Old age- Housing and care

STATE OF NEW YORK

HOME CARE AND HOUSING NEEDS OF THE AGED

A REPORT ON A STUDY

FOR THE

NEW YORK STATE DIVISION OF HOUSING

Conducted By

JOHN G. STEINLE AND ASSOCIATES

[New York, 1958]

JOHN G. STEINLE

AND ASSOCIATES

44 Nassau Boulevard
Garden City, N.Y.

Pioneer 7-3688

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Joseph P. McMurray, Commissioner
New York State Division of Housing
270 Broadway
New York 7, N.Y.

Dear Commissioner McMurray:

We are pleased to transmit herewith our final report on home care and housing needs of the aged.

It was a distinct pleasure to work with you and your staff whom we found to be tremendously helpful, analytical and imaginative. We will be glad to assist whenever possible in the implementation of the results.

Very sincerely yours,

John G. Steinle

JOHN G. STEINLE
& Associates

jgs/gf

HOME CARE AND HOUSING NEEDS OF THE AGED

TABLE OF CONTENTS

I - INTRODUCTION

This is the report of a special study conducted under contract with the State of New York to determine the need for and feasibility of special programs to meet the requirements of home care for the aged in public and private housing. Although this was a research project conducted primarily by John G. Steinle and Associates, it also represents a cooperative effort with the New York State Division of Housing. The excellent research staff of the latter organization contributed valuable assistance and technical knowledge of the housing field.

SCOPE AND PURPOSE

The scope and purpose of this study may be summarized as follows:

- To determine the feasibility of and requirements for a housing program that will meet home care needs of the aged

- To prepare an outline for an action program for housing in conjunction with home care services provided or to be provided in the community.

METHODS OF STUDY

In the course of this study

- Articles, reports, results of research projects and surveys were analyzed

- Officials of agencies, institutions and others in the field of providing home care and related hospital and welfare care were interviewed

- Attitudes of residents of selected housing projects were determined

- Special research was conducted on the need to relieve hospitals of patients not actually requiring hospital care but who must remain in hospitals because other resources are not available.

ACKNOWLEDGMENTS

In addition to the services of Mr. Gabriel Avallone, architect associate of the surveyor, specialized advice and assistance were provided by the following well-known architectural firms:

- Neutra and Alexander, Los Angeles, California
- Urbahn, Brayton and Burrows, New York City
- Pereira & Luckman, New York City

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The cooperation and assistance of officials of many hospitals and homes for the aged in New York City and, specifically, of the following agencies are gratefully acknowledged:

- Hospital Council of Greater New York
- Greater New York Hospital Association
- United Hospital Fund of New York
- Department of Hospitals of the City of New York
- Federation of Jewish Philanthropies
- Catholic Charities of the Archdiocese of New York

ORGANIZATION OF THIS REPORT

In addition to this introduction there are the following major divisions in this report:

- Total medical needs of the aged
- General housing problems of the aged in New York State
- Home care and the aged
- Conclusions and recommendations
- Summary report on location of hospital beds in urban renewal areas
- Bibliography.

II - THE TOTAL MEDICAL NEEDS OF THE AGED

In order to identify the role that home care can play in providing medical care to the aged the total problem is discussed in this part of the report. It is impossible to isolate the housing, economic, medical and social problems of the aged. Each aspect influences the others. Similarly, it is impossible to intelligently analyze one phase of the medical or housing problem of the aged without first identifying the place of the particular part in the total complex whole. In a word, this chapter of the report is concerned with establishing the setting for further and specific discussion of home care and its possible role in the care of the aged.

A - THE AGED AND CHRONIC DISEASE

Traditionally, medical care is planned and provided for all elements of the population according to "acute" or "chronic" needs.

Acute illness generally can be approached on the basis that a single type of facility, the acute general hospital, can meet most of the problems of those requiring institutional care. After hospitalization, the acute patient is returned home for a short period of convalescence following which he is able to resume his daily occupation and activities. For the chronically ill patient, on the other hand, it usually is necessary to retrain him completely and develop an entirely new orientation to his way of life. The achievement of this objective often involves the use of a wide array of community resources.

The problems of the aged are closely identified with the problems of the chronically ill. The incidence of chronic illness, as discussed later in more detail, is in direct proportion to the age of the population. Because of the time required by aged patients to make an effective recovery, conditions that in younger persons may be classified as acute must be considered chronic in the aged. Thus, the problem of providing medical care to the aged can be considered two-fold:

1. To provide early diagnosis and treatment to prevent a long term chronic disease.

2. To provide continued care for those with chronic disease.

AGE DISTRIBUTION FACTORS

The greatest part of the population, 89,000,000 persons, fall in the 20 to 64 age group, of which 18,000,000 have one or more chronic disease manifestations. Today, there are approximately 15,000,000 persons 65 years of age or older in the United States. This is approximately 8 percent of the population, but these

older people have more than 21 percent of the chronic illnesses - more than two and one half times their per capita share.

Serious as it is already, the problem of chronic disease is becoming even more so as a result of the changing age distribution of the population. Chronic disease problems rise sharply after the age of 50, when one third of the people report one or more such conditions. In 1900 only 13 percent of the population was over 50 years of age. Today the proportion is 22 percent. Thus, the current rate shows there will be nearly 30 million persons with chronic disease by 1980.

Hagerstown Study

One of the first chronic disease surveys on a controlled basis was made in Hagerstown, Maryland in 1923. Twenty years later there was a careful follow-up of these same families and individuals. In this way, a 20-year rate of incidence of chronic disease and major physical impairment was calculated from a population of 5,027 persons who were well in 1923 and dead or in a known state of health in 1943. From this study a five year rate of incidence of chronic disease and major impairment was estimated. In summarizing these estimates the following conclusions were made:

> "These estimates reveal that up to 25 years of age, the rate of occurrence of new cases during the five-year period increases slowly to 35 persons per thousand. A gradual increase then takes place to about 100 cases per thousand at age 45. From this age on, the five-year incidence increases rapidly to nearly 250 per thousand at age 60, 400 at 70 years, 575 at 80 years and 900 at 90 years. (1)

The following table shows the age distribution of persons who were well in 1923 and who by 1943 had died, had a chronic illness, or were still well.

(1) Lawrence, P.S., "An Estimate of the Incidence of Chronic Disease", Public Health Reports - 63: 69-83 (January 16, 1948. Washington, D. C. Government Printing Office, 1948).

SUMMARY OF HAGERSTOWN STUDY

Age	Dead In 1943					Ill In 1943				
	Well In 1923	Acute Disease Or Violence	Un-Known Cause	Chronic Disease	Total Dead	Known Chronic Disease	Chronic Illness Of Ill-Defined Or Unstated Cause	Major Permanent Impairment	Total Ill	Well In 1943
Under 5	670	23	0	1	24	30	26	4	60	586
5 - 9	663	19	3	10	32	32	26	4	62	569
10 - 14	570	8	3	17	28	31	22	1	54	488
15 - 19	474	11	5	18	34	35	20	6	61	379
20 - 24	402	12	2	11	25	37	13	3	53	324
25 - 29	406	19	5	31	55	29	26	3	58	293
30 - 34	381	18	2	32	52	38	25	7	71	258
35 - 39	318	7	13	48	68	33	28	2	63	187
40 - 44	303	16	4	55	75	49	21	4	74	154
45 - 49	256	5	5	73	83	40	16	4	60	113
50 - 54	188	12	9	87	108	22	14	1	37	43
55 - 59	138	4	7	79	90	14	5	1	20	28
60 - 64	108	3	4	78	85	3	5	1	9	14
65 - 69	77	4	2	63	69	1	4	0	5	3
70 - 74	51	3	2	44	49	0	1	0	1	1
75 Over	22	0	1	20	21	0	1	0	1	0
All Ages	5,027	164	67	667	898	394	254	41	689	3,440

Massachusetts Study

In 1929 and 1930, a comprehensive study was made of chronic diseases in the State of Massachusetts. The following table indicates the incidence of chronic disease in terms of the rate per thousand population by age distribution according to this study.

Rate Of Incidence Of Chronic Disease
According To The Massachusetts Study
1929-30

Age	Rate Per 1,000 Population
Under 20	18.5
20 - 39	60.0
40 - 44	171.9
45 - 49	214.2
50 - 54	251.0
55 - 59	310.3
60 - 64	374.6
65 - 69	437.3
70 - 74	562.7
75 - 79	661.7
80	707.5

Correlation With Age

Analysis of the Hagerstown Study and the Massachusetts Study indicate that both arrived at approximately the same results as to the high correlation of chronic disease to age.

Following is a table which is given for purposes of computing expected incidence of chronic disease by age. By grouping the total population of the community according to the nearest ages in column 1, and multiplying this figure by the corresponding multiple, the expected incidence of chronic disease by age can be obtained. When these are totaled, the result will be the expected number of persons with chronic diseases in the community. This formula is based on the foregoing material, and on the results of the various studies of the correlation between incidence of chronic disease and age.

