Housing and Health Facilities For Our Senior Citizens

LIVING arrangements for older people who are well, sheltered care and medical supervision for those who are ill and feeble, and custodial care for those whose health is uncertain, must be tailored to meet individual needs and wants. This threefold emphasis on personal desires, and on recognition of individual differences among senior citizens in our population, keynoted the 3-day conference on "Housing the Aging" held July 24–26, 1952, at the University of Michigan, Ann Arbor.

We Grow Older

The significance of shelter for the aging and its relationship to health was underscored at the conference by realization that, although the decrease in mortality at the middle and upper ages has not been conspicuous within the last half century, it has been considerable at the younger ages, resulting in a material increase in the number of people attaining maturity and old age. This condition is likely to improve and continue, raising the proportion of older persons in our population.

Population statistics for men and women present contrasts which must be considered in meeting the problems of older people, particularly with respect to their housing and their maintenance. In 1950, in the 65 and over age group, women exceeded men by over one-half million. For every 100 women there were fewer than 90 men. Perhaps more important is that there is a higher mortality among males and that women usually marry about 3 years earlier than do men. Widowhood is a characteristic marital condition of older women. In 1950, more than half the women of 65 and over were widows, but only about one-fourth of the men were widowers.

Where Older People Live

Of the 12.3 million persons aged 65 plus in 1950, and representing 8.1 percent of the total population, about 94 percent (or 11.6 million) lived in households. Only 6 percent, about 700,000, lived in rooming houses, institutions, hotels, and homes of various types. Of those 65 and over living in households, the largest group, comprising 5.4 million individuals, were married couples living in their own households. The next largest group of individuals lived with relatives and numbered 3.9 million.

According to a special sample study by the Census Bureau and the Housing and Home Finance Agency, about two-thirds of our older families lived in nonfarm dwellings in 1950 which had modern conveniences. The other third lived in substandard housing ranging, in condition, from dilapidated to without running water or private toilet. One important clue may be found in the Census Bureau's estimates of family income for 1950; 51 percent of all families in which the family head was over 65 had incomes of less than $2,000 a year, and more than 30 percent of them had incomes of less than $1,000. In this group, those who lived alone or with nonrelatives fared even worse—over 89 percent had annual incomes less than $2,000, and more than three-fourths had incomes less than $1,000. These resources, unless coupled with savings or other income, cannot rent or buy homes.

Older people, like the rest of the population, have concentrated in the urban areas, it was brought out in the discussions. Around 1945, about 60 percent of the total population as well as the aged fraction of the population were classified as urban dwellers. Since that time, the elder group, congregating in city centers, has increased faster than the general popula-

The 5th Annual Conference on Aging was held at the University of Michigan in July. Represented were governmental agencies, real estate and housing interests, both public and private, university and professional groups, architects and builders, nursing and convalescent home organizations, and labor unions and hospital authorities. Over 500 attended the sessions, which were sponsored by the university in collaboration with the Committee on Aging and Geriatrics of the Federal Security Agency, the Federal Housing and Home Finance Agency, and the Michigan State Medical Society.

The conference provided opportunity for an integrated review of knowledge about the housing of healthy, disabled, and sick older people. A full accounting of the discussions will be published as proceedings in the near future.

At this time, *Public Health Reports* presents on pages 1192–95 Dr. Masur's paper on the establishment of housing standards, and the accompanying report of Irving Ladimer which summarizes the health features of the conference. Mr. Ladimer, with the research planning branch of the National Institutes of Health, Public Health Service, participated in the conference.

Housing for the aging is a field of challenges and unknowns, calling for incisive thinking. Even where facts are agreed upon, different emphases modify their use and implications. Dr. Masur's paper and Mr. Ladimer's report reflect the variety of interests and opinion which so often characterizes discussions of health and medical services for our older citizens.

tion. They are found predominantly in the large industrial States. New York, Pennsylvania, California, Ohio, and Illinois claim about 40 percent of the aged population.

