Establishing Housing Standards for the Aged

By JACK MASUR, M.D.

THE PROBLEM of providing housing for older people is by no means a new one. Last summer in Brussels I met an old friend, a Dutch physician and director of an excellent small hospital, who brought this fact forcefully to my attention. During the meeting, we discussed at some length the new and highly important developments in the housing of the able-bodied aging. I noticed that my friend seemed impatient with the discussion and asked him what was wrong. He said, "I'll tell you about it later."

About 2 weeks later, on our way to visit some health officials in Holland, we stopped in the city of Delft. Here he took me down a pleasant street. He stopped before a small door in a neat, red brick wall, opened the door, and stood aside for me to enter. We stepped into a beautiful garden, surrounded by a quadrangle of single-story rooms. Each room seemed to have different furniture, and there were nicknacks of all sorts about—photographs, pottery, books. My friend explained that these rooms were the homes of elderly women who had brought in their own furniture and other possessions so that they would feel at home. Some of them were out visiting friends, he said. Others were shopping or working a few hours. I expressed a great deal of satisfaction with such an arrangement for the care of able-bodied aged ladies. Then he took me to the cornerstone and pointed to the date: "Established in 1607."

He said, "Now perhaps you will understand my impatience with the great new thinkers who have arrived at the principle that it is highly desirable to provide older people with the opportunity for some independence of living and some self-reliance. We Dutch thought it was a pretty good idea 350 years ago."

Many of you are now faced with the task of establishing standards of institutional care for the aging, as provided by the recent amendment to the Social Security Act. Congress outlined the problem as follows:

"Tragic instances of failure to maintain adequate standards of care and adequate protection against hazards threatening the health and safety of residents of institutions emphasize the importance of this function of State government. . . . Persons who live in institutions, including nursing and convalescent homes, should be assured a reasonable standard of care and be protected against fire hazards, insanitary conditions and overcrowding."

This amendment will support the efforts of public and private agencies to strengthen institutional care, services, and programs. But our responsibility reaches beyond this immediate requirement of the Social Security Act. We are concerned with housing for all the aged—the able-bodied who live in public and private institutions, the sick in nursing and convalescent homes and in hospitals, and the great majority of our elder citizens who live in private homes.

A beginning has been made in the establishment of standards of care through such organizations as the American Association of Nursing Homes and many State organizations. Most

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States have limited standards for the licensure of homes for the aged, though many such standards hardly deserve the name.

It has been said that much more information is needed in the field of geriatrics before standards can be established. Obviously, we need to know more about chronic diseases, the physiological process of aging, the effect of diet on longevity and on glandular activity, and the work capacity of older persons. We must learn more about the psychology of aging and more about what older people want. But there is already a considerable body of knowledge, and we dare not delay constructive action indefinitely on the pretext that we need additional information, data, and guidance.

From Ideas to Reality

The establishment and maintenance of adequate standards in a field as complex as this is an enormous task. No matter how great the need, no matter how fully the importance of such standards are understood, the task of transposing them from thought into reality is enormous. Still, it has been done in other fields; for example, in hospital care.

In 1940, when the Hospital Survey and Construction program was being seriously discussed by the hospital and medical professions and the Public Health Service, the same problem arose. There was no uniform pattern of standards for hospitals, and there was grave doubt as to the possibility of establishing such standards on a systematic basis. Many felt that such action would be an invasion of the rights of the States, local communities, and private interests. Nevertheless, a few far-sighted hospital people insisted that standards could be established.

These people called upon leading physicians, hospital administrators, architects, and other interested persons to assist in drawing up hospital care and construction standards. In 1946, these standards, with innumerable variations to make them adaptable to all State and local needs, were made the minimum requirements of the National Hospital Survey and Construction Act. Communities applying to their States for funds under this program were required to meet these standards. In a short time, States and communities throughout the country had accepted and carried these concepts forward to practical application.

Major Steps

With certain variations, the three major steps taken in the development of standards for hospital construction and care can be used to develop standards of housing for the aged.

First, you who are directly engaged in the care of the aged can select what you believe to be the minimum standards. Your knowledge and your experience are invaluable. Though you may feel that your information is incomplete and inadequate, you are the only experts in the field.

There are several sets of standards available which can serve as guides. The Welfare Council of New York City has issued a pamphlet called "Suggested Standards for Homes for the Aged." The Methodist and the Lutheran Churches have set up standards for the management of their own homes and hospitals. The National Committee on Aging is now working on a set of standards and a subcommittee of the Committee on the Hygiene of Housing of the American Public Health Association is developing a special report on housing for the aged. This latter committee has also established a guide, "The Basic Principles of Healthful Housing," which can serve as an excellent framework for developing standards.

Practically every health department in the country has had experience with the development and administration of standards programs for hospitals and related institutions. Obviously, the State health department can be a key official agency in the formation of these standards.

The second step is really a check and balance on the first. When a set of standards has been drawn up, a group representing all interests concerned with problems of the aging should be called together. This group should include physicians, psychiatrists, and welfare workers; representatives from the health department, fire department, building inspector's office, and any other branch of the municipal government concerned with either shelter or care of the

aged; and representatives of industrial, labor, religious, civil, and other local organizations. Do not, under any circumstances, limit the membership of such a committee to a single group of health officials, welfare authorities, or architects. It is invaluable to obtain the support of all who are concerned with the aging.