Formula For Determining Incidence Of Chronic Disease
By Age Distribution Of The Community

Column 1	Column 2
Age	Multiple
7.5	0.02481
12.5	.02695
17.5	.02956
22.5	.03231
27.5	.03365
32.5	.04090
37.5	.05146
42.5	.06617
47.5	.08528
52.5	.17725
57.5	.18035
62.5	.21456
67.5	.27746
72.5	.35182
77.5	.43289
82.5	.52237
87.5	.62748
92.5	.78367
97.5	1.00000

ECONOMIC FACTORS

One of the most comprehensive studies of its kind was a survey made of ten localities covering all types of illnesses and accidents during a three-month interview period in 1933. Ailments were classified as disabling or non-disabling. These conditions were further divided into two groups; those which had an onset during the three-month interview period, and those which were contracted before this period. Conditions which had existed prior to the three-month period constituted a group which, more or less, can be classified as chronic in nature.

It was found that among persons interviewed in the three-month survey period, those who dropped from a moderate, comfortable economic status in 1929 to a poor status in 1932 had a disabling illness rate of 174 per thousand. This compared with the rate of 120 per thousand for persons who remained in good circumstances during the same period.

The rate for disabling diseases which had an onset prior to the three-month interview period was 53 per thousand for those who had dropped from a comfortable economic status in 1932. The rate was 30 per thousand for those persons who remained in fairly comfortable circumstances from 1929 to 1932.

Thus, the sickness rates were substantially higher among families who suffered a greater change in living standards. An added factor was that the higher illness incidence existed among children, as well as among adults. It was concluded that the income loss had a substantial part in causing these higher sickness rates. (2)

An illness survey was conducted in Hagerstown, Maryland in 1943 by the family study section of the Public Health Service. It dealt with white families that had been included in the comprehensive study during the three-year period between 1921 and 1924. (The study of 1923 to 1924 has been previously discussed.)

The families and persons surveyed in 1923 were classified into five socio-economic groups. Those families which had completed original records and which were traceable and unbroken in 1943 were restudied and reclassified into similar economic groupings. Analysis of the data revealed:

"1 - For families and for persons the prevalence of chronic diseases progressively increased from the 'well-to-do' to the very poor in 1923 and also in 1943.

"2 - Families which had a reduction in socio-economic status between 1923 and 1943 had an adjusted chronic disease rate in 1943 of 87.2 percent, almost twice as high as the rate for families with an 'improved' status.

"3 - Among families which were free of chronic illness in 1923, those which were in favorable socio-economic circumstances in 1923 and which remained in favorable circumstances, developed chronic disease at a rate which was only slightly lower than the computed expected rate. Families which were poor in 1923 and which remained poor developed chronic illness at a rate of slightly above the expected. For families the differences between observed and expected figures are without statistical significance. When individuals are used as the unit of observation, the trend is the same as for family unit, but the differences though small are probably outside the limits of chance variation. It is concluded that socio-economic status is a factor, but of slight importance in the chances of occurrence of chronic illness in this population.

(2) Parrott, G. St. John and Collins, S. C., "The Relation Of Sickness To Income And Income Change In Ten Survey Communities." Health and Depression Studies No. 1 - Public Health Reports 50: 595-622 (1935).

"4 - Chronic disease is a significant factor in causing reduced socio-economic status. Of the families in which there was no chronic illness in 1923 or in 1943, none had a reduction in status and 21.6 percent showed an improvement. Of those families which had no chronic illness in 1923, but which in 1943 reported illness or death from chronic disease, 9.2 percent 'improved'. Among families in which chronic illness existed in 1923 and in which there was reported chronic illness or death in 1943, there were 5.5 percent with 'reduced' status and 11.5 percent 'improved'. The same picture is presented when the material is studied for individuals but the difference between the percentages for the well population and for the chronically ill population are not as marked as in the case of families. This results from the fact that 2.4 percent of the well persons in this study had a reduction in status, but all these persons were members of families in which chronic illness occurred." (3)

REGIONAL FACTORS

There are a number of regional factors which influence the incidence of chronic disease.

"In an attempt to obtain the data that could be used as a basis for corrective programs population surveys have been made. The results of these studies are not strictly comparable because of differences in enumeration techniques, in definitions of terms and in the exclusion of specific categories such as mental illness and tuberculosis. It is possible, however, to draw general conclusions which may be useful in planning " (4)

Variations naturally will exist between states and even among communities within a single state in incidence of chronic disease. Geographic and regional factors enter the picture, as do such elements as industrial accidents and degrees of disability.

(3) Lawrence, P.S., "Chronic Illness in Socio-Economic Status." Public Health Reports, Volume 63, No. 47, Pages 1,507 to 1,521 (Nov. 19, 1948)

(4) Gerber, Jos. Hanford, M.D , "Planning For The Chronically Ill", unpublished manuscript, doctor dissertation, School of Medicine, Yale University, 1948, Pages 41 and 42.

Generally, as is indicated by the various case counts and chronic disease surveys, there is little regional variation in incidence of chronic disease except as it may be affected by the age composition of the population.

There are a number of socio-economic factors which affect the age distribution of the population of the United States. For example, the general pattern of the United States has been for urban families to move to suburban areas until after their children are reared; thereafter, the parents return to the city. This tends to make the suburban population younger and the urban population older.

The rural farm areas tend toward a higher birth rate, with the parents returning to urban centers when children are mature and able to take over the operations of the farm. This makes the rural farm population comparatively younger in composition. For example, according to the 1950 population, the median age for the urban population was 31.5, while for the rural (nonfarm), it was 27.7.

Also of importance is the migratory pattern of the United States which has been in a western and northern movement from the south after the individual reaches maturity. The following table shows the median age by regions.

Median Age - 1950 By Regions

Northeast	32.5
North Central	31.0
South	27.1
West	30.6

DISABILITY RESULTING FROM CHRONIC ILLNESS

In addition to the high incidence of chronic disease among the aged, the extent of disability inflicted is important.

The Yale chronic disease survey of New Haven (5) found 5.2 percent of

(5) Gerber, Joseph Hanford, M.D., "Planning For The Chronically Ill", unpublished manuscript, doctor dissertation, School of Medicine, Yale University, 1948.

those with chronic disease were bed or wheelchair cases. The Heiser Report (6) (a survey of indigents in Connecticut in 1944) indicated 7.9 percent. The following is a detailed comparison of the findings:

Percentage of Disability - Those With
Chronic Disease in New Haven County Connecticut

	Percent	
	Yale Study	Heiser Report
Bed or Wheelchair	5.2	7.9
Ambulant, Limited Activity	26.7	26.3
Ambulant	67.9	65.6

The Heiser survey found that 60 percent of the bedridden and 33 percent of the partially ambulant had been separated from their own homes and families, and had been cared for elsewhere. This is probably quite high because the Heiser Report was concerned only with welfare cases in Connecticut.

The New Haven study indicates 6.4 persons per thousand are either bedfast or confined to their home. This is substantially in accord with the Massachusetts survey, the Hagerstown Study and a study conducted in New York City.

An obvious question is raised as to the extent to which chronic disease affects the ambulant patient. In a survey of white families in the eastern health district of Baltimore, which ended in June 1939, a study of this question was made. (7) The following table shows the annual days of disability among persons with chronic disease and among those with no chronic disease in the eastern health district of Baltimore in 1939 and 1940.

(6) Heiser, Carl F., Research Director: "Need For A State Infirmary For The Care And Treatment Of Aged, Infirm And Chronically Ill Persons". Report to the 1945 General Assembly, Hartford, Connecticut. Page 19, Table VII; Page 22, Table X; and Page 73, Table XVI.

(7) Downes, Jean, "Chronic Disease Among Middle And Old Age Persons", Milbank Memorial Fund Quarterly, XIX; Pages 18 and 19, January 1941.

Population, Class And Sex	Annual Days Per Person Observed: Disabled Days	Bed Days	Hospital Days	Number Of Days: Disabled Days	Bed Days	Hospital Days	Number of Persons
Persons with Chronic Disease							
Males	30.4	13.8	6.2	2,611	1,186	535	86
Females	34.4	7.8	2.8	5,257	1,201	431	153
Persons with No Chronic Disease							
Males	3.4	1.3	0.7	2,412	949	479	704
Females	5.5	1.3	0.4	3,781	918	278	682

SUMMARY

There is a direct correlation between the incidence of chronic disease and the number of aged in the population. Chronic disease is a major contributing factor to the incidence of indigency. Chronic illness of the aged is the nation's number one health problem, and may well be the nation's number one social problem.

B - THE NEED FOR A TOTAL PROGRAM

In the higher age brackets there are large numbers of people who do not need continuous medical and nursing care and yet are unable to care adequately for themselves. Because community resources are insufficient, these people often occupy hospital beds.

