Home, Sick: Implications of Health Care Delivery in the Home

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Changes in technology as well as new policies concerning the public and private sectors have encouraged the growth of new activities in the home, including the care of people who previously would have been treated in a hospital. A good deal of interest in this issue has been generated in Sweden as of late, partly because of the promise of more humanitarian health care but also because of a hope that such reforms could lead to a reduction of public expenditures. The purpose of this article is to explore various consequences which may arise when schemes for health care in the home are implemented. The focus is on arrangements whereby patients are treated for a serious illness and spend their time recovering or receiving treatment in their own place of residence. Emphasis is placed on how being sick at home might affect the individual in question, how the position of other household members might be altered, and how relationships with health-care workers might evolve. In each case, the article attempts to show the variety of ways (“positive” as well as “negative”) in which the use and meaning of the home may be altered.

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INTRODUCTION

In recent years, research in a number of academic fields has begun to focus on the home, on how it is used and the meanings which people attribute to it. Part of this attention is a response to new activities which can be undertaken in the home. Here I am referring to trends of gainful employment in the home rather than in an office or factory (Tate, 1995), of home schooling (Van Galen and Pitman, 1991), and of prisoners serving their terms at home under electronic surveillance rather than in a prison (Somander, 1996). Although many of these activities were commonplace in the domestic sphere of a hundred and fifty years ago, they receive new impetus today from advances in information and other kinds of technology. Changes in the roles of the public and private sectors have also had a great influence (Smith and Mallinson, 1997).

Staying at home while seriously ill is another activity which involves a shift from an established institutional environment – in this case the hospital – to the domestic sphere or place of residence. Here I am not talking about recovering from a mere cold or the like, but rather recovering from or being treated for a major illness such as a heart attack, a stroke or cancer. In some respects such a shift can be considered a reversion to a much earlier pattern in which those who could afford it were examined and treated in their own quarters by a private doctor. One of the themes in the paintings of domestic scenes in 17th century Holland, for instance, was the visit by the doctor (Brown, 1984). The modern hospital as an institution arose as a place to treat poor
people whose living conditions in terms of cleanliness and overcrowding were detrimental to their health (Bergman and Dahlbeck, 1995).

In Sweden, the issue of allowing people to stay at home rather than in a hospital has become manifest in various programs, for instance those referred to as avancerad hemsjukvård (hospital-at-home). The considerable interest in this area during the last few years is partly due to its potential for major economic savings. But the increased interest also derives from a humanistic ideology which holds that individuals feel physically and mentally better in an environment which they themselves control, and that they will more likely achieve this state of affairs in their own home than in a hospital. Even though the latter notion is commonly emphasised, most of the investigations into this new area of health care have been carried out from the perspective of administrators or of various other professions. The position of the patients – or, perhaps more fittingly, the residents – is often assumed but is seldom dealt with systematically, at least not in relation to their actual dwellings. The general problem left to be studied is the effect of health care in the home on the residents and their dwellings.

The purpose of this article is to explore the consequences which may arise when schemes for health care in the home are implemented. The focus is on arrangements whereby patients are treated for a serious illness and spend their time recovering in their own place of residence. This represents an alternative to traditional care in a hospital and is more than just a complement to hospital care.

In exploring this issue, emphasis will be placed on how being sick at home may affect the individual in question, how the position of other household members may be altered, and how relationships with health-care workers might evolve. In each case, an attempt will be made to show the variety of ways (“positive” as well as “negative”) in which the use and meaning of the home may be altered.

This article will not take up the issue of whether this phenomenon actually generates economic savings for the public sector (or for the individual) or whether such arrangements help people to recover faster or medically more fully than conventional treatment. The article begins with a brief description of why such schemes appear to be interesting in Sweden today. Thereafter follow three sections dealing successively with the individual sick person, with other household members, and with the relationships between the sick resident and health care workers. In a concluding section, the overall position for individuals about to be part of such schemes is summarised.

