Better Care for Older People

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WHEN PEOPLE with common responsibilities and common problems get together at a "brass-tacks" meeting of this sort with the intention of finding out how they can put sound principles into practice, we really get down to immediate details of practical importance. It is then that we begin to feel the forward thrust of movement toward a common objective.

This regional conference—the first of three to be held by the National Committee on the Aging—meets the requirements of a "brass-tacks" meeting. The 2-year study on Standards of Care for Older People in Institutions, conducted by the committee under the able direction of Mrs. Edith Alt, is based on the experience of hundreds of organizations, institutions, individual experts, and older people themselves. Out of these experiences and collected facts, the study has drawn some basic principles—in a field of service so new that there were very few guides to the formulation of principles. Now the time has come to test the principles in the fire of new experience; specifically, in the future action of responsible officials and operators of institutions for older people; in the decisions of boards of trustees and other policymakers; and in the action of religious, voluntary, and professional groups. This new experience will be further judged by other citizens—the older people themselves, their families and friends, and the large group we call the "whole community."

There are more than 4 million men and women, 65 years of age and over, in the 13 States and the District of Columbia, which you represent at this conference. This means that what you decide here over the weekend and what you do at home next week and the months ahead will affect profoundly the health and happiness of more than one-third of the Nation's older people. That is a sobering thought. So let us first consider the health of older people in homes for the aged and in nursing homes.

Dr. Scheele, Surgeon General of the Public Health Service, presented this address at the Regional Conference on Methods of Establishing and Maintaining Standards in Institutions for Older People, sponsored by the National Committee on the Aging of the National Social Welfare Assembly, in Washington, D. C., February 1954. Represented at the conference were the 13 States, Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania, Delaware, Maryland, West Virginia, and Virginia, and the District of Columbia.

The Problem as We See It

The need for facilities of this type has grown—and is growing rapidly. To supply the need is a problem which, like old age itself, has crept up on us—on the Nation, on our communities, and on the old people and their families. Probably no two groups represented at this conference will view the problem in precisely the same way. I am sure, however, that we all

agree it must be solved in such ways as will protect and promote the health of all older people.

We cannot do justice to one of the major issues of our generation if we approach the problem of better care for older people in institutions narrowly. We must relate our thinking about institutional care to the entire spectrum of physical, mental, social, and economic factors that make up the total problem of aging.

Health is at the heart of every aspect of aging. Every study that has been made in the past 25 years bears out this viewpoint. The more recent data underscore the findings of a generation ago—and show that the burden of ill health among the elderly has increased in volume. It will continue to do so.

Older people get sick more often and their illnesses are more frequently disabling and last longer. Most of you would confirm that statement on the basis of your daily experience—whether you are a physician, social case worker, public health nurse, welfare administrator, or manager of a nursing home.

In planning for the better care of older people, however, it is important for us to realize that chronic "degenerative" diseases occur four times as frequently among the old-age group as in the general population. Long-term illness, disabling 30 days or longer, occurs twice as frequently among the elderly and the average period of disability due to chronic illness is more than four times as long for the older person as for the average person in the general population.

Diseases of the heart, blood vessels, and kidneys account for nearly one-third of the disabling illnesses among older people. Arthritis, tuberculosis, other diseases of the bones and joints, accidents, diabetes, cancer, and eye diseases make up the remaining major causes of long-term, disabling illness among the elderly. Nevertheless, we find in the same old-age groups high case rates for such acute ailments as bronchitis, influenza, pneumonia, and diarrhea.

Findings from the survey in the Eastern Health District of Baltimore, covering the 5-year period 1938–43, also reveal significant differences in the sickness experience of the two sexes. Older women, for example, are more frequently confined to bed than are older men, but on the average, the total days in bed are fewer for the women.

Disabling home accidents occur among older people three times as frequently as in the general population. Among older women, however, the disability rate is more than double that among older men and is nearly five times that in the general population.

These findings bring into sharp focus the relationship of health to the total problem of aging. It is true that we can confidently expect advances in medical science with respect to the diagnosis and treatment of the major causes of disability in the general population and in the older age-groups. Physicians undoubtedly will be able to deal more effectively with many of the disabilities of old age. Nevertheless, the disabilities must be dealt with in individual patients, whose numbers will increase.

Parallel with the anticipated increase in numbers of older people, we can expect increased demands for physicians' services, hospital care, and nursing services. The aging of the population also means an increasing concentration of such services on the chronic diseases. Only by increased efforts to prevent chronic diseases or modify their disabling effects will we able to reduce significantly the burden they impose upon our medical and hospital resources and on the total national economy.