The resources necessary for those unable to care for themselves may be classified as follows:

1. Those in need of a substantial amount of medical care.

2. Those who need continuing nursing care.

3. Those who can remain in their home with some housekeeping assistance.

4. Those who can be placed in foster homes.

5. Those who may live in community accommodations such as cottages, apartments or homes.

6. Those who need a substantial amount of custodial supervision. (This group usually includes senile dementia patients).

Adequate care of the sick aged is based on the integration of facilities and resources within the community. There must be full utilization of diagnostic, therapeutic and welfare resources within the community.

Undue emphasis on any one aspect of the total problem; prevention, research, medical care in the home, hospital and nursing home care, and convalescent care would be unwise, uneconomical and ineffectual. The total problem is a complex one of interrelated problems requiring simultaneous solution. (8)

Many authorities have given suggested approaches to the problem of comprehensive care. For example:

> "...Any medical approach to control of a disease problem has five aspects in the following order of importance as far as the public is concerned: Prevention, early diagnosis, cure, alleviation, and terminal care..." (9)

On the other hand, Boas believes that an understanding of the medical and social problems of the aged chronically ill is best gained by grouping them according to the medical care that they require. This is determined by the nature, progress, and degree of advancement of their illness, and the amount of incapacity that ensues. He separates cases into three classes: patients requiring medical care for diagnosis and treatment, patients requiring chiefly skilled nursing care, and patients requiring only custodial care. (10)

(8) American Hospital Association, American Public Welfare Association, American Public Health Association, American Medical Association, Joint Statement and Recommendations by "Planning For The Chronically Ill". Journal of the American Medical Association. 135: 347, October 11, 1947.

(9) See footnote (4).

(10) Boas, Ernest P., M.D., The Unseen Plague - Chronic Disease. New York, J. J. Augustin, Publisher, 1940, Page 24.

The publication "Medical Care In The Counties Of Maryland" distinguishes five categories: those capable of self-support, those disabled to the extent that they need boardinghouse care with occasional medical supervision, those sufficiently handicapped to require infirmary care with nursing attendance and regular medical supervision, those who are bedridden and require chronic hospital care, and those who require the type of medical care which can be given only in a general hospital. (11)

Doctor Goldmann lists the following as components of a comprehensive program:

1. General services designed to minimize the incidence and severity of chronic illness;

2. Special services designed to meet the needs of persons with chronic illnesses and permanent impairments, including

a. diagnostic clinic services;

b. chronic disease hospitals;

c. infirmaries in homes for the old as well as small home-like facilities with nursing services;

d. physician's services in the home, office, clinic, hospital and custodial institution;

e. dental services in the office, clinic, hospital and custodial institution;

f. home nursing and visiting housekeeping service;

g. medical social service in the clinic, hospital, custodial institution, and all administrative agencies concerned;

h. essential drugs and appliances;

i. occupational therapy and recreational services;

j. provisions for economic security of disabled persons.

(11) Maryland State Planning Commission, Committee on Medical Care. "Medical Care In The Counties Of Maryland". Baltimore, April, 1944. Page 71.

3. Intensive research on problems of chronic illness and the aging process, including socio-economic and psychological as well as clinical aspects.

4. Postgraduate professional education in the diagnosis and treatment and in the socio-economic and psychological aspects of chronic illness. (12)

PROGRAMS FOR EARLY DETECTION

The best prophylaxis for disabling diseases even in the aged is early detection and immediate treatment of acute illnesses. To accomplish this there must be emphasis on complete physical checkups at regular intervals. Screening examination programs, such as those focused on tuberculosis, cancer, diabetes mellitus and rheumatic heart disease are beginning to be correlated rather than segregated by disease categories. (13)

HOME CARE

Outpatient departments have an important place in prevention of chronic disease as instruments for early diagnosis and the implementation of rehabilitation. The outpatient department has long been a traditional adjunct to community service; however, it is restrictive in that the traditional outpatient department is a place to which the patient comes for diagnostic and treatment services. The great problem of the chronic patient is ambulation and a large percentage of the chronic patients require almost continuous bed care. In order to meet the needs of the semi-invalid, some method must be devised to bring the hospital to the patient.

Several hospitals on the Eastern Seaboard have established programs in which the patient maintains a continuing relationship with the hospital through home visits by the medical and nursing staff. The reports on the success of these programs have indicated potential economic savings as well as better patient response to treatment. By reducing the day stay in the hospital, the patient's confidence

(12) Goldmann, Franz; "Public Medical Care Principles and Problems". New York, Columbia University Press, 1945.

(13) "Mass Multiple Test Screening - A New Survey Technique". E. M. Holmes, Jr., M.D., Director; Paul W. Bowden, M.D , Assistant Director; and James H. Stone, Health Educator, Department of Public Health, Richmond, Virginia.

is more easily restored. He does not get an institutional attitude which builds up resistance to discharge. (14)

The experience of these hospitals has indicated that the care of certain patients in the home eliminates the need for costly capital investments, assures comfortable medical care at a fraction of the cost of inpatient care, and stimulates the patient to all important early ambulation. Finally, it eliminates the possibility of family-patient indifference which so often develops during a long period of inpatient care, making reorientation of both family and patient necessary after discharge.

It must be pointed out that probably only about one-fourth of the patients in the lower income levels have proper environment for an effective home care program; however, the importance of this environmental factor is greatly reduced in some situations by the utilization of "visiting nurse service" and an imaginative administration which is willing to install standard equipment in patients' homes. (15)

HOME NURSING AND HOUSEKEEPER SERVICE

The Works Progress Administration made a great contribution by showing what can be accomplished by housekeeping services. W.P.A. housekeeping care, as a service to invalid and semi-invalid persons in New York City, was begun in 1935. Assistance was given to approximately 6,000 families. A large number of the persons involved were physically incapacitated because of chronic conditions. A patient receiving assistance from the housekeeping organization was usually one who had no other source of care in the home, and if this assistance had not been available, the patient would have needed hospital or custodial bed care.

Invalidism at a specific time did not necessarily imply permanent housekeeping care. Care for two years or more was required in only 11 percent of the cases. This service was probably responsible in many instances for shortening the illness which made assistance necessary.

(14) Cherkasky, Martin, "Eighth Annual Report", Jan. 1956, Department of Home Care, Montefiore Hospital, New York City. (multilith).

(15) Bluestone, E.M., Introduction to "Medical Care - A Community Plan", The Survey, March 1949.

An analysis of the Works Progress Administration housekeeper service in New York City proved that this service was a definite economy to the community. It resulted in a reduction of 13.5 percent in the number of admissions to hospitals and a reduction of 34.9 percent in the length of hospital stay. (16)

> " The project demonstrated the value of housekeeping service for patients in the rehabilitation stages of chronic conditions and provided comfort for those in remedial stages. Moreover, for old people who were reluctant to leave their homes for institutional care, housekeeping service prevented or delayed the need for such institutional care. Especially in the case of elderly couples where an old and infirm spouse was no longer able to carry the double burden of household and personal care of the disabled partner, the housekeeping project solved the problem of keeping the couple together in their own home. In addition, this service relieved the shortage of hospital and institutional beds." (17)

The Henry Street Visiting Nurse Service (New York City) in a review of the case load for one day found that without housekeeper service 45 percent of the patients would have required additional care; of these 18 percent would have required extra nursing visits; 14 percent would have required institutional care; and in 13 percent of the cases shelter for small children would have been needed.

The Brooklyn Visiting Nurse Association found that at least 24 of the 41 patients receiving housekeeping service otherwise would have had to go to an institution, and nine would have required additional nursing visits.

Madison is headquarters for an extensive statewide home service project in Wisconsin. In 1956, 27 workers were employed to provide services for about 400 patients in their own homes. No limit was placed on length of service for any one case.

A chronic disease unit has been completed in a general hospital in Madison, Wisconsin, and has as one of its important functions the integration of the home

(16) Fraenkel, Marta, "Housekeeping Service for Chronic Patients; An Analysis Of a Service For The Chronically Sick And The Infirm Aged Operated By The Works Progress Administration " New York, Welfare Council of N.Y.C., 1942, Pages 30-31.

(17) Robeck, Anne H., "A Study Of The Developments In Progress For The Care Of The Aged (With Emphasis On New York State and New York City)", Albany, New York, New York State Department Of Welfare, May 1, 1943, Page 123.

nursing program with the services of the hospital. The plan calls for the inclusion of offices for visiting nurses and family social service agencies in the hospital. This acquaints the patient, while in the hospital, with the visiting nurse and social worker, and gives the patient a feeling of continuous identification with the hospital. It is believed that discharging patients with a nurse following him into the community will appreciably decrease the average day-stay in the hospital. Thus, the space released will more than reimburse the hospital for the cost incurred.