**RECENT DEVELOPMENTS IN SWEDEN**

The interest in health care in the home has grown considerably during the last 10 years in Sweden. In many respects it represents a logical extension of programs initiated during the 1980s and early 1990s which “de-institutionalised” the care of people with diagnosed psychological problems and the care of people with functional disabilities, mental as well as physical (Gaunt and Lantz, 1996). In these areas too, it was reasoned that the individuals in question would fare better in homes of their own. Lately, central providers of health care have also been giving more attention to the rights of patients and to the notion that patients will be more demanding in the future (Berg and Skoglund, 1998). This too can be seen as providing ideological support for programs involving hospital care in the home.
In addition to ideological factors, there is a hope that such schemes will result in substantial savings of public funds. One source points to the possibility of a 75 per cent reduction in the number of patients treated in emergency hospitals (Hollo, 1996a). Although such arguments are undoubtedly welcome at most times and in most countries, they have been particularly welcome in Sweden, where the public sector has been under very severe pressure to economise during the last decade. The demographic structure of Sweden can also be seen as encouraging an interest in health care in the home in that a large and growing proportion of the population is over 80 years of age. This group of the very old can be expected to suffer from more serious illnesses than younger groups, thus increasing the pressure on the health care system to economise. Administrative changes such as the recent Ädel reform, which shifted responsibility for certain kinds of care from the county to the municipality, also created an interest in new forms of care, particularly those involving care in the home (Johansson, 1997).

Sweden is well-equipped to start a program of health care in the home in the sense that the housing stock is very modern. The average living space per resident is among the highest in the Western World and central heating is nearly universal. In the planning process a good deal of attention is paid to reducing architectural barriers in the home – a crucial factor for people convalescing from an illness. Wheelchair access for instance, is now a requirement for all new buildings. But the housing stock varies and in the older sections and in parts of the countryside care at home would be less readily managed. Finally, home health programs are very interesting for developers of communication technology as well as medical technology and Scandinavia has a number of companies who are advanced in these fields.

In summary, the various circumstances described above make for a situation which is highly favourable to the start of such schemes. Even though these have not, as yet, been put into practice on a wide scale, the average number of beds in emergency hospitals has been drastically reduced – by 50 per cent during the 1990s, according to an expert from the Landstingsförbundet (The Federation of Swedish County Councils) (Lindvall, 1998). As far as social services are concerned, the domestic help provided to the elderly in their homes includes more and more minor medical services. Today the need for conventional help such as shopping and cleaning almost never is the sole reason (as it was 10 years ago) for being granted assistance (Johansson, 1997).

A number of investigations which shed light on health care in the home were commissioned in Sweden during the 1990s (Berg, et al., 1997; Hollo, 1996b; Lundh, 1996). They arose out of a general concern with increasing the quality of care for old people. Several of these were specifically designed to identify programs already implemented on the local level. Arriving at generally agreed upon definitions in this field, however, has not been easy. There is a wide variety of treatments which can be classified as health care in the home and children as well as old people can be the object of such care. In addition, the care can be given by a variety of health-care professions.

In one of these commissioned investigations (Hollo, 1996b), there was an attempt to differentiate between two levels of health care in the home. One, hemsjukvård (community health care), consists of basic health care provided by domestic-help assistants and nurses. This is in contrast to a more qualified form of care labelled avancerad hemsjukvård (hospital-at-home). A criterion for the latter form is that a team of health-care workers (led by a physician) is involved and that this kind of care is available 24 hours a day. In many respects such attempts to differentiate levels of
health care in the home simply follow administrative lines (physicians are employed by the county, domestic-help assistants are employed by the municipalities). It has not been possible, however, to arrive at clear and agreed-upon distinctions between various levels of care in the home using more substantial demarcations having to do, for instance, with the type or severity of the resident's ailment.

At present in Sweden, the most common kind of care given to patients at home is so called “palliative care,” i.e. care which does not aim to cure the patient but to make the symptoms (for example with cancer) more tolerable. But various kinds of rehabilitation, for example from strokes or from hip operations, are also commonly carried out in the home. In the future, however, the scope of care will probably be widened considerably as there are few limits to the kinds of ailments the treatment of which, if properly organised, can be carried out in the homes of the patients. Emergency operations and treatments involving environmentally dangerous technology such as x-rays will undoubtedly remain in the hospitals for the foreseeable future. Otherwise, the potential to be treated at home is very substantial (Lindvall, 1998).

The discussion in this article will follow a loose definition of health care in the home which includes health care where a physician is not necessarily involved. There are two reasons for this. First of all, from an administrative point of view, the critical issues seem to be more or less the same — the quality of care, the demands placed upon third parties, and the conditions of the work place (Lundh, 1996). Secondly, from the resident’s (patient’s) perspective, the ability to retain independence and integrity in the home is a major concern regardless of whether a physician is, or is not, a member of the health care team.