We do not have adequate estimates of the number of elderly patients hospitalized annually in our general hospitals, nor of the number hospitalized for chronic disease. The American Hospital Association, however, estimates that from one-fourth to one-half of the annual days of hospitalization provided in general hospitals is for chronic diseases. In view of the higher rates of chronic disease in the old-age group, it is safe to assume that a considerable share of those days is devoted to older people.

Some significant figures have been issued recently by the Public Health Service's National Institute of Mental Health regarding older people in State mental hospitals. The rate of admissions for persons over 65 has increased from 148 per 100,000 population in 1933 to 225 per 100,000 in 1948. Mental diseases of old age account for about 27 percent of first admissions and for 11 percent of all resident patients. Of

those patients who have been in the hospital from 1 to 4 years, 21 percent have been admitted for diseases of old age. New York State estimates that 2 percent of its entire older population (65 years and over) is resident in mental hospitals.

The data I have presented do not reveal the true magnitude of disabling illness among older people. When we consider the available figures, however, we cannot avoid consideration of the social and economic implications of the problem.

The cost of prolonged hospitalization of patients in general hospitals is likely to be prohibitive—not only for the vast majority of elderly persons, but also for their families and for the community in its provisions for the dependent aged and disabled. Chronic disease hospitals, constructed as units of general hospitals, offer many economic advantages in providing hospital care for the aged. In 1952, such hospitals were operated at $6.63 per patient-day, in contrast with a cost of $18.35 per patient-day in general hospitals. At the present time, the Nation has a total of about 55,000 beds in chronic disease hospitals. State hospital agencies report that one-fifth of these are nonacceptable beds because they are in structures that are not fire resistant or that lack essential facilities, or are otherwise defective.

We have no precise estimates of the total amount spent annually for medical and hospital care of the aged from private and public funds. Expenditures by the older people and their families from private income for that purpose, however, must account for a substantial share of the total annual $9 billion expenditure by consumers for medical care. In addition to the costs of maintaining older people in public mental institutions and tuberculosis hospitals, public assistance funds in the amount of nearly $200 million are spent annually for medical and hospital care of the aged alone.

Old age, ill health, and financial difficulties go hand in hand for the great majority of our older people. Ill health is a major cause of retirement when the beneficiary of old-age and survivors insurance reaches age 65, and his reduced income is seldom equal to the strain of heavy medical expenses in a critical or prolonged illness. His savings and other assets may be sharply depleted, even wiped out, in a single year. Financial disaster and dependency are too often the end result of illness in old age.

Better Health—Better Care

Under these conditions, many of our older people watch their long-cherished hopes for self-financed "gracious living in the later years" vanish. And with their hopes, their will to regain health vanishes. Can we at this conference and our counterparts in other parts of the country do anything to revive those hopes and make "gracious living" a reality for more older people? I think we can—if we begin to think and act now as though better health and better care were but two sides of one coin—inseparable.

Homes for the aged, nursing homes, and similar facilities are providing care for a small but significant proportion of our total population in the old-age group. These institutions are destined to play an increasingly important role in the Nation's overall programs for the aging. The waiting lists of individual institutions and the difficulties that referring agencies have in finding a place for clients are only one indication of the increasing consumer demand.

Many older people now hospitalized for long-term illness could be cared for more satisfactorily and at less cost through home care programs or in nursing homes. Many other sick old people, who are now being cared for under unsatisfactory conditions outside of institutions, could be better cared for in nursing homes or chronic disease hospitals. Many others who have no recognized illness or handicap could undoubtedly benefit from some type of sheltered care.

The health status of such an important segment of the population is of serious concern to public health agencies. Likewise, the environmental conditions under which older people live and the health services provided them are of public health concern.

Our State and local health and welfare agencies have a background of experience in this field. Their technical staffs can help tremendously in the development of satisfactory facilities and programs for the care of older people. These official agencies realize, however,

that practical advances in this field depend upon the maintenance of standards which have been jointly developed and agreed to by all of the official and voluntary organizations directly concerned.

In our country, we have relied upon self-discipline and cooperation with State and local governments to give us standards of medical, dental, nursing, educational, legal, and many other professional services. The high quality of professional services in the United States shows that our confidence in this process of partnership has not been misplaced.

The initiative and current activity of the National Social Welfare Assembly and its Committee on the Aging in the field of institutional care for older people, therefore, are in the best traditions of our country. The report on standards of care which you are considering at this conference will be a landmark for all future advances in this field.

Much additional factfinding remains to be done. I am happy to report that the health and welfare departments of 11 States are now cooperating with another voluntary agency—the Commission on Chronic Illness—in a study of nursing care patients in institutions in their jurisdictions. The Public Health Service is cooperating with the commission in this study.