Neighborhood Demands and Planning

The conferees saw the need for development of new community understanding to offset fears concerning the burden of old age and misconceptions concerning the wants and requirements of older individuals. It was clear that older people strongly prefer to remain independent, to earn their own way as long as possible, to remain active participants in their communities, and to make a contribution in keeping with their experience and maturity. In short, they want to live their own lives.

As one participant declared, children have the right to think and act as they wish, and we have the right to think and act as we wish.

Whether they prefer individual homes or group living, older people want to be near public transportation or, preferably, within walking distance of community facilities such as stores, churches, libraries, and movies. They want to be able to carry out the same kind of activities as others: shopping, visiting relatives, relaxing, and working when possible. They do not wish to be segregated in planned projects, and have no great desire to move to new communities. Although there is a sizable group that looks forward, upon retirement, to moving back to the farm or to the sunshine States, most older people finally realize that they want to continue their familiar activities.

Conferees admitted that there were many individuals who did find it possible to carry out their youthful dreams of a retirement devoted to hobbies, to travel, or to new ventures, but that most of them continued lifetime pursuits if possible. Older individuals want to be near medical facilities and want doctors, nurses, and family confidants available in their later years. This yearning is particularly important when health is failing and problems of remaining healthy become paramount. The ability to get up and go cannot be taken for granted.

Consequently, neighborhood planning plays an important part in meeting the needs and desires of older people. Although there have been a number of very highly successful group living arrangements established for older people, the conference recognized the basic objective of keeping a place in the main stream of life for our older citizens.

The conference suggested that zoning ordinances and related land use control should be examined critically. Suitable housing for the

physical and emotional requirements of the older ones should be widely distributed throughout the community. Consideration should be given to population density, need for privacy, parking, and community centers. The development of neighborhoods which provide a variety of conveniences—from small neighborhood stores to large shopping centers—requires large-scale planning rather than lot-by-lot consideration.

Private enterprise representatives asserted that the home-building industry can achieve results at the instigation and promotion of community leaders. There was also strong feeling, on their part, that leadership for such improvement would have to come from informed consumer action—possibly through public agency cooperation and control.

Design and Sheltered Care

In designing housing for older people it was recognized that there are certain conveniences and safety measures which are important. Today, builders tend to consider the young family and to overlook the needs of later years.

However, it was the consensus of the conference that homes suitable for the young family were essentially adequate in construction, in design, and in durability for older people. True, certain additions or improvements are available and should be introduced to meet individual physical and psychological problems and declines in basic abilities in much the same way as changes are made when children are introduced into a home. But housing experts pointed out that relatively few older people require significantly different or special features in homes, apartments, or institutions. Basementless homes and single-story houses were suggested as features which would be preferred by many families but which would be particularly adapted to the shrinking capacities of the senior group. Here again it was affirmed that aged people are individuals—human beings—and not a monolithic group.

Major issues at the conference of special importance to public health officials related to requirements of our elders for sheltered care and for medical supervision. Conference discussions centered on the need for appropriate participation by health workers in city planning, in home design, and in building. Health workers must gain more insight into the factors relating to population change, education, family life, creative and recreational activities, religious programs and services, income and resources, and community organization. Healthful living and creative contribution depend on all these.

The doctor, the nurse, and the health worker, whatever his specialty, must be observant, sympathetic, and alert in recognizing these varied elements and the opportunities to cooperate with other professions and disciplines. The health officer, potentially, if not always in fact, is a community leader when it comes to health education and provision of medical care. The special skills and experiences which medicine and public health training have to offer can probably best be evidenced in the provision and management of general and special hospitals and neighborhood clinics and in the support of the large variety of nursing homes, convalescent homes, and old age institutions.

Quite early in the discussion of supervised care for older people, it was concluded that there were three distinct but overlapping groups of older people: the able bodied; the infirm; and the disabled—counting those acutely ill and those suffering prolonged ailment or other conditions requiring medical or special care.

It was agreed that mostly it was unnecessary to provide institutional care and complete medical supervision for older people as such. Even for the unwell with long-term stabilized infirmity or for older people with periods of good health matched by strain or fatigue, there may be question about utilizing expensive hospital beds and providing full medical treatment. Many such persons probably need, more than anything else, just assurance, sympathetic understanding, and general surveillance of their health, with, of course, suitable treatment available for acute conditions.