Research into the area of health care in the home is generally lacking in Sweden (Evertsson and Johansson, 1994; Gaunt and Lantz, 1996). This is particularly true if the focus is on social science research highlighting the perspective of the residents and the use of the home in such circumstances (Hollo, 1996b). Most of the work to date is from an administrative point of view dealing with questions such as how the care can most effectively be organised in terms of economical as well as medical results; how the work of the various professions is affected; or how preconditions differ between the city and the countryside. Statens beredning för medicinsk utvärdering (the Swedish Council on Technological Assessment in Health Care) expects to be finished by the close of 1999 with a major review of the medical as well as the economic effects of hospital-at-home programs.

Researchers connected to the Swedish social services have probably come furthest in delineating the perspective of the residents in that these researchers are acutely aware of how the paternalistic tradition in the social services can lead to a loss of integrity for old people seeking assistance (Gaunt and Lantz, 1996). The role of the dwelling, however, is seldom dealt with in any detail. There is a tradition among architects and others to consider how people in general value and use their dwellings (Eriksson, 1993). There is also a great deal of consideration of the housing demands of people with special requirements such as the elderly and people with permanent physical impairments (Thiberg, 1990). However, the phenomenon of being discharged from the hospital for convalescence and treatment in the home and how this may affect the way members of the household value and use the dwelling are not usually considered.
HEALTH CARE IN THE HOME: IMPLICATIONS FOR THE INDIVIDUAL SICK PERSON

This section will briefly review some of the research which has dealt with the use and meaning of the home, point to a classical sociological analysis of what it means to be sick, and attempt to see how these two fields of interest together can help us to understand the various ways an individual may use and experience his or her home when seriously ill.

The late 1980s and early 1990s witnessed a considerable interest among researchers in the meaning of the home and its various uses. Among social scientists, this paralleled a social-political interest in questions of privatisation (Saunders and Williams, 1988; Munro and Madigan, 1993). Among behavioural scientists and architects, this reflected a classic interest in attachment to place (Altman and Low, 1992). In a review of the literature up to the 1990s, Després (1991) noted at least ten categories of meaning for the home which had been used by various authors. The list included psychological/emotional factors such as “security” and “control,” cultural factors such as “indicator of social status,” as well as social factors emphasising the home as a centre for activities, particularly involving relationships to family and friends.

In a theoretically ambitious article, Somerville (1997) recently approached the question of how various meanings of the home may be constructed. He singled out meanings having to due with “privacy,” “identity” and “familiarity” but also forcibly underlined their inter-relatedness. He reasoned that “subjects, whether they be individual persons, households, ethnic groups, or nations, are at home if they control their own boundaries, if they can be themselves with those boundaries, and if the world within those boundaries is one which they have made or are making for themselves” (Somerville, 1997: 235).

The classical treatment of sickness in the sociological literature was made by Talcott Parsons (1952). In his view, everyone in the social system is charged with the duty to contribute to the attainment of societally approved goals, most clearly in the world of work. The “sick role” released people – temporarily – from this obligation. It enabled them to rest and recover from an illness without feeling that they were parasites. The theory of the sick role has been widely discussed and criticised; it tends to ignore conflicts in society and is more applicable to acute than to chronic illness (Svensson, 1993; Lindqvist, 1997).

The notion of the sick role, however, does help us to understand the hospital as we know it today (or yesterday). The hospital more or less epitomises the idea of an “institution.” It is comprised of fundamental rules and norms calling for passive behaviour on the part of the patients. They are encouraged to follow the instructions of others higher up in the system, particularly the physicians, and to have faith that this will lead to their rapid and thorough recovery. The improvement in their physical well-being is attributed primarily to the treatment given by the various medical professionals but also to the feelings of security which the hospital as an institution supposedly generates. For some proponents of the hospital-at-home, however, the “the hospital culture” is one of the major obstacles to their program. They emphasise that a strategy to develop the hospital-at-home must fundamentally seek to change this attitude on the part of the general public, the patients and their relatives (Bergman, 1996).
What is it like for an individual to be home and sick? For many people in society (including many researchers) there is no question but that being sick at home is to be preferred to being sick in a hospital. The following case from the hinterland of Sweden illustrates how strong the desire for independence can be:

The 87 year old man had returned home after a week in the hospital. The neighbours who usually looked in on the old man had not done so on this occasion. Perhaps it was because moose hunting season had begun and they didn’t have time. Maybe it was because they didn’t know that the old man had returned from the hospital. In any case, the conditions in the cabin were wretched. In the middle of the floor stood a bucket with urine and excrement. The old man was weak and apparently unable to make it to the outdoor toilet. But he appeared to be quite happy lying on the wooden sofa in the kitchen. The old man threw out his arms and exclaimed ‘to be home again – there is no better place than here’ (Tuulik-Larsson, 1994:58).