Extensive home care nursing programs have been recommended as the result of practically all recent chronic disease surveys as well as by the 1948 National Health Assembly which issued the following statement:

> "Well organized visiting nurse service can go far toward meeting the needs of those patients with chronic conditions who are not seriously incapacitated, and toward preventing a certain number of admissions to institutions. Encouragement should be given to the wide use of practical nurses and nurses' aides, working under the direction and supervision of graduate nurses and of visiting housekeepers. As ample experience has shown, well organized housekeeping service benefits the patient and his family, the health professions, and the community."

Approximately one third of the chronically ill can be cared for at home. For this a housekeeper's service is required and nursing service is essential.

It appears that the greatest needs for home nursing services are in the urban communities. The needs in the rural communities are more easily met by unorganized sources. The following recommendations, based upon a number of considered opinions but offered merely as a guide, are made for visiting nurse needs:

Cities of over 100,000 . . . . . .one nurse per 5,500 population

Cities with 50,000 to 100,000 . . . . . one nurse per 6,500 population

Cities with 20,000 to 50,000 . . . . . one nurse per 8,000 population

Cities with 5,000 to 20,000 . . . . . .one nurse per 9,000 population

The records of the W.P.A. experience show that approximately 50 percent more housekeepers than nurses are needed.

NURSING HOMES

Nursing homes, if properly supervised have an important place in the program for the aged sick. Many chronic invalids are happier in a nursing home than in a larger and more formal institution.

A number of county and municipal hospitals have established the equivalent of nursing homes to operate in conjunction with the general facilities. Usually such relationships include the exchange of medical and nursing personnel and continuous medical supervision by the general hospital. There are several instances of voluntary general hospitals providing similar relationships with nursing homes. This relationship usually exists where the nursing home and hospital are owned by religious organizations; however, there are some instances in which a general hospital has developed a relationship with a number of nursing homes.

It has been suggested that religious organizations now operating hospitals undertake the operation of nursing homes, too. (18)

The 1957 revision of the New York State Hospital Survey and Construction Plan (prepared according to the requirements of the Hill-Burton Program) provide for construction grants to municipal and voluntary nonprofit nursing homes only if there is a close working affiliation with a general hospital.

Under the general head of nursing homes should be included certain types of "county homes". Most of these county homes grew grew out of county "poor farms". Shortly after passage of the Social Security Act in 1935, many of the county homes for the indigent and aged were closed. In later years when pressure for housing became acute, some of them were reopened either as county homes extending custodial care or as boarding homes which were publicly owned but leased to private operators.

Both Illinois and Kansas have state-approved systems of county nursing homes open both to financially independent patients and to those on public assistance. Former empty almshouses have been converted into nursing homes. Where buildings were fundamentally good and could be repaired they have been equipped to meet medical and nursing needs of the patients.

(18) Griffin, John J., "Nursing Home Care." The Catholic Charities Review XXIX: 147. June 1945.

The recommendations for nursing homes made by the Joint Committee On Chronic Disease embody the general over-all principles for a good nursing home program:

> " Nursing homes, both private and public, should be brought under state licensure laws with minimum standards not only for physical equipment and sanitation but also for medical and nursing supervision and for certain special aspects as privacy, individual attention, recreation and occupational therapy, and cheerful, homelike surroundings." (19)

BOARDING HOMES AND COMMON SHELTERS

Boarding Homes

Boarding home care has been suggested by a number of authorities as one way to provide minimal care to the aged.

Boarding homes for the aged and chronically ill in New York City were studied in a cooperative project by members of the New York Department of Welfare. In general, it was found that welfare recipients who are cared for in boarding homes received satisfactory services. For example, it was necessary for the landladies to give assistance in dressing and bathing to 24 of the boarders, and to furnish guide service to 7 boarders who were partially or totally blind, services beyond those expected in a boarding arrangement. The landladies appeared to be willing to cooperate with the welfare department's program which provided for inspection of the homes used by recipients of public welfare. (20)

Boarding homes of this kind (called hostels) have been used quite extensively in Great Britain. Facilities of this kind provide a great deal of individual care and attention. (21)

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(19) American Public Health Association, American Medical Association, Joint Statement and Recommendations by "Planning For The Chronically Ill". Journal of the American Medical Association, 135: 347, October 11, 1947.

(20) Calperm, Marie and Roncoli, Fannie, "Boarding Homes for the Aged in New Public Welfare", 4:32-35, February, 1946.

(21) "The Chronic Sick" - A Summary of an Address given to the Parliamentary Medical Group by Lord Amulree, M.B., and Dr. E. L. Sturdee. British Medical Journal, April 20, 1946. Page 617.

In Cleveland, the Benjamin Rose Institute has supervised a boarding home program for its clients for many years, and has recently established its own boarding home, Belford House, as a model. The Cleveland program indicates that boarding home care can be provided at a lower rate than nursing home care and that it is a valuable resource in the rehabilitation of persons suffering from chronic illnesses.

The Department of Public Welfare of New Orleans and Orleans Parish found it desirable to set up a special administrative unit within the Public Assistance Division responsible for services and boarding homes. Experience there revealed that a special administrative unit is of value in controlling standards for boarding homes, directing publicity necessary to find homes and maintaining continuous relationships with matrons of homes. Boarding home care has been given special emphasis by this department during recent years. (22)

Cottages And Other Forms Of Common Shelters

European countries have had a great deal of experience in caring for the aged and semiambulant in cottage type facilities.

> "An example of accommodation of this type provided by a local authority is in the Crookston Homes belonging to Glasgow Public Assistance Committee. These homes consist of small cottages, some for married couples and others for single persons . . . The cottages are built in blocks containing either eight cottages for married couples or sixteen for single persons. Each cottage has a livingroom with a bedroom opening out of it, a small kitchen with an electric cooker and bathroom . . .
>
> "An example of cottage homes supplied by a voluntary association is the Bethany Homestead, Northampton. These homes were started in 1926 as a charitable venture by the Congregationalists and Baptists of Northampton . . . The Homestead consists of two-room cottages for healthy old couples." (23)

(22) New Orleans Department of Welfare, 1956 Annual Report.
(23) The Lancet, February 2, 1946.

The cottage plan is thoroughly discussed also in "Living In A Small Group - Hill Homes, Highgate." (24)

Sir Lancelot Keay, architect for the Liverpool Housing Committee, has drawn up extensive plans for combining cottage type facilities with large semidomicilliary facilities, with the medical and nursing staff of the semi-domicilliary institution available for the cottage residents. This facility would give the chronic semiambulant person the same supervision he would have in a custodial institution, at the same time ensuring him the comfort and independence of home life. (25)

The Tompkins Square Apartment House on the lower east side of Manhattan, New York City, is a community residence for elderly persons. This housing arrangement, which provides furnished apartments and gives special services at a moderate rental, is operated by the Community Service Society, a private welfare agency financed by endowments. Tenants are independent but have available special services such as a cafeteria.

REHABILITATION

Rehabilitation of the aged is a problem that has many parts. Twenty years ago there was little or no attempt made at rehabilitation of the aged. Today, it is recognized that many of the older individuals can profit greatly from physical medicine; others can learn new functions that permit an increased earning span; some may learn adjustments that permit continuation in their occupation at a reduced rate of physical demand. Many older persons must learn new recreational habits. All of these are parts of the total program of rehabilitation.

In the rehabilitation of patients there is a need for three distinct types of facilities. While these may be carried on in the same location, they have different functions. Doctor Howard A. Rusk has referred to these services as "work shops". It is believed that for psychological reasons this is excellent labeling and fits closely the concept that the patient's further recovery is almost completely identified with his own efforts. In

(24) "Living In A Small Group - Hill Homes, Highgate." The Lancet CCLLII.

(25) The Journal Of The Royal Institute of Public Health & Hygiene, 10:152, May 1947.

the work shop the patient has the opportunity to observe others who have progressed through his current condition to one of success on the journey toward rehabilitation. In the work shop the patient is encouraged by the accomplishments of others.

Dr. Rusk has described and distinguished these three types of work shop facilities as follows: (26)

1. The Therapeutic Work Shop

> "As the name implies, therapy is the objective of the therapy work shop. Such therapy may be in terms of functional occupational therapy to restore strength and range of motion, to teach the skills of every day living and working with a physical disability or to assist in the social and vocational reorientation of the patient following prolonged hospitalization and illness."

2. The Retraining Work Shop

> "The function of the retraining work shop is to teach skills either for general activities of daily living or working, or the specific skills leading to placement in a particular job."

3. The Sheltered Work Shop

> "The sheltered work shop . . . is a work shop for those persons whose physical limitations are so great that they cannot work in competitive industry even with the advantages of careful selective placement. Despite all efforts toward rehabilitation, there always have been and always will be a small group of persons in this category."