Five of the States engaged in this survey are represented at this conference: Connecticut, Maryland, New York, Rhode Island, and Vermont. The remaining six are California, Colorado, Georgia, Indiana, Minnesota, and New Mexico.

The pilot study has been conducted by the Maryland State Department of Health to obtain data on the numbers, characteristics, and conditions of the people receiving care in nursing homes and similar establishments, and on the types of care they receive. When the commission completes its task of projecting the results from the State surveys on a national scale, we will have a more objective understanding of the situation and a better basis for the measurement of needs.

The survey reveals that in Maryland the proprietary nursing homes are the largest group of establishments providing long-term nursing care for adults. They provide 40 percent of the beds, as contrasted with 20 percent provided by homes for the aged licensed for nursing care, 17 percent provided by chronic disease hospitals, 16 percent by almshouses, and 7 percent by nonprofit nursing homes.

Information about the patients in the proprietary nursing homes thus gives us a significant picture of the older people needing such care in one State. Two in every three are 75 years old or over. Nearly three-fourths of them are women. Two-thirds of the group are widowed and one-fifth were never married. Many of them have outlived all members of their immediate family.

They have been in the home a long time—half of them for more than 1 year; one-fourth, more than 2 years.

The health picture is not encouraging. Two in every five are in the home primarily for heart disease, stroke, or other circulatory disease. Senility is reported as the primary problem in another 20 percent. Fractures, arthritis, mental disorders other than senility, paralysis, and cancer account for the remaining major reasons for being in the home.

They are helpless old people: More than one-third are completely bedfast or are able only to be taken up and put in a chair. One-fourth need an attendant or a wheel chair or "walker" to get about at all. One-third are incontinent. And 60 percent are mentally confused all or part of the time.

Although there is a general similarity in the personal, physical, and medical characteristics of the patients in different types of institutions included in the Maryland study, the available data reveal some significant differences among the institutional types. As Dr. Dean Roberts, director of the Commission on Chronic Illness, has pointed out in a recent paper (*1*), "the general tenor of severity of the patient's condition seems to follow a gradient from those receiving care in chronic disease hospitals through the proprietary nursing homes, the nonprofit nursing homes, homes for the aged, and finally the almshouses where the residents evidence the least extent of disability." Undoubtedly, the complete findings and report of the pilot study will reveal many factors to account for these variations, and these will require careful study in the evaluation of needs.

Against the reported health status of the pa-

tients in Maryland's proprietary nursing homes, the arrangements for medical care by the patients, their families, or the responsible agencies seem to leave much to be desired. Only 3 percent of the patients were reported as having no specific illness as a cause of their invalidism. Yet, at the time of the study, one-fifth of them had not been seen by a physician for 6 months or more. About 8 percent had not been seen by a physician since they entered the home, and nearly one-half of this group had been in the home for periods ranging from 6 months to 10 years or more.

Generally speaking, old people with a known chronic disease or impairment may go along for many months requiring only routine medical supervision. But without medical supervision, it is unlikely that impending crises will be detected and possibly averted. In many cases, the diseases which make invalids of so many older people have not been brought to the attention of a physician early enough to avert prolonged disability. They are difficult to detect; and especially among the elderly, premonitory signs—which in younger people would flag attention—are too often regarded as "normal" signs of the aging process.

Moreover, the occurrence of multiple causes of ill health must be anticipated in caring for older people. A chronic disease may supervene in a patient who on admission is suffering the effects of a fractured hip. In reverse, an acute infection may supervene in a cardiac or diabetic patient. A disease which produces only a minor illness in a healthy person may be very serious in a patient already enfeebled by a chronic disease or extreme age.

For these reasons and others involved in the health and welfare of the aged, arrangements for the care of older people should include specific provisions for medical supervision, as well as for affiliation with appropriate hospitals so that when the need arises, services beyond the reach of a nursing home will be provided promptly. Provisions for assuring a safe and healthful environment, adapted to the special needs of aged and infirm people, are equally important.

Institutions located in our cities are usually within convenient reach of the facilities, professional personnel, and health agencies necessary for assuring their patients medical, hospital, and public health services. Often, however, even these favorably located homes have difficulties in making satisfactory arrangements. Institutions located in rural or semirural areas are more likely to have such problems, especially when many of the patients have been admitted from distant communities and thus have lost contact with their personal physicians.

Joint planning is the first step toward overcoming these difficulties. The health and welfare agencies, both official and voluntary, as well as private and public institutions providing nursing care, could obtain much valuable advice and practical assistance—if they would more frequently bring their State and local medical societies in on the ground floor of such planning. The active participation of the local medical profession is indispensable in the development and operation of any constructive health program for the aging—be it on a statewide basis, in a community, or in an individual institution.