In the above study, the home as a location for care was the preferred solution for the ailing residents as well as for the administrators. How can one begin to explain such findings? On a mundane level, being sick involves a lot of time spent alone and at home one might have better access to the television, books, telephones and visiting that one might desire. But it involves more than just diversions. In the home a certain degree of privacy can be achieved and this, according to Somerville (1997) and others, is fundamental for how one sees and constructs one’s identity. In familiar surroundings people can see evidence of their activities in many sectors of their lives – as parents, as spouses, as sports heroes, as homemakers, as amateur photographers, and so on. Maintaining one’s identity in the home is seen to be superior to the “identity stripping” which can occur when one is reduced to being merely a “patient” in a hospital (Higgins, 1989). The ability of the home to act as a stable foundation for one’s identity takes on an extra significance when one is reminded that serious illness can easily provoke fundamental existential questions and doubts.

In addition to being a potentially more secure place psychologically, the home also charges the individual to be more independent. This can lead to the individual being more active and more responsible for his or her own recovery. Modern public health seeks not only to make people more conscious of what leads to good health, but also to give them knowledge of how to recover more quickly. These are some of the arguments put forward by those who claim that people recover more quickly and more fully at home than in the hospital. The problem with hospitals is not just the risk of infection (Hollo, 1996a), but also that in hospitals many patients are passive and lose their independence.

Arguments similar to those above can be found in a number of discussions concerning the home and sickness, and they undoubtedly reflect a reality experienced by many people suffering from a wide range of maladies. But is this the whole story? Some authors ask if being sick at home is the preferred solution for everyone or all of the time (Bergh, 1996).

The home might very well be a receptacle for important symbols of peoples’ identity, but that identity could also include some undesirable features or aspects which hinder rest and healing, for instance the role of wife/servant to a disagreeable man. Homes require cleaning and other forms of maintenance. Laundry and shopping must also be done and food must be prepared. Such tasks might very well function as pleasant diversions for some people, but for others, such chores might be a real burden. One should not forget that a large proportion of people needing medical care are elderly, and that among the elderly a very large number live alone. In other words, the
home is also a place for work, and for many people being sick at home might not permit the level of relaxation which is actually required (Ruddick, 1995).

As we have seen, there is a tendency to think of the home as the place or residence of the "real self." The self who returns from the hospital, however, may very likely be altered. Many people will be returning with swellings, bandages, and sores – is it always clear that they would want to return to their everyday haunts under such conditions? A quite drastic illustration of altered self would be the case where the resident (patient) is so thoroughly and permanently connected to some form of medical apparatus that it becomes unclear what is part of his or her body and what is not (Arras and Dubier, 1995).

It is quite common that residents as well as researchers make a strong association between the home and ideas of freedom and independence. However, although some dwellings allow people a good deal of freedom even while they are sick, other dwellings do not. Although stairways, high thresholds, noise, and great distance from shops and taxis might be easy to tolerate when one is entirely healthy, these circumstances might create an environment which is much less free than a well-designed hospital. In such cases, the home becomes less of a "castle" than a "cage" (Allan and Crow, 1989).

Lying in a hospital, many individuals may yearn to return to their own bed in their real home. Paradoxically, however, returning home ahead of time may transform this home into something quite different from what they left and what they yearned for. Various machines and contrivances from special beds to advanced medical equipment may now dominate the dwelling. These may need to be cleaned and dusted, thus making for even more work. For some people, returning home might be returning to the bedroom only; for others, the once so proper living room may now be turned into a permanent bedroom.

To summarise, one can point to many likely positive effects of being at home when one is recovering from a serious illness. Many people would prefer being at home because it gives them more control of their lives and they feel more genuine and less alienated. But some authors do remind us that the home which people return to can in some cases be radically transformed. It may become less and less like the original home and more and more like a mini-hospital.

HEALTH CARE IN THE HOME: IMPLICATIONS FOR MEMBERS OF THE HOUSEHOLD NOT RECEIVING CARE

One of the fundamental meanings involved in the construction of home according to Somerville (1997) is "familiarity." This refers to the fact that feelings of identity and privacy are usually achieved while interacting with others with whom one shares space. Much of this interaction is involved with "caring" – for others and for the home itself. In this sense, the assistance and caring-for which a sick person will potentially require when he or she returns from the hospital is activity which is central to the meaning of the home.