CONCLUSIONS

In order to provide effectively for the medical care needs of the aged a wide range of facilities and programs are essential. The services provided must range from those that supplement in only a limited degree the resources of the individual to those that provide complete care. Home care is only one of many resources that must be available in a community that is implementing a total program for the care of the aged, a large number of whom have disabling chronic diseases.

(26) Rusk, Howard A., in letter to J. Steinle.

III - HOUSING PROBLEMS OF THE AGED IN NEW YORK STATE

A major problem confronting New York State is the provision of adequate housing for a large number of the aged population at a cost they can afford to pay. Although this is part of the over-all problem of providing adequate housing for all elements of the population it has certain special aspects. The process of aging is accompanied by certain social, economic, and health characteristics which make the problems of the aged particularly difficult and complex.

SCOPE OF THIS CHAPTER

This chapter is concerned with

- General background on the housing needs of the aged
- Special housing projects for the aged
- Facility requirements for aged residents of New York State.

As the term is used in this chapter, the aged are those who are 65 years of age or older.

METHODS USED

The methods used in developing data for this chapter included:

- Analyses of pertinent reports
- Evaluation of existing programs for the care of the aged
- Original studies and analysis of census data
- Interviews with persons with special, expert knowledge of the housing needs of the aged
- Visits to operating housing developments that provide special facilities for the aged.

GENERAL BACKGROUND

The population of the United States is termed an aging population because the number and proportion of elderly persons have been growing rapidly and are expected to increase. On a national basis, the proportion of the total population increased from 4 percent in 1900 to 8 percent in 1950. In New York State the proportion of persons over 65 was below the national average from 1900 through 1920. This was due principally to the high immigration of younger persons. Since 1930 the proportion of persons over 65 in New York State has rapidly increased. In 1950 it exceeded the national average. Following is the growth by percentage of total population.

Percent Persons Over 65 - New York State

Year	Percent over 65
1920	4.5
1930	5.4
1940	6.4
1950	8.5
1957 (estimate)	9.4

It is estimated that there are now (1957) 1,543,000 persons in the State of New York who are over 65.

While nationally the ratio of those 65 years and older is greater in urban areas than in non-urban areas this is not true of New York. In New York, in 1950, 8.6 percent of the population was 65 or over. Only 8.1 percent of the urban area population were in this age group. This disparity is due to the proportionate high percent of nonwhite persons in the urban population. Only 3.7 percent of the nonwhite were 65 or over.

The number of persons in the older age group in urban areas is much higher than in non-urban areas since approximately 82 percent of the total population in New York State is in urban areas. The percentage of persons over 65 varies substantially among communities. For example, the percentage of the total population over 65 was 10.0 in Albany, 8.4 in Buffalo, 7.7 in New York City, 11.0 in Rochester and 9.5 in Syracuse.

Data on the housing arrangements of the aged are exceedingly lacking. The principle body of information on the housing for the aged is based on special sample tabulations of 1950 census data prepared by the Bureau of the Census under an agreement with the Division of Housing Research, Housing and Home Finance Agency. The sample was limited to the 5.6 million non-farm families and individuals who maintain their own quarters.

Household Status Of The Elderly

The effect of the aging process on the housing status of elderly persons is indicated by contrasting the household relationships of those over 65 with those in the age group, 45 - 64 years. (27)

- In that part of the population age 65 and over, only 68.9 percent live in their own households. This compares with 92.8 percent in the 45-64 age group. Of the total population age 65 and over
  - 43.9 percent live with spouse
  - 10.6 percent live with relatives other than spouse
  - 14.4 percent live alone or with non-relatives in households of which they are head.
- In the 65 and over age group, 25.4 percent live in households not their own. Of this group
  - 21.1 percent live with relatives
  - 4.3 percent live with non-relatives.
- Among those 65 and over, 3.1 percent live in institutions and 2.6 percent live in other quasi-households.

By 1975 the ratio of persons over age 65 will be 72 men per 100 women. Nearly one-fourth of the men and over half of the women are widowed. This difference may be attributed to

- Shorter life expectancy of men
- Husbands generally being older than wives
- Elderly widowers being more likely to remarry.

A higher proportion of the aged live in substandard dwellings. In 1950, 37.7 percent of persons over 65 in New York State lived in dwellings which were dilapidated or were without adequate plumbing facilities.

(27) From basic data presented in "Staff Report To The Subcommittee On Housing, Committee On Banking And Currency, United States Senate", 84th Congress, 2nd Session.

Income Status Of The Elderly

Generally, income declines sharply after the age of 65. A large number of persons over 65 have inadequate income with which to obtain minimal housing.

Analysis was made of Census Bureau data and reports of Old Age and Survivors Insurance; Department of Health, Education and Welfare; Social Welfare Department of New York State; United States Bureau of Labor Statistics; United States Veterans Administration; and the Labor Department of New York State. From these records the sources of income of those over 65 in New York State were computed. The following table summarizes the distribution of income by source.

Income Source By Percentage

Of New York State Residents Over 65.

Source	Percent
O.A.S.I. and other employment security (a)	60.6
Old Age Assistance (only) (b)	11.1
Old Age Assistance and O.A.S.I.	6.2
Old Age Assistance and other income	3.3
Employed	6.1
Private industrial or union pensions, Income from investments and insurance	6.4
No money income except from families	6.3

(a) Includes railroad retirement and government employees' retirement.
(b) Includes aid to the blind and aid to the totally disabled.

From the Housing and Home Finance Agency Division of Housing Research special sample tabulation of 1950 census data the following table was prepared:

Receipt of Money Income and Median Income, 1949 For Persons Aged 65 and Over, By Age, Sex, and Living Arrangements, 1950

Sex and Living Arrangements	Percentage with no money income			Median Income 1949		
	Total	65-74	75+	Total	65-74	75+
MEN	18	14	27	$1,150	$1,440	$770
In own household	14	12	20	1,290	1,540	810
Head of primary family (a)	14	12	21	1,420	1,640	850
Married, wife present	13	11	19	1,460	1,680	860
Other	22	17	29	1,000	1,290	800
Primary individual (b)	15	13	19	790	860	690
Not in own household	33	26	42	810	920	650
Living in home of relatives	38	32	46	770	870	630
Parent of head	42	34	48	730	870	630
Other	30	39	39	850	870	640
Living with nonrelatives	29	17	28	890	1,000	700
WOMEN (c)	42	39	47	680	720	620
In own household	31	29	33	720	750	660
Head of primary family (a)	41	40	42	720	740	680
Primary Individual	23	22	26	720	750	660
Not in own household	54	51	58	640	680	580
Living in home of relatives	58	56	61	610	630	570
Parent of head	62	60	63	570	590	560
Other	49	47	53	680	730	600
Living with nonrelatives	33	29	39	750	810	640

(a) One or more related persons present

(b) Living alone or with nonrelatives present

(c) Excludes married women living with husband

Ability To Purchase Adequate Housing

The Bureau of Labor Statistics periodically develops a "modest but adequate" budget for families of various sizes living in different urban areas. By deducting from this budget allowances for meals away from home, insurance, alcoholic beverages, snacks, occupational expenses, Federal and State income taxes and medical expenses, a bare minimal budget results.

In 1950, the latest census, the minimum budget for single persons was $1,603 for Buffalo and $1,587 for New York City. For two persons, the minimum budget was $2,265 for Buffalo and $2,242 for New York City. Applying the lower budget figure (New York City) to the entire state; there were, in 1950, 328,000 single persons over age 65 and 182,000 married couples of whom one or more was over 65, with total incomes from all sources below the minimum budget.

In 1950 there were 1,258,457 persons in New York State over 65. Of this number 82.3 percent were in urban areas, 13.2 in rural nonfarm areas, and 4.5 percent in rural farm areas. Of those below 65 with income below a minimum budget all but 7.6 percent of the single persons and 12.6 percent of couples were in urban areas.

Health Factors

Commenting on the national problem of health and housing of the aged the United States Senate staff report to the subcommittee on housing (28) stated:

> "Long-term illness and infirmity are closely associated with age, and help to determine the kind of housing one needs. Well before age 65, there is usually a decline in energy reserve and a need to slow down. In general, most people in their sixties and seventies will look for living arrangements that are not overly taxing to their strength. Others will be definitely handicapped and may need special facilities and services. Just under 1,500,000 persons 45 to 64 years of age who are not in institutions and 1,750,000 who are 65 or more years of age, report long-term disabling illness. This does not mean that they are all helpless invalids, although some are. What it does mean is that these people are unable, over an extended period of time, to work or perform their normal household duties.

(28) "Housing For The Aged", staff report to Subcommittee on Housing, Committee on Banking and Currency, United States Senate, May 21, 1956.

> Many of these 3,250,000 aging and aged persons require a good deal of care from their families or others, and some of them are, or will be, candidates for expensive care in institutions unless appropriate living arrangements are made for them."