There was disagreement among the conferees on the advantages of geriatric units or of special facilities for infirm older patients which would be physically attached to and integrated with general hospitals. Is it more feasible and economical perhaps to establish in separate institutions patients who are well as often as they are sick?

No disagreement existed, however, concerning the need for a close relationship between the general hospital and such centers, for staffing them with well-trained doctors, nurses, and medical aides, and for equipping them with general and emergency treatment facilities. It was pointed out that in a hospital an older person may face the possibility of realizing a surrender of independence and responsibility which is accompanied by a loss of sense of security. He sometimes associates illness with aging.

In emphasizing the desirability of closely relating the hospital and geriatric unit for infirm older people, these advantages of such an arrangement were noted: It allows approved medical supervision. It provides better records through integration with the hospital system. It offers access to hospital facilities, especially for diagnosis. It permits lower capital outlay for geriatric structures and lowers over-all unit costs. And, finally, it lessens the problem of moving the older person from one unit to another.

At the same time, older people who are confined to separately constituted public or private rest homes or to custodial institutions have a constant fear of falling ill, unless they have confidence that the organization can quickly provide necessary medical care.

Older people in good health usually do not need institutional care. Even without family or resources, it is possible for an older person to set up a new home with similar friends in a regular community or through congregate living arrangements, if he has been stimulated and aided in making the new arrangements. But, the conferees noted, there is a fallacy in not recognizing that people do become feeble and infirm as they grow old so that some type of medical supervision for older folks is essential, whether they live independently or live in a home that is essentially a boardinghouse or an old age institution.

Ideally, the services of both a general hospital and of a specialized institution should be provided for older people, with the closest interplay of staff and exchange of services. Older individuals may then proceed at their own rate in keeping with their abilities and their interests. They have the assurance that a helping hand is ready when they falter.

As one speaker summarized: "Although the problems of the aged and those of chronic disease are not synonymous, they are so closely interrelated that they cannot be studied in separate parcels."

Nursing and Convalescent Homes

Nursing and convalescent homes and other institutions for the aged, needy, or infirm may be variously classified according to the purpose of study or function. For example, they can be grouped by ownership, that is, public or private; and by size, structure, or nature of service provided. The most useful classification probably is the last, nature of service.

Statistics on the number of such institutions are not yet validated because of State differences in definition, licensure requirements, and regulation. A listing of institutions in 1948 and 1949 prepared for the 1950 census indicates that there were then about 5,200 old age homes. About a fourth of these were public; another fourth were private and nonprofit; and half were proprietary establishments. In that list, there were also 6,400 nursing and convalescent homes, mostly private commercial ventures.

Many conference participants strongly assented to the proposal that the quality of service to be available at nursing homes should, at most levels, be of the same caliber as that provided in hospitals. Financial studies covering a wide range of nursing, convalescent, and other institutions which provide medical care indicated that costs of care in such institutions came to about two-thirds the cost of general hospital care.

One participant who had made a survey of the several types and categories of homes caring for old people and other individuals not requiring hospitalizing urged the conference to promote uniformity of service standards for all places accepting responsibility for sheltering persons who require nursing assistance or medical supervision. The speaker said that a nursing home is a substitute for the patient's own home—not a diagnostic or specialized treatment facility. Hospitals are available for diagnosis and special treatment and should be integrated within the pattern of geriatric care. It was recognized that, traditionally, professionals in

the hospital field and in the area of chronic illness recommend special facilities and different standards for the major categories of facilities. If the service classifications in the homes were well accepted and were followed, and if older people were properly diagnosed, this uniformity could be achieved. Since there is considerable lack of uniformity as to designation, size, and legal status, it was felt that at least all facilities represented as providing medical care should be held to a basic standard.

All participants strongly emphasized that both the general hospital and the nursing home, or the home for the aged—under any name—must go beyond custodianship to engage actively in rehabilitation programs. As put by one speaker, the operation must constitute "reverse social service," with strong accent on returning patients to their homes and communities rather than placing patients in institutions. Some participants went so far as to declare that there was no such thing as chronic illness if it were understood within the meaning of a generation ago as hopelessly disabled or incurable—that there was only acute, subacute and inactive disease, always allowing the possibility of cure, restoration, and rehabilitation.

