed that this was due to the large numbers of people with high degrees of dependency or severe cognitive problems living there. Many gave this is a reason for infrequent visits from family and friends. According to several testimonies, visits by relatives were restricted to the payment of the monthly fee and to "fetching" residents on weekends to take them to their homes or on outings. Weekend outings with relatives were seen as practically the sole means of social integration. Almost all of the people who did not have offspring or grandchildren, and with impaired walking, remained in the establishment, only venturing into the outside world during organised outsings. Organised gym sessions and outings were perceived very positively by all the informants. By contrast, handicrafts or other recreational activities organized by establishments sometimes elicited negative comments, even among women, because many residents felt they were performed in a childish style. According to one resident:

> "On Thursdays a girl comes here to sing…It's meant to be music therapy, but its very average [laughs]".
> [92 year old woman, admitted 2 years previously].

Other resident from a different home, commented:

> "There's always something to entertain you. Sometimes a man comes with his guitar and does some singing. And he plays with us sometime…I would say quite silly games [laughs], but they pass the time. And I like just lying quietly in bed. I do a lot of meditation. That helps me a lot. I should be doing my meditation now."

[10] Since this survey has been conducted there has been a radical extension of old age pension coverage in Argentina, and it is claimed that more than 90 per cent of people aged 75 and over now receive a benefit (Roca and Bourquin 2007). To date, no research has assessed the extent to which residents of care homes have benefitted from this extension.

[89 year old woman. Admitted eight years previously].

From the ten in-depth interviews, only one case suggested that living in long-term care had a therapeutic and restorative effect. In this case, certain particular features of the institution and of the resident contributed to this success. The institution was a non-profit private organization sponsored by a government health agency. It had a lengthy academic history and particular expertise in rehabilitation for people with severe motor disabilities. The institution placed considerable emphasis on residents' personal growth and social inclusion, regardless of their physical impairments. Its success was reflected in the experience of one female resident who had lived there for forty-five years. This woman reported that her quality of life had improved significantly after admission and that this had since been sustained. This single case shows that, even when institutionalization occurs for very prolonged periods, the lives of individuals in long-term care does not inevitably entail "*social exclusion*".

Depressingly, these progressive principles only guided the activities and services of one of the non-profit institutions included in the survey. All the establishments where interviews took place were concerned with the preservation of the life and with the comfort of residents. Nevertheless, many failed to deliver key services. For example, nearly 15 per cent did not offer basic protein-rich menus on the day of the interview, and a similar percentage did not organize any type of recreational, cultural or rehabilitation activity. Overall, it was apparent that most of the establishments for long-term care for dependent persons in Buenos Aires conformed more closely to traditional management models than more progressive approaches.
Research from developed countries has concluded that abusive practices are often widespread in care homes for older people (Clough 1996; Sims 2007). This issue has not been systematically researched in developing country settings. Both the questionnaire and in-depth interviews included questions about the general treatment of care home residents and provided opportunities for residents to report cases of abuse or neglect. Taking a more direct approach in the questioning would have raised a number of problematic ethical and legal issues. The questionnaire responses were almost unanimous that residents were treated kindly and with respect: 93 per cent of informants gave this response. The indepth interviews were not always as positive.

According to one informant:

> "When I came here, I had a diary. The worst thing they could do was to take my diary away from me.
> Interviewer: Why did they take it away?
> "Because they just take things off people in this place [lowers voice]. They take money, anything. Can you see that we have to keep the keys to our lockers around our necks?

> [49 year old woman. Admitted four years previously].

In another case:

> Interviewer: How are you treated here?
> "More or less. Like now, the one I have problems with is the doctor, and with the owner too. Because he said that I was hitting other old people here. Why would I do such an awful thing? I never argue or fight with people, because I don't like that sort of thing, you know. And just because PAMI pay for me here…there was a bit of bother…I was just listening to it with a woman, but just because she's a private resident they didn't do anything to her. But they grabbed me and made me go upstairs. So that's why I have to eat my lunch upstairs"
> [89 year old woman, admitted eight years previously].