This step can lend prestige to the program. It can contribute to the workability of the standards, and it can establish a foundation of professional and official support that is essential to their acceptance.

The third step is to give the standards legal status in order to prevent abuse by unprincipled persons. Here, again, the backing of all the above-mentioned groups must be obtained. Ultimately the translation of the standard from paper to reality depends upon widespread public understanding and active support.

A Broad Approach

I would like to emphasize the importance of a broad approach to the problem of housing for our older citizens. Housing is so complex and is woven in so many ways into our whole pattern of living that significant progress in providing housing for a major segment of older persons can be achieved only as basic progress is made in providing decent housing for the Nation as a whole.

Substantial reduction in the cost of housing for aged persons will be achieved only in the measure that we reduce the cost of housing for all people. Extensive revisions and improvements are needed in designs, materials, construction methods, financing, and even perhaps in our concept of housing if real progress is to be made in cost reduction.

Another basic consideration is the important financial and therapeutic relationship of housing to medical care and hospitalization. Although this relationship is important for the general public, it is particularly significant for the aged, infirm, and chronically ill.

Recent pilot studies in home care for prolonged illness indicate that patients who do not need hospitalization but require more care than just out-patient clinical services are more comfortable and get well more quickly in their homes than in a hospital. The economic differences are even more striking. Today, hospital costs are about $20,000 per bed. If the average cost of hospitalization per patient-day and the average cost of home care per patient-day are compared, the cost of care for a patient at home is one-fifth to one-third the cost of hospitalization.

We are particularly interested in good housing for all our older people because we realize that medical care facilities are seriously overcrowded and must be saved for those patients who need hospitalization. Furthermore, the lower cost of home care will allow more funds to be used for better housing, education, and food. Unfortunately, there are several factors limiting the use of home care, particularly for the low-income persons who most need its financial advantages.

According to the 1950 housing census, there are at least 16,000,000 dwellings that have one or more basic health deficiencies. For example, more than 12,000,000 urban and rural dwellings have no bathtub or shower, and nearly 8,000,000 urban and rural dwellings have no running water inside the structure. Surprising as it may seem, only about 40 percent of these health deficiencies occur in rural farm areas. The millions of American citizens living in such housing know that it would not be adequate, let alone suitable, for use in home care of a patient. Hospital administrators are all too familiar with the need to postpone the discharge of a large number of patients because they would have to return to housing totally unsuitable as a convalescent environment.

What is to be done to bring about conformity with even the present established standards of housing for the population as a whole—the simple basic requirements necessary for elementary decency, cleanliness, and health?

Rehabilitation of Substandard Housing

An attack on housing conditions is being made through new construction, redevelopment, public housing, and special institutional housing. But the opportunities for improving existing substandard housing by the application of health regulations have been given far too little attention. Certainly a tremendous volume of new housing is needed. But the housing problem can also be attacked by

prevention of accelerated rates of deterioration of dwellings and their environment and by rehabilitation of existing substandard housing that has a sound frame and foundation. In short, prevention, rehabilitation, and production are all necessary to improve housing conditions. As general housing conditions are improved, progress will be made in the provision of decent housing for aged people as well.

It has been demonstrated in more than a score of communities in the last few years that rehabilitation of substandard dwellings is practical and productive of immediate results. It is no panacea; it is not the end; but it is a necessary and salutary beginning. After this fundamental approach has been made, attention can be given to other needs. We can begin to consider standards for institutions and for care for the aged.

Public Interest and Support

Of prime importance before effective standards can be established is recognition of the fact that the public must be interested in the problems of the aging. The formulation of public policy in this regard is of the essence.

During the past few years there have been dozens of magazine articles and books on the aging, even a play. Today there is far more interest than there was at the end of World War II. But this appearance of interest does not constitute the backing necessary to transpose a set of professional standards into a practical and acceptable way of life. Specific action must be taken.

First, I suggest that you look to your State health and welfare departments as the official agencies to provide leadership in establishing and maintaining standards; second, crystallize your ideas about standards of facilities and care, and set them down in detail; third, seek out all interested persons and groups concerned with the problems of aging and enlist their aid.

Perhaps public understanding and support can best be achieved by forming a local organization which can serve as a rallying point for all who are interested in the problems of the aging. When such organizations are formed in many communities, in the States, and in the Nation, they will raise a voice that must be heard. This voice will provide the support necessary to give legal status to the establishment and maintenance of the standards, which can then serve as the springboard for national action.

To interest the public in making a reality of a standard of decent shelter we must mean business; we must close our ears to the counsel of despair and disillusion. Throughout history there have always been timid souls who would not venture to walk to the rise of the next hill. There have been those whose fears of disaster paralyzed their will to act. But the majority force in society today is the force that has a will to grow and to live.

Rehabilitation Reduces Assistance Cases

During the past fiscal year, 63,632 disabled civilians were rehabilitated, and more than 12,000 of these were public assistance recipients, the Office of Vocational Rehabilitation recently reported. The successful employment of one out of five rehabilitated disabled persons meant an aggregate earning of $22½ million for this group which the year before received about $8½ million in assistance.

This percentage of rehabilitated persons removed from public assistance case loads was the highest ever recorded; 12 percent was the figure for the preceding year. Taken from the case load were 5,200 disabled parents in families who had received aid to dependent children; 1,200 who had received aid to the blind; 800 who had received aid to the permanently and totally disabled; 400 who had received old-age assistance; 4,000 who had received general assistance, and about 400 who had received unspecified aid.