Problems and Standards

Nursing and convalescent homes, it was constantly noted, have various names. They are strictly regulated in some States and are not even registered in others. Some are subject to State legislation and local ordinance. They provide a variety of services, in physical structures of all types. It is estimated that nursing, convalescent, and boarding homes of various types care for well over 100,000 individuals annually, and constitute an important and indispensable adjunct to the Nation's hospital beds. In 16 States for which data over a period of years were collected, there would appear to have been in 1950 an average of 1.05 nursing beds per 1,000 population, or about a third of the non-Federal general hospital beds in those States.

Those homes which assume responsibility for patient care and treatment under suitable medical standards for cure and rehabilitation should be able to provide the physician and his patient with some of the same services a general hospital provides with the exception of specialized diagnostic, laboratory, and surgical and technical service. Such homes could profitably be used as adjuncts to general hospitals in the best sense with special concern for the relatively stabilized infirm and for those wavering between good and ill health.

It was the plea of the nursing and convalescent home operators attending the conference that the medical profession should give more attention and recognition to these facilities and should take responsibility for educating owners and operators concerning their needs in order to elevate standards. But, they added, if all superior features of design, staff, and equipment were incorporated, the attractive lower rates which such homes now offer might no longer be possible. At present, estimates indicate that, for the best-staffed homes providing care of good quality, operating expenses are from two-thirds to three-fourths that of general hospitals in the same area, and their daily rates are commensurately lower.

Usually, nursing and convalescent homes have been established in structures and large old mansions which have been equipped for bed and ambulatory care. These homes do not usually incorporate desirable design nor are they always easily accessible or close to medical centers.

Nursing home operators admitted that advances were desirable, but that they could be achieved only by increasing rates. There is, in many States, the essential division of responsibilities between regulation and standard setting by one State agency (the health department, for instance) and payment for care of public assistance and State ward cases by another agency (such as the welfare department). The first seeks to improve service and thereby raises operating expenses whereas the latter naturally seeks to get maximum service at the customarily low rates determined by the legislature. The conference recognized that the improvements sought could not reasonably be provided unless public payments were increased.

In one of the closing conference addresses on the subject of establishment and maintenance of standards, the speaker strongly advocated immediate action on the basis of available knowledge. Three steps were outlined:

Agree on minimum standards.

Get community support and aid from groups representing all interests.

Then get legal status for the standards approved.

Many suggestions were offered for improvement of design, architecture, engineering, and management of the nursing or convalescent home, but no standard pattern was generally accepted by the conferees.

It was agreed that any plan should respond to the program or objective of the institution. Popular and widely advertised features such as treatment rooms, equipment, day rooms, and recreational areas, individual bathtubs and the like, while helpful, are not always essential for the provision of high-quality care. More important are factors of leadership, motivation, and adequate staff training. Remodeled old residences can be quite satisfactory and of great assistance in providing sheltered care facilities for the Nation when they are properly licensed, inspected, and maintained.

Nursing home operators, it was noted, have made substantial contributions to the widely ignored problem of care for the aged infirm population. They should now concentrate on developing standards; on cooperating in research on physical design and structure; and on promoting effective criteria for licensing, inspection, and control. They should concentrate on working out spheres of activity and functioning with hospitals and prepayment plans. They were urged to get positive public recognition of their role in medical care.

Financing

One of the most significant and acute problems facing older people is that of adequate financing of medical care. Maintenance of older people in general hospitals for long periods of chronic illness which does not require hospital care constitutes a great and questionable economic burden. It is not, however, sensible or justifiable to exclude from general hospitals older people requiring hospital care, unless other acceptable high standard facilities are available.