It is not easy to assess whether these two testimonies in themselves demonstrate cut and dried cases of abuse, since they are highly subjective and could not be verified or traingulated. However, they do call into question the more positive questionnaire findings. It could be the case that most questionnaire respondents and some interviewees did not feel enough confidence or security to report such malpractice. This is an issue which requires a carefully designed specialist survey, drawing on the lessons of research into other aspects of abuse behaviour, such as domestic violence.

Conclusions

There is an evident dearth of research on residential care for older people in developing countries. This paper makes a small contribution towards filling this worrying gap in knowledge, although the extent to which its findings may or may not represent wider experiences should not be taken as read. Given survey's likely bias towards more formalised establishments, it is likely that the quality of services offered more generally in Buenos Aires will be significantly worse than reported here. Nor should it be assumed that the city's care homes are in line with services offered elsewhere in Argentina. As such, these findings should not be taken as representative of similar countries in the region, let alone the "developing world" as a whole. Nevertheless, they draw attention to the urgent need for research on this topic. Despite the absence of robust data from other developing countries, there are grounds for speculating that many could face similar or more severe problems in the quality of old age care services. In most cases, the role of governments as direct providers of care services is minimal and there is no evidence of effective regulatory agencies (refs). At the same time, policy-maker and popular awareness of issues such as elder abuse is extremely limited in most countries. Thus, there are few grounds for

assuming that care homes in low and middle income countries take a more enlightened approach than those reviewed in this paper.

As well as developing research and raising popular awareness, there is also an urgent need to disseminate the wider range of options for meeting older people's long-term care needs, as set out in Table 2. A large proportion of respondents in the Buenos Aires survey appeared to have experienced relatively low levels of dependency before admission, and might have been better served by other forms of support. Many of these had not been involved in the decision to admit them to a care homes. Other residents had been admitted for social reasons, such as poverty and housing problems, which had nothing to do with special care needs. Perversely, those older people most in need of institutional care, such as dementia sufferers and other highly dependent individuals, were the ones least likely to be granted it by government homes. As the prevalence of conditions like dementia continues to rise in countries like Argentina, there is a clear case for substantial investment in specialised services. The continued policy of excluding highly dependent older people from government-run care homes is both illogical and inhumane.

The survey found that most residents had a poor quality of life, which had not been improved by becoming institutionalised. To some extent, this could be blamed on the prevailing traditional and repressive models of care home management. All the same, it is generally recognised that institutional living should be viewed as a last resort, however it is organised and managed (Wilson, 2000). If the extensive network of day care centres developed by PAMI before the 1990s had not been allowed to lapse, this might have challenged the all-or-nothing approach to home care and institutional care which still largely prevails in Buenos Aires. In recent years, PAMI and other government agencies have expanded programmes for training home care workers, but it is recognised that they only provide for a small proportion of the real need. As such, the expansion of poorly-regulated care homes following dubious practices is set to continue.

References

Aboderin. I. (2004) "Intergenerational family support and old age economic security in Ghana" in P.Lloyd-Sherlock, ed. *Living longer. Ageing, development and social protection.* Zed Books, London.

Bhat, A. and Dhrubarajan, R. (2001) "Ageing in India: drifting intergenerational relations, challenges and options" *Ageing and Society* 21:621-640.

Brodsky, J. et. al. (2003a) "Key policy issues in long-term care" Geneva, World Health Organisation.

Brodsky, J. et. al. (2003b) "Long-term care in developing countries: ten case studies" Geneva, World Health Organisation.

Burín, M. (1990) *El malestar de las mujeres. La tranquilidad recetada*. Buenos Aires. Paidós.

Castel, R. (2004) *Las metamorfosis de la cuestión social*. Buenos Aires. Paidós.

Clough, R. (1996) "The abuse of older people in residential and nursing homes" *Nursing Times Research* 1(6):419-428.

Cristini, M. and Bermudez, G. (2007) "El mapa económico de las mujeres Argentinas (1998-2006)" Fundación de Investigaciones Económicas Latinoamericanas, Working Paper 93, Buenos Aires.

Della Paolera, G. and Taylor, M. (2003) "Introduction" in Della Paolera, G. and Taylor, M. eds. *A new economic history of Argentina* Cambridge University Press, Cambridge.