Earlier we reasoned that it would be easier for the sick person to feel more like a whole person at home than in a hospital because of the nearness to his or her own possessions and the like. The same reasoning can be applied to the presence of other household members – of spouses, of children, of brothers or sisters, or even of pets – who “know” the sick person in many different ways and not just as a patient. For the individual sick person, aid from these quarters could be of a higher quality in the sense...
that more of his or her needs are recognised. For the other members of the household, caring for the sick person could be part of a loving relationship or the paying back of past obligations. From the perspective of the health care administration, such contributions of course reduce the need for paid professionals.

Can one expect these positive results to dominate in all situations? Regardless of whether the personal relationships between the people living in the household have been loving, cool or hateful, the return of a sick person would generally mean that the other members of the household will be taking on a greater share of daily household tasks such as cleaning, doing the laundry, and so forth. But there is no guarantee of this. Women might be expected, by the men and by themselves, to continue doing all of the housework even if they (the women) have just returned from the hospital.

Health administrators tend to view next of kin as an undifferentiated group of people who are potentially available to help when the need arises. Sometimes even neighbours and friends are placed in this pool (Johansson, 1993, 1997). Family sociologists, however, would be likely to point to the different obligations and patterns of help depending upon whether the other person is a spouse, an off-spring, or a non-family member or whether the other person is a woman or a man (Teeland, 1978). It is not uncommon that sick people need help in cleaning themselves and going to the toilet. It might be more natural and “easier” for spouses to contribute such services than it would be for children, sisters and brothers, or friends.

In addition to everyday household tasks and personal help, a seriously sick person’s presence in the home could very likely place new, sometimes complicated, demands upon the other members of the household. For instance, some of the medical technology may need to be monitored. This situation may entail an increase in responsibility, limit mobility out of the home, and create stress. There is a potential for guilt feelings if things go wrong.

Earlier we noted that the home itself may be transformed when a sick person returns from the hospital. This phenomenon may affect the other members of the household as well. The day may have to be scheduled in new ways, and former rituals, such as eating at a certain time and place, may have to be abandoned. Researchers have pointed out how space in the dwelling is often differentiated into zones including different rules for different members of the household (Munro and Madigan, 1993). These rules might now have to be re-negotiated and the other household members might lose the privacy – so important for the construction of meaning in the home – which they once had. The healthy person may find that their home too has come to resemble a hospital.

Some authors reason that the home is ideologically charged because it is associated with feelings of freedom (Allan and Crow, 1989; Gaunt and Lantz, 1996). Considering this, it will also be important to ask to what degree other household members’ freedom to come and go is restricted by the presence of a sick person “at home”. Do the other household members have to choose between being available to help 24 hours a day or a bad conscience for leaving the person alone? The other household members might also be restricted in their ability to invite guests back to their home. If the home has been transformed into a semi-hospital, then it might not be the ideal place for a social gathering with third parties.

Health care in the home will always be performed in a particular context which varies with the dwelling, the illness, the composition of the occupants, and the behaviour of the visiting health care workers. It may be satisfactory for all those
involved. But there is also the possibility that the healthy members of the household find that their “home” has vanished and that they now reside in a semi-hospital.

**HEALTH CARE IN THE HOME: IMPLICATIONS FOR VISITING HEALTH CARE WORKERS**

As health care at home represents a new situation for most of the people involved, the relationships between the care-receiver and the care-giver may be quite open for negotiation. The home is the territory of the resident and the health-care workers are guests. As such it is the residents who control the boundaries, not only vis-à-vis who is allowed to enter the dwelling but also with regard to the areas inside the home which are open to visitors. This situation is in marked contrast to the traditional hospital where most patients have little privacy and where their lack of power is symbolised by the doctor’s rounds.

A new status of the nurses working in such programs is illustrated, in Sweden at least, by their civilian dress. Not only are such nurses deprived of the authority traditionally ascribed to those wearing medical uniforms, but they now appear as individuals and not merely as the nurse who happens to be on duty that particular hour. There are also reports that health care in the home has brought with it a shift in the relationships between the various corps of health-care workers, for instance between doctors and nurses. The district nurses are now mobile agents of health care and as such work more independently of their direct superiors. The position of the nurses is also strengthened in relation to the physicians, who are not as mobile (Arras and Dubler, 1995).