Some hospitals, notably Montefiore Hospital in New York and Michael Reese in Chicago, have successfully experimented with home care programs. Here chronically ill persons, young as well as old, are supervised in their own or in convalescent homes or in boarding houses. Such a program involves the extension of the medical, nursing, and staff services from the hospital and requires greater reliance upon such community facilities as visiting nurse care and recreational and educational resources. It has the great advantage, of course, of enabling the patient to stay in his own environment and of lessening his adjustment problems while it frees hospital beds for acute cases. For the hospital, there is a much lower cost for patient care. For the economy generally, home care is to be preferred. Good family housing can be provided for as low as $3,000 per person, but hospital beds may each cost about $20,000 a year to maintain. The average cost of home care per patient is between a third and a fifth of the cost of his hospitalization. Even where hospitalization is undertaken initially, every effort at rehabilitation and early homecoming should be made.

Such home care arrangements cannot, however, be extensively established or promoted unless the general hospital is willing to accept its role as an operational base and unless the community and family are willing and able to assume appropriate responsibility. In the individual home, such responsibility at minimum requires healthful quarters. Certainly, it would not be suitable to refer patients home for care to any of the 16 million dwellings in the United States that have one or more health defects, as, no bathtub or shower or no inside running water. This program underscores the significant relationship between hospital or sheltered care and family housing. The one cannot depend on the other to prevent illness or to restore health unless housing conditions generally are vastly improved. Consequently, additional ways to reduce the general cost of care must be sought.

Community Attitude

A physician who is now successfully conducting a joint hospital-community service on behalf of the aged declared that housing needs of older people requiring sheltered care and medical supervision can best be met when it is realized that:

1. Well oldsters can generally care for themselves in individual or congregate households and perform normally when given understanding and sympathetic assistance;

2. Failure to provide in advance for the problem of growing old results in economic, physical, social, and emotional tragedy among the elderly.

Above all, he added, in prescribing for an older person, as for any other, regard the individual as a whole and consider not only physical care but social and emotional rehabilitation. The money cost of preventive service for the older population will in the long run be far less than the cost of neglect, he concluded.

Prepayment Plans

It was proposed that medical prepayment plans be adjusted to include aged persons. These people face the same problems as the rest of the population in paying for medical care, but their problems are much more acute than that of the average person. Their incomes are low. They need more than the average amount of medical service, over longer periods. As a consequence, they have generally been considered poor risks and have less opportunity for enrolling in voluntary prepayment or insurance programs. Most group plans will continue the insurance rights of persons over 65, but most will not accept them on an individual basis after retirement or after age 65 or 70. At the heart of this problem is the fact that prepayment plans are relatively new so that older persons have had no chance to enroll and many who did have found it difficult to keep up the payments.

For the one-fifth of all men and women over 65 now receiving old-age assistance from the Federal and State governments, there has been some amelioration of the problem, conferees noted. Public responsibility for care has been enhanced by the 1950 amendments to the Social Security Act permitting Federal matching of payments for direct payment to institutions and others who provide certain types of medical services. Excluded are institutions for medical and tuberculous patients—an omission which should encourage the financing of these institutions through health channels rather than through public assistance channels, it was suggested.

Important contributions to solution of the problem, the conference noted, can be looked for from the development of pooled-fund arrangements, increased cooperation between health and welfare departments, and from the medical and hospital professions working together with governmental agencies.

The development of adequate facilities is another step which, it was felt, might be taken immediately to provide medical care for older people. An example in the hospital field was cited. Under the impetus of the Hospital Survey and Construction (Hill-Burton) Program operated by the Public Health Service, volunteer groups, local and State governments, and communities have united in the planning and building of general hospitals. Attention might be given to the requirements of older people by studying the applicable features of the Hill-Burton program and related programs.

Finally, conference discussions emphasized one must not lose sight of—but rather point up—preventive measures. Efforts should be redoubled to keep the elderly who are well out of institutions and thereby save institutional resources for the truly sick and disabled. The individual patient, the family, the community, and all who are concerned with the growing problem of the aged must unite to keep as many of our older people as vigorous and productive as possible.

For the aged and others who must receive medical care it is important to place the right patient in the right bed at the right time. It was reiterated that the expansion of adequate family housing could probably do more to keep the older group out of institutions, particularly boarding and convalescent homes. Failure to utilize appropriate resources represents a waste of money and a public burden.

—IRVING LADIMER