Analyses of data of 25 hospitals, of various sizes and locations in New York State indicates that persons over 65 average 2.58 hospital days per person, each year. This is more than twice the hospital utilization by the total population.

A detailed study was made of the immediate and continued care required by patients over 65 in six New York hospitals on a specific day. Three of these hospitals were municipal and three were voluntary, nonprofit hospitals. In these hospitals a comprehensive evaluation was made of each patient hospitalized on May 6, 1957. There were 699 patients over 65.

The physicians determined whether each patient could currently be cared for at home under certain conditions or in another type of institution instead of the hospital. The institutional requirements of the patients after discharge also were estimated by the medical staff. The latter determination was based on the type of program, in or out of an institution that would best fit the patients' needs and would accelerate the patients' discharge from the hospital.

It was found that 145 of these patients, or one out of five, were currently ready for discharge but were being kept in the hospital because of lack of facilities to provide the combined shelter and care they required. It should be noted that a similar proportion of the others not yet ready for discharge will probably have to be kept in the hospital after they are ready for discharge because of inadequacy of living facilities or resources to provide minimal care. Only 28 percent of the patients over 65 were considered to have adequate housing even if home care were provided after discharge, and 22.3 percent require home care in a hostel or in adequate housing.

The following table summarizes the results of this special study conducted by the surveyors.

FACILITY REQUIREMENTS OF

PERSONS OVER 65 IN SIX GENERAL HOSPITALS

As Of May 6, 1957

TYPE OF FACILITY	Could Be Discharged Immediately to	Can Be Discharged Later To	TOTAL FACILITY NEED Number	Percent
Infirmary	68	50	118	16.9
Nursing Home	52	33	85	12.2
Supervised Boarding Home	6	8	14	2.0
Cottage	5	7	12	1.7
Hostel without home care (a)	8	27	35	5.0
Hostel with home care	-	23	23	3.3
Adequate household without home care	2	142	144	20.6
Adequate household with home care	3	69	72	10.3
Present household	-	136	136	19.4
Present household with home care	1	59	60	8.6
TOTALS	145	554	699	100.0

(a) The term hostel, as used here, refers to a hotel designed specifically for the aged.

The above study does not define the housing needs of the aged but it does identify the close relationship of the housing and hospital needs of the aged. It is obvious that many aged persons must be hospitalized because of the lack of adequate housing. The term "adequate" must include consideration of the following factors:

- Health resources such as home care

- Special services such as housekeeping and shopping services

- Housing features such as special equipment and ease of ingress and egress.

HOUSING FACILITIES FOR THE AGED

In order to identify housing features necessary to provide adequate facilities for the aged a study was made of programs either designed specifically for the aged or with special units for the aged. Examples of living facilities for the aged are listed in Exhibit III-1 following this page.

Many local and state housing authorities have recognized the need to provide special housing for the aged. Most of these authorities have been greatly concerned over the problem of whether the aged should be segregated from other families or placed in special units of regular housing projects.

Housing facilities that are provided for the aged may be classified as follows:

- Regular apartments coincidentally occupied by the aged

- Efficiency apartments for single persons, primarily identified for the aged

- Specially equipped and designed apartments for the aged.

In New York City, out of a total of 450 single person apartments, 331 have been set aside for the aged. Out of 1,680 two room apartments, 425 have been occupied by the aged. Daily, more apartments are being occupied by the aged and specially designed apartments are being planned. New York City provides apartments for the aged, in regular projects rather than segregating the aged in special projects.

Chicago and Cleveland have provided special projects for the aged. (See Exhibit III-1). Officials of the housing authorities in both of these communities stated that segregated projects simplified fund raising for and financing of supplemental programs such as occupational therapy and recreation. It also made it easier to provide and maintain special services. For example, in Cleveland, the board of Education provides special classes in the Cedar Apartments project.

NEW YORK STATE DIVISION OF HOUSING

EXAMPLES OF FACILITIES FOR THE AGED

CEDAR APARTMENTS EXTENSION
Cleveland, Ohio

Type Of Facility:	Elevator building
Ownership:	Public Housing
Eligibility:	104 units for the aged 48 units for couples with children
Financing:	Public Housing and private charities
Distribution Of Units:	One bedroom, convertible so that two older persons may live together each with private living room and bedroom and shared kitchen
Charges:	$41 - $49 per month
Special Services:	Lounge, living room, craft and hobby shops, excellent cafeteria, Golden Age Center (a separate agency), and educational classes.

EXAMPLES OF FACILITIES FOR THE AGED

COBBS HILL VILLAGE
Rochester, New York

Type Of Facility:	Converted emergency housing, one-story
Ownership:	Nonprofit organization
Eligibility:	Persons over 65 with income less than $65 per week
Financing:	Emergency housing
Distribution Of Units:	21 - one bedroom units 5 - two bedroom units 1 - studio
Charges:	$52.00 per month
Special Services:	A limited recreation program, nurse from health department.

EXAMPLES OF FACILITIES FOR THE AGED

FLORIDA LUTHERAN RETIREMENT CENTER
De Land, Florida

Type Ot Facility:	Motel type cottages
Ownership:	Cooperative
Eligibility:	Retired Lutherans have preference
Financing:	Lutheran Social Service
Distribution Of Units:	Cottages for 2 and 4 persons
Charges:	$110 per month, single $210 per month, couple
Special Services:	Central dining room and living room. Limited recreational facilities.

EXAMPLES OF FACILITIES FOR THE AGED

HOME FOR THE AGED AND INFIRM
New York, N.Y.

Type Of Facility:	2 groups of apartment buildings and 6 interconnected buildings
Ownership:	Nonprofit organization
Eligibility:	Older persons
Financing:	Jewish Federation and other gifts
Distribution Of Units:	(a)
Charges:	(a)
Special Services:	Dining rooms, recreation program, complete social facilities and infirmary with complete hospital care available.

(a) Data not available at present time.

EXAMPLES OF FACILITIES FOR THE AGED

IDA B. CULVER HOUSE
Seattle, Washington

Type Of Facility:	Elevator building
Ownership:	Cooperative
Eligibility:	Retired teachers
Financing:	Bequest and private
Distribution Of Units:	All single rooms, half with bath
Charges:	$3,000 - $3,750 and maintenance
Special Services:	Facilities for overnight guests. Dining facilities, laundries, and limited recreational facilities.

EXAMPLES OF FACILITIES FOR THE AGED

MARY MANNING WALSH
New York, N.Y.

Type Of Facility:	A large converted hospital
Ownership:	Nonprofit organization
Eligibility:	Older persons (about 80% on Old Age Assistance)
Financing:	Catholic Charities
Distribution Of Units:	
Charges:	
Special Services:	Dining rooms, complete social facilities, special club rooms, fairly complete medical facilities.

EXAMPLES OF FACILITIES FOR THE AGED

MOOSEHAVEN
Orange Park, Florida

Type Of Facility:	Model community, residences, dairy farm, hospital and convalescent unit
Ownership:	Nonprofit organization
Eligibility:	Elderly members of Loyal Order Of Moose
Financing:	Loyal Order Of Moose
Distribution Of Units:	Large residence for 12 to 58 persons
Charges:	Based on ability to pay
Special Services:	Dining, recreation and occupational facilities. Complete diagnostic and medical treatment service. Monthly newspaper and gerontological lab.

EXAMPLES OF FACILITIES FOR THE AGED

OMAHA EDUCATION ASSOCIATION
Omaha, Nebraska

Type Of Facility:	Elevator building, (another building planned)
Ownership:	Cooperative
Eligibility:	Retired teachers
Financing:	Sec. 213, National Housing Act 1949
Distribution Of Units:	50% - 1 bedroom units 25% - 2 bedroom units 25% - efficiency units
Charges:	$120 per month including board
Special Services:	Lounge, craft shop and laundry. Dining room facilities. Recreational and cultural program.

EXAMPLES OF FACILITIES FOR THE AGED

PILGRIM PLACE
Claremont, California

Type Of Facility:	Residence halls with small apartments and small homes, infirmary and nursing home.
Ownership:	Nonprofit ministers personnel
Eligibility:	Retired missionary and other church
Financing:	Contributions and private loans
Distribution Of Units:	Half in residences 25% in nursing home and infirmary 25% in homes
Charges:	$55 - $85 per month
Special Services:	Dining and recreation facilities, complete medical facilities.

EXAMPLES OF FACILITIES FOR THE AGED

PRAIRIE COURTS
Chicago, Illinois

Type Of Facility:	Elevator building, 75% of units for aged, 25% for young families
Ownership:	Public Housing
Eligibility:	75% of units for aged persons
Financing:	Public Housing Authority
Distribution Of Units:	36 - one bedroom units
Charges:	$40 - $45 per month
Special Services:	Limited recreation

EXAMPLES OF FACILITIES FOR THE AGED

SENIOR CENTER
Santa Barbara, California

Type Of Facility:	14 cottages adjacent to a senior center
Ownership:	Nonprofit organization
Eligibility:	Over age 70 in good health
Financing:	Individuals, Foundations
Distribution Of Units:	Each unit 2 rooms, kitchen, bath and porch
Charges:	$40 per month
Special Services:	Central recreation room, laundry, hostess and volunteer who provide transportation services.