Even though the authority of the health-care professionals may be reduced in such programs, their presence in the home – accentuated by the various items of medical technology – can nevertheless be quite strong. Any readjustment of power depends on the sickness in question and the negotiating position of the residents. The smaller the dwelling, the greater is the chance that the visitors will dominate. At the hospital, it was the professionals who decided when to visit and how long to stay; at the home of the patient, these matters may have to be negotiated.

When entering the home of the sick resident, the health-care workers bring themselves, their technology, and also a definition of the resident’s/patient’s difficulties as being basically a medical problem. Some would argue that the home visit is a needed corrective for the health-care worker who is now able to see the individual as a whole person in a real context and not just as “a patient” (Arras and Dubler, 1995; Berg et al., 1997). Some Swedish authors, however, are critical of the way social service workers and social service definitions are being supplanted by health workers and narrow bio-medical problem-definitions in the homes of older people (Tuulik-Larsson, 1994; Evertsson and Johansson, 1994). Apparently, these writers are not convinced that health workers really are capable of modifying their original definitions of the problem.

Another critical point of view starts with the notion that knowledge of the whole person can also lead to control and domination (Svensson, 1993). Even though the health professionals may be well-meaning, there may be no escape for the patient/client/resident. In a hospital, the health professionals have a pretty fair idea what goes on inside the body of the patient. In the new programs, the professionals still have that but now they also know what is going on inside his or her home, perhaps including intimate aspects of the individual’s personal and social lives. The mobile health
workers would normally meet the spouse or the next of kin and in many cases even come in contact with agents such as local representatives of the social services or even the landlord. This gives the health worker a more complete picture of the sick person, but it is clearly asymmetrical; the sick person knows little of the health care worker’s personal life. It remains to be seen whether home health care enables a more two-sided exchange by facilitating interpersonal dialogues that would otherwise have been constrained in the hospital environment. This would seem to depend on factors such as the continuity of service from a given health care worker, the worker’s willingness to engage in such personal dialogue, and the patient’s interest.

The basic question is whether the dwelling is to be the home of the resident/patient or the place of work for the health-care professional. Professionals naturally demand working conditions which are safe and easy to use (Evertsson and Johansson, 1994; Berg et al., 1997). This might go along with what the sick person wants too, but it should not be assumed to be so.

In reality the outcome will depend on many factors, among which is the negotiating power of the resident/patient. In one study in Stockholm (Bergh, 1996), an ethnologist found that visiting professionals behaved strictly as guests when the sick person was alert and could make demands. In other cases, when the residents/patients became very ill, the position could quickly be reversed. Furthermore, the professionals seemed to exercise even more authority when creating a “good home” for the patient than they would have used if it would have been a conventional hospital situation.

SUMMARY AND CONCLUSION

This article has discussed a new organisation of health care and how it may change the use and meaning of the home for various people involved. Even though there are, in Sweden at least, only a few instances where such plans have been implemented, there are many forces which encourage developments in this direction. Improvements in technology and the need for the public sector to save money work essentially as push factors and have already succeeded in reducing the role of emergency hospitals. The basic pull factor is the attractiveness of the home and the ideological importance it has for most people, whether they are sick or healthy.

An actual movement in the direction described would have major consequences for the role of hospitals and the employment situation for a number of health professionals. In this article we have argued that the use and the meaning of the home for the sick people, as well as for other household members, could also be altered substantially.

The phenomenon of health care in the home is quite complex and at the moment stands for a wide variety of activities. To predict how it will develop in the future is even more complicated and will depend on legal, geographical, and economic factors in addition to characteristics of the sick people themselves. The latter factors include the patient’s physical and psychological health status, social class, gender, marital status, age and so on. The influence of these factors could be examined in a number of empirical studies which focus on people with particular kinds of ailments or on residents in particular housing environments.

Recognition of this complexity, however, should not overshadow one fundamental question. Should the notion of health care in the home be considered as part of a larger movement towards empowerment of the patient? Will it give patients, when at home on their own turf, more knowledge and more to say about how they are to be treated
when they are sick? Or will health care in the home lead to the opposite result? Will it contain the seeds of further subservience of the residents/patients in that the home itself – that shelter for the private lives and integrity of the residents – will be invaded by medical professionals, medical technology, and medical definitions? These are very general questions, but they should nevertheless be kept clearly in mind when designing empirical studies which attempt to trace the actual development of this new phenomenon.

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