Donzelot, J. (1979) *La policía de las familias*. Valencia. Spain. Pretexts.

Gastmans, C. and Milisen,K. (2006) "Use of physical restraint in nursing homes: clinical-ethical considerations" *Journal of Medical Ethics* 32(3):148-152.

Howse, K. (2007) "Long-term care policy: the difficulties of taking a global view" *Ageing Horizons* 6:3-11.

Jelín, E. (2005) "Las familias latinoamericanos en el marco de las transformaciones globales. Hacia una nueva agenda de las políticas públicas" in Arraigada, I., ed. "Políticas hacia las familias, protección e inclusión social". ECLAC, Serie Seminarios y Conferencias, No.46, Santiago de Chile.

Kagan, C. and Burton, M. (2004) *Exclusión, discapacidad, y cambio social*. University of Manchester. Paper given at the Universidad Nacional Pedagógica de México, Cuernavaca and the Universidad Autónoma de México, Iztapalapa, March 2004.

Jamuna, D. (2003) "Issues of elder care and elder abuse in the Indian context" in Liebig, P. and Irudaya Rajan, S., eds. *An aging India. Perspectives, prospects and policies.* The Haworth Press, London.

Lloyd-Sherlock, P. (2003) "Financing health services for pensioners in Argentina: a salutary tale" *International Journal of Social Welfare* 12: 24-30.

Lloyd-Sherlock, P. and Locke, C. (2008) "Vulnerable relations: lifecourse, wellbeing and social exclusion in a neighbourhood of Buenos Aires, Argentina". *Ageing and Society* (2008) 28 (6): 779-803.

Monteverde, M., Noronha, K., Palloni, A. and Angeletti, K. (2008) "Costos individuales esperados de cuidados de larga duración en Buenos Aires, México y Puerto Rico". Paper presented at 3rd Conference of the Latin American Population Association, Córdoba, Argentina, 24-26 September 2008.

Palloni, A. (2000) "Living arrangements of older people". UN Population Division Technical Meeting on Population Ageing and Living Arrangements of Older Persons, New York, February.

Pan American Health Organisation (PAHO) (2001). "Encuesta Multicéntrica SALUD, BIENESTAR Y ENVEJECIMIENTO (SABE) en América latina y el Caribe". Informe Preliminar. División Protección y Promoción de la Salud (HPP). Organización Panamericana de la Salud (OPS/PAHO). Washington. USA.

Pan American Health Organisation (PAHO) (2004) *Marco conceptual para el desarrollo de una red de servicios y programas para personas adultas mayores con discapacidad*. Washington D.C. Working Paper.

Patel, V. and Prince, M. (2001) "Ageing and mental health in a developing country: who cares? Qualitative studies from Goa, India" *Psychological Medicine* 32(1):29-38.

Phillips, D. and Chan, A. (2002) "National policies on ageing and long-term care in the Asia-Pacific: issues and challenges" in D.Phillips and A.Chan (eds) *Ageing and long-term care. National policies in the Asia-Pacific*, IDRC/Institute of Southeast Asian Studies, Ottawa/Singapore.

Redondo, N. (2008). "La medición de la discapacidad y la dependencia: aspectos conceptuales y evaluación de las experiencias en Argentina". (Working Paper). Dirección de Estadísticas Poblacionales. INDEC. Argentina.

Reynolds, J. (2007) "China's elderly care conundrum" BBC News Online 23 August 2007.

Roca, E. and Bourquin, M. (2007) "Las modificaciones al sistema previsional argentino: indicios de universalización?" *Estudios de la Seguridad Social* 100: 91-132.

Sims, B. (2007) "Abuse in care homes" *Nursing and Residential Care* 9(4): 142-143.

United Nations Population Division (2002) *World population ageing: 1950-2050*. UN, New York.

United Nations Department of Economic and Social Affairs (2005) Living *arrangements of older persons around the world*. UN, New York.

Wilson, G. (2000) *Understanding old age. Critical and gobal perspectives.* Sage, London.

Woodrow, P. (2002) "Theories of biological ageing" in Woodrow, P. ed. *Ageing. Issues for physical, psychological and social health* Whurr, London.