EXAMPLES OF FACILITIES FOR THE AGED

TOMPKINS SQUARE
New York, N.Y.

Type Of Facility:	Elevator building
Ownership:	Nonprofit organization
Eligibility:	Aged persons
Financing:	Voluntary funds and a bequest
Distribution Of Units:	44 single rooms 8 - 2-bedroom apartments
Charges:	$30 - $40 single unit $60 for 2 room suite
Special Services:	Cafeteria, living room, roof garden, laundry, cleaning service

EXAMPLES OF FACILITIES FOR THE AGED

WASHINGTON RETIREMENT
Washington, Iowa

Type Of Facility:	Central buildings with radial wings
Ownership:	Cooperative
Eligibility:	Retired persons
Financing:	Gifts and trust
Distribution Of Units:	1 and 2 rooms
Charges:	$100 per month including board
Special Services:	Central living rooms, dining room, limited recreational facilities.

Following are public housing programs in other representative cities:

Memphis, Tennessee

The Memphis Housing Authority has set aside for aged persons part of its new low-rent project, Dr. H. P. Hurst Village. Four 3-story walk-up buildings contain units especially designed for occupancy by aged persons. Stair climbing has been eliminated by ramps with an 18-degree grade. These ramps run from galleries on each floor down to the ground level. Open galleries along each floor provide an opportunity for outdoor living without the necessity for climbing stairs.

Providence, Rhode Island

The Providence Housing Authority set aside 64 apartments for older couples in the Admiral Terrace project. In the New Hartford Park project, one 10-story building made up entirely of 1-bedroom units is reserved for older persons without children.

Syracuse, New York

The Syracuse Housing Authority set aside two 7-story buildings in James Geddes Homes for exclusive occupancy by aged couples. These buildings have automatic elevators and a central recreation room.

St. Louis, Missouri

The St. Louis Housing Authority has plans calling for Federal aid in order to build a low-rent public-housing project designed especially for aged persons. The Authority's plan calls for two 13-story buildings with 750 apartments. Most of the units would be small, but there would be some 2 and 3 bedroom units for elderly persons living with married sons or daughters.

Other cities have made similar provisions, and many others have projected plans.

Attitude Toward Separate And Combined Facilities

In order to evaluate whether aged persons preferred being in separate housing projects for the aged or preferred being in combined projects that provide apartments for both the aged and other family units, 300 aged persons

living in housing projects were interviewed. (29) Interviews were held with 250 persons located in New York City and 50 of those interviewed were in Cedar Apartments Extension in Cleveland, Ohio, (a housing project specially for the aged). The sample included 25 persons from each of the three following projects: Tompkins Square, Mary Manning Walsh Home, and apartments in the Home for Aged and Infirm. Each of these are separate facilities for the aged in New York City. The remaining 175 New York City interviews were in New York City housing projects that combined the aged and regular family units. From the questionnaire used and from observation, the health and the ability of the interviewee to ambulate was evaluated. The following table summarizes the results of this study.

Attitude Of Aged Regarding
Combined Or Separate Housing

		Prefer Housing That Is:	
Now living in separate housing		Separate	Combined
Health and ambulation	Good	26	20
	Fair	24	16
	Poor	27	12
Sub Total		77	48
Now living in combined housing			
Health and ambulation	Good	23	83
	Fair	18	20
	Poor	20	11
Sub Total		61	114
TOTAL		138	162

It should be emphasized that the above table represents a limited sample. However, there appear to be indications that the attitude of the aged toward combined or separate facilities is closely related to their health and ability to ambulate. Among those whose health and ambulation was poor, 67 percent preferred separate facilities for the aged. Seventy percent of those whose health and ambulation was good preferred living accommodations in projects that included other than the aged. It also should be noted that 64 percent of the total persons interviewed preferred their present accommodations.

(29) Interviews were conducted by Adelphi College students.

Closely related to the attitude of the aged in the matter of their preferences in accommodations is the influence exerted by social agencies. One study that clearly illustrates this fact was a 1952 survey study of 552 people being helped by chicago's major family agencies both public and private. (30) The study showed that the public family agencies (i.e. Welfare Department, etc.) tended to try to place older people in their own apartments or rooms or with relatives while the private agencies tended to look for congregate or sheltered care arrangements. It is true that some of the aged placed in their private quarters found living alone too "expensive, too strenuous or too lonely", and in some cases, those who found homes with relatives thought them too "noisy, unpleasant or culturally uncongenial", but in the majority of cases this kind of living found good acceptance. Preference was for smaller, less formal housing usually in one's own neighborhood. More privacy, more individual attention and affection from family members, inability to adjust to institutional living and the independence associated with living in one's own home were the reasons most frequently given for preferring their own homes to congregate living arrangements. Often it was necessary to place a client in an institution simply because:

- Proper housing facilities could not be obtained

- There was a lack of housekeeping arrangements

- When housing could be found there was insufficient privacy.

The survey found that although most old people prefer living in their own homes that this was, to a large extent, impossible since the agencies (Welfare Department, Salvation Army, United Charities, Jewish Family and Community Service, Catholic Charities Bureau) did not make arrangements to bring their services into their client's homes.

> "For none of the persons living alone had the agencies, either public or private, been able to provide continuing help in their homes . . . no indication whether the help was occasional or regular. Services which would enable the old person to maintain his independence in reasonable safety and comfort are lacking."

About one fifth of all the home care families included in the Hospital Council of Greater New York study (31) were elderly patients living with and supported by

(30) Welfare Council of Metropolitan Chicago, Community project for the aged, "Community Services for Older People, The Chicago Plan", 1952.

(31) Hospital Council of Greater New York; "Organized Home Medical Care In New York City." Harvard University Press, 1956.

younger people, usually their own children. There are definite advantages to this arrangement. Financial support, care and companionship are provided to the elderly patient. However, there are indications that this type of situation is both forced on the patient and on the patient's adult children, and both parties would often prefer to live independently of one another. There is much evidence to the effect that the adult children often prefer their parents or in-laws to live elsewhere if possible. As stated by one authority:

> "When should parents leave home? The damage done to the middle generation by the protracted residence of a senile, infirm, truly useless person in the midst of the family is great. The younger generation is hog-tied and feels cramped. They cannot have friends in. They cannot go out. The psychological damage is immense. One sees it all the time." (32)

That many oldsters prefer to be away from their adult children is even more evident. Social workers, medical men and surveys all seem to maintain this view. For instance, M. Linden, M.D., says in Social Casework: (33)

> "A recent poll of older people revealed that a great preponderence of them also prefer not to live with their children. This feeling is not necessarily due to lack of affection, but is based upon universal preference for independence in our society."

Another authority stated:

> "It may be assumed that within the census group of 24 percent living with children or close relatives, many aged would have preferred independent homes if available."

(32) Stieglitz, E., "Relation of Gerontology to Clinical Medicine", Problem of Aging 12th Conference, Feb. 6th and 7th, 1950.

(33) Kraus, Hertha, "Older People Have Special Housing Needs", New York State Joint Legislative Committee on Problems of Aging, 1950.

In a staff report of the United States Senate entitled "Housing For The Aged", it was maintained,

> "Many aging persons, their children and their grandchildren, prefer to live together. The preservation of this type of family living is commendable. But most of the elderly prefer their own quarters because of a sense of security and independence."

It is generally accepted that under ordinary conditions older persons prefer to live in mixed environments. The acceptance of this concept has been somewhat influenced by disastrous experiments in communal segregation of the aged in Europe. On the other hand, there are highly successful experiments of aged living in special facilities or in their own colonies. Perhaps the most important thing in considering attitudes towards segregated aged projects and projects that include all age elements is the desire of the individual. As cogently stated by a well known architect:

> "Some of the problems may be solved without legislation, or even by the threat of it, but public action is inevitable. Some has already started. But when it comes, we pray it will not force us into ghettos of private or public old age homes, nor prevent us from living with our peers if we want to. May every legislator, administrator, designer, and manager remember: Elderly people are people." (34)

Special Construction Considerations

Analysis of projects, both public and private, indicate that in most housing for the aged special physical facilities are provided. The most common of these are:

- Orientation to provide sunshine, ventilation and a pleasant view. Housing for the aged is generally located in a quiet area, usually with a generous set back from the street.

- Units at ground level, avoiding steps where possible.

- Building materials selected to reduce fire hazards and sprinkler systems and alarm systems more generously provided than in other types of housing units.

(34) Robert E. Alexander, "Designing The Right House For Aunt Lizzie", The Housing Yearbook., 1956.

- Increased lighting but often with glare controlled. Large window surfaces which may cause glare and be a danger are usually avoided.

- Guard rails provided near windows and other danger areas.

- Crank operation to simplify the opening and closing of windows.

- Walls made impervious to sound to avoid annoyance of elderly residents by others.

- Electric stoves to avoid the possibility of asphyxiation and self-defrosting refrigerators in the kitchen.

- Kitchen floor space reduced to a minimum with shelves and cabinets low and recessed to avoid bumping.

- Floors smooth but not slippery and an absence of thresholds and interior steps. If steps are necessary, they are generally of a low, consistent riser. Some authorities strongly recommend low riser steps instead of ramps.

- Hand rails placed in public areas and conveniently located grab rails in bathrooms.

- Wide doors and corridors with mechanical devices to simplify the opening and closing of doors in public areas.

- Elevator closing mechanisms which are slow and equipped so that doors reopen on a "feather touch". Elevators are usually selected on the basis of a slow, smooth speed and quiet operation.

Community Services

Most authorities agree that in order to have effective housing for the aged a number of community services must be made available which ordinarily are not included in housing projects. The physical and psychological conditions of the aged often change almost imperceptibly and in a relatively short period of time. This requires an aware supervision and, ideally, facilities that can provide medical and nursing care during the periods when the residents are not entirely able to care for themselves. Such facilities are not uncommon in private developments (See Exhibit III-I) but seldom exist in public housing in the United States. Public housing in foreign countries are reported to provide special

services. For example, the larger projects in Sweden have resident nurses and the newer projects are providing central cafeterias. Whiteley Village in England includes in its facilities a rest home and a hospital.

Following is a list of services that are provided in some projects either public or private, in the United States or abroad:

1. Housekeeping service. This service is often required either to do all housekeeping for an aged resident or to supplement in such activities as window washing.

2. Dining service. This includes either a central cafeteria or decentralized small lunch rooms.

3. Shopping service. For those unable to go to stores this service is important and may keep a resident from being institutionalized.

4. Laundry facilities. Such facilities are useless to the aged if they are located centrally, often a distance from the resident. Ideally, a small laundry unit should be provided on each floor.

5. Instructional service. Often the culture, experience and background of the new resident is such that she needs assistance in learning how to use electric stoves, automatic laundry equipment and other appliances. An orientation visitor who spends several days with an aged new resident may be the difference between a happy tenant who will live successfully in a project and one who will be discontented and frustrated and finally must be placed in an institution.

6. Transportation service. This service is generally voluntary. It provides transportation by care to clinics, hospitals, for shopping trips and for a myriad of other purposes.

7. A visiting nurse service. Often the aged have health problems that require attention but because of timidness, false fears and uncertainty, the aged do not search out the health resources of the community. The visiting nurse can help with this problem. Other residents require medications that can be given by the nurse rather than requiring the resident to go to a doctor's office or to a clinic.

8. Occupational and recreational programs. Such programs include games, crafts, motion pictures, adult education, publication of newspaper, operation of a hospitality and gift shop and other activities.

9. Health programs. Some projects have emergency first aid rooms, others have small infirmaries or even hospitals. In Europe, it is not uncommon to have a physician located in the project. Health and medical facilities have not been generally provided in public housing in the United States.

FACILITY REQUIREMENTS FOR THE AGED IN NEW YORK STATE

The previous sections of this chapter provided general background information on the total housing problems of the aged. The previous chapter presented data and information on the health needs of the aged. In order to estimate the housing needs of the aged in New York State, consideration must be given to

- The age distribution of the population
- The economy of the aged
- Housing of the aged
- The medical needs of the aged.

Population Factors

Based on the estimated 1957 population, there are approximately 1,543,000 persons over 65 in New York State. As discussed in an earlier section of this chapter, in 1950 there were 328,000 single persons and 182,000 couples over 65 with incomes less than adequate to meet a minimum budget. Projecting these figures to the estimated 1957 population over 65, there would be 402,000 single persons and 223,000 couples over 65 with less than adequate income for a minimum budget.

Of the 402,000 single persons, 44,000 live in some type of institution (35) and 124,000 live with relatives. Thus, there are approximately 234,000 single persons over 65 who presumably do not have resources to pay for adequate housing.

Of the 223,000 couples over 65 with less than adequate income for a minimum budget 2,000 are in institutions and 44,000 live with relatives, leaving 177,000 with insufficient income to pay for adequate housing. The total number of persons in these two groups, single and couple is 588,000. This represents 38.1 percent of the total population over 65. This percentage closely approximates that of the aged who, in 1950 lived in dilapidated dwellings or without adequate plumbing facilities - - 37.7 percent.

(35) Projection of statistics based on Bureau of Census, special sample tabulation of 1950 census data.

Special Facilities For The Aged

In the previous chapter it was pointed out that between 5.2 and 7.9 percent of the aged are bed or wheelchair cases; approximately 26 percent are ambulant with limited activity and from 65 to 68 percent are ambulant. It therefore, may be concluded that the ambulant group can ordinarily be provided for in combined projects. This group generally will not require extensive special community resources. On the opposite end of the scale, the wheelchair and bed-ridden patients will require supervision and care that ordinarily will not be available in a housing project regardless of the supplemental services available. (36) In considering the need for special housing facilities for the aged, those for whom plans must be made, are the 26 percent who are neither bed-ridden nor totally ambulatory. Applying this 26 percent to the estimated 234,000 single persons and 177,000 couples over 65 who do not have sufficient resources to obtain adequate housing, the following estimate of need for housing units with special community resources for supplemental and medical care results:

- 60,840 single units

- 46,000 double units.

(36) The next chapter identifies problems inherent in the care of persons requiring extensive nursing care and supervision.

IV - HOME CARE AND THE AGED

The previous chapter discussed the general housing problems of the aged. It was estimated that approximately 60,840 single persons and 46,000 couples over the age of 65 are unable to pay for adequate housing, and also are in need of supplemental services not generally provided in housing projects. These individuals are not confined to wheel chairs or beds.

The problem of providing adequate facilities for these persons is not simply the problem of providing adequate shelter. It also involves providing supplemental services that permit these persons to live adequately in their own household.

There is one indispensable service that may well be the key to enabling these persons to live adjusted lives in their own households instead of being institutionalized. This service is medical care. Since one of the primary factors used to estimate the number of persons requiring supplemental services was inability to meet a minimum living budget, presumably all of the persons in this group are unable to pay for their medical care.

One of the methods suggested as feasible to provide medical care to the aged in housing projects is "home care". This chapter is concerned with the problem of the aged and home care, and presents the results of a comprehensive, special study of this subject.

In the course of this study, the literature in the field was surveyed and a bibliography of the current literature prepared. Evaluation was made of existing home care programs, and data and reports on these programs were analyzed. Organizations and institutions providing home care were observed. Administrators, physicians and others concerned with providing home care were interviewed.

GENERAL BACKGROUND

Almost everyone agrees that, basically, the home care idea is a good one. Scarcely anyone finds fault with a program which permits qualified indigent patients with chronic or certain types of acute ailments to live in their own homes and be treated from a central point; a hospital, local health department, or voluntary health agency. For many patients, basic needs such as nursing care, physical and occupational therapy, application of medications, and social services can be made available in the patient's own home. Home care is a highly advantageous form of treatment both from the standpoint of the patient and from the standpoint of the general hospital. The advantages a home care program offers may be summarized under the following three headings.

1. Psychological

Many older persons fear the hospital ward. For them, it is a strange and forbidding environment. As persons become older they feel less and less secure in strange places. The hospital ward, even at its best, is impersonal. It cannot provide the assurance of a familiar, secure environment. Living at home rather than in an institution often fulfills a need for privacy, quiet and independence.

2. Financial

It obviously is more economical to provide supplemental services to persons in their homes than to maintain them in a hospital or other type of institution. However, many authorities believe that home care should not be advocated on a financial basis. For example, one authority states:

> "....home care should receive consideration, not as a substitute for any other facility, not as an economy measure (because medical care costs money), but for what it is . . . a worthwhile additional resource in total medical care which can be utilized effectively by some patients." (38)

3. Educational

It has been reported that "home care offers challenging opportunities for developing medical teamwork relationships and opportunities for teaching students." (39) Definite success has been reported by New York Hospital - Cornell Medical Center, Montefiore Hospital, and the Richmond Academy of Medicine in Richmond, Virginic in using students supervised by qualified physicians in a home care program. The advantages are that the student is given a chance to assume responsibility, to see the patient for the first time in a home environment, and to observe the prosaic in medicine.

(38) Shindell, Sidney M., "Preliminary Report On The Gallinger Home Care Study", American Journal of Public Health, Vol. 43, May 1953.

(39) Rosenfeld, E. D., Eger, Saul; Axelrod, Joseph; Margolin, Eleanor, "Hospital Care Goes Home", GERIATRICS 6; March-April, 