Time for Prevention

The central position of modern medical and public health services in better care for older people is stated explicitly and frequently in the report of the National Committee on the Aging. In this connection, I was particularly impressed by the last section of the report—Developing Alternatives to Institutional Care. Pointing first to the rapidly increasing values of apartment projects, group homes, residence clubs, foster home care plans, home medical care programs, and other arrangements for older people outside institutions, the report continues:

"As alternatives . . . are developed, institutional care itself assumes a specialized function, that of providing a therapeutic, rehabilitative, and consistently supervised environment for older people with special needs" (*2*).

As a sum in public health arithmetic, these challenging new arrangements outside institutions plus the emphasis on the therapeutic, rehabilitative function of institutional care add up to the right answer—prevention.

The time is ripe to extend the concept of prevention to our aging population. In many instances, prevention of chronic diseases and disabling accidents is possible. In almost all

cases, prevention of prolonged and total disability is possible. Never before has medical science had such a wealth of pertinent knowledge and effective techniques ready for application to the health problems of older people. A few years ago, we could only report that medicine was at a stage in its care of the aged comparable with that which saw the birth of modern pediatrics. Today, we can say that geriatrics has attained considerable growth and development and is now able to assert itself with increasing independence. Parallel with that development, we have seen many remarkable advances in the diagnosis and treatment of a wide variety of chronic diseases and serious impairments.

If we are to apply these advances effectively to the health problems of our aging population, however, we must begin to build for better health far in advance of that 65th year which supposedly signifies the onset of old age. The aim in our personal health practices, as well as in our professional relationships and in our community programs, should be to prevent the serious, disabling conditions associated with old age.

There are several ways of looking at the possibilities of this emphasis on prevention. It would give the older people a larger measure of health and happiness and would free them and their families of a considerable economic burden. It would give the community a deeper satisfaction in its efforts to meet one of its most urgent problems, as well as substantial reductions in the costs of long-term care of the sick. And it would mean that a large proportion of old people requiring sheltered care would enter the institutions in better health than many of those now receiving institutional care.

To achieve these results, we will have to emphasize prevention all along the line: chronologically, in the lives of individuals; and organizationally, in our education of professional personnel, in all our hospitals and related facilities, and in our community programs and services.

Better health for the aged may often begin before birth. Dr. Joseph P. Hoët of Louvain University recently reported that by discovering a prediabetic condition among mothers during pregnancy and by treating those with an abnormal blood sugar and their offspring, there is an excellent chance of preventing a high proportion of cases of diabetes in adults. The disease may be present in a latent stage from birth.

I am sure that I do not have to spell out for those of you who have aged diabetics on your public assistance rolls or in your nursing homes, the advantages of such a preventive program in lightening the burden of care for older people.

Recent findings in a number of American research centers—including the Clinical Center of the Public Health Service—point not only to the possible but also to the probable development of new, simple, and relatively inexpensive methods for communitywide attacks on other serious diseases.

If, for example, medical scientists can find some chemical means of detecting and blocking the specific changes in metabolism that lead to certain common forms of arteriosclerosis, we will have a preventive technique as important to medical and public health practice as was the discovery of vitamin C in the prevention of scurvy and vitamin D in the prevention of rickets. It is easy to visualize the changes for the better that such a discovery would make possible in our care of older people in institutions.

Moreover, there are already available a wide variety of new drugs and surgical techniques, advances in physical therapy, and restorative medicine which would greatly improve the health status of our older people. Unfortunately, the older people in institutions are too often the forgotten men and women to whom these effective techniques are not applied.

I do not wish to suggest that medical science has discovered—or is about to discover—elixirs of eternal youth and vigor. I do want to emphasize the medical means now available to make our later years healthier and happier, and to make our aging easier. More such advances are on the way.

We need not have high proportions of the older people in institutions bedfast, dependent, mentally confused—and leading a worse than vegetable existence. Their care need not be such a heavy task, physically; and such a discouraging task, spiritually. The place to begin better care for better health is here—at confer-

ences like this—and in our States and communities, in their health and welfare programs, and in the work of public and private institutions.

The time to begin is now—for the sands of time are running fast for many patients now in institutions. They are running fast for you and me, and for every other adult in our aging population. Will better health and better care await us when it is our turn? In large measure, the answer depends upon what you and your counterparts in the remaining 35 States do. If the spirit of this conference be a guide, I am sure that the answer will be "Yes."

REFERENCES

(*1*) Roberts, Dean W.: The characteristics of patients in nursing care institutions. Am. J. Pub. Health 44: 455–466 (1953).

(*2*) National Social Welfare Assembly. National Committee on the Aging: Standards of care for older people in institutions. Section II. Methods of establishing and maintaining standards in homes for the aged and nursing homes. New York, The Assembly, 1953, pp. 74–75.