Restorative Services for Older People

The following text was issued in a limited edition as a leaflet for the Federal-State Conference on Aging, June 5–7, 1956, Washington, D. C., prepared by the Hygiene of the Aging Section (now the Health of the Aged Section) of the Chronic Disease Program, Division of Special Health Services, Public Health Service. It is published here to emphasize that many forms of rehabilitation may be constructive, whether or not the patient recovers full physical and economic independence.

There is convincing evidence that a substantial backlog of aged patients for whom restorative services would be appropriate has accumulated in the institutions and communities of this country. All professional workers in the health field should be alive to the opportunity for restoring many of these older people to self-care. The private physician, the health officer, the director of an institution—all should inform themselves concerning the highly significant possibilities in this area.

Restorative services for older people aim at permitting resumption of necessary daily activities by patients themselves through physical and psychological restoration, and at maintenance of maximum self-care by followup procedures. The group for which restorative services are most appropriate is made up of those aged patients who would otherwise be committed to a virtually helpless condition for the rest of their lives, but no disabled patient should be denied services which will maximize his physical and mental capabilities. In certain cases patients not only can be physically restored for daily living so that need for care is reduced, but can, through further rehabilitation, become employable again.

Three questions are significant in this field:

1. To what extent is restoration to self-care possible?
2. What kind of personnel does the job require, and how many?
3. What is the cost of the service?

Results of Restorative Services

Reports on the extent of possible restoration to self-care are not numerous, nor always comparable, but certain salient facts have already been recorded. In England the United Oxford Hospital reported that three-quarters of the surviving patients who received these services were rehabilitated by the end of 3 months. At the District of Columbia General Hospital roughly two-thirds of the patients receiving restorative services returned to the community capable of self-care (including both inpatients and outpatients). At the Allegheny County Home (Pennsylvania) the proportion of patients achieving self-care after restorative services varied from 40 to 70 percent: arthritics, 60 percent; amputees, 70 percent; hip fractures, 60 percent; stroke cases, 40 percent.

Personnel

Ideally, the restorative service team includes: physician director (preferably a physiatrist), psychiatrist, psychologist, physical therapist, occupational therapist, speech and hearing therapist, recreational worker, social worker, nutritionist, and nurse. Few institutions can afford ideal staffing, but much can be accomplished by (*a*) inservice training of the existing staff, (*b*) the addition of a few rehabilitation specialists (either full time or on a consulting basis), and (*c*) the maximum use of community resources. The Allegheny County Home program is a successful example of what can be accomplished through this approach.

Cost

Accurate cost analysis of restorative service programs cannot be made at this time because of variations in cost accounting and in staff and equipment. For example, the District of Columbia General Hospital charged against these services $58,501 for treatment of 883 patients over a 14-month period, an average charge of about $66 per patient treated. On the other hand, the New York University-Bellevue Medical Center estimate for the annual cost of rehabilitation personnel operating a 100-bed restoration service is $104,000 (unpublished data). Each institution must estimate its own costs. It should be noted that the services normally show successful results within 3 months, if success is to be achieved.

In summary, restorative services for older people have been proven to be effective; it has been established that personnel are available or can readily be trained for this work; the cost of the program can be kept within reasonable limits.

On the basis of these facts, it is hoped that early action will be taken in communities throughout the country to initiate these activities.

Finally, it must be constantly emphasized that this problem and this opportunity confront the entire medical profession; restorative services are by no means limited to institutional situations. Wherever old people can benefit by this type of service—in the home as well as in the hospital or the nursing home—the service should be supplied. This is a medical, a health responsibility. It is a challenge to everyone responsible for the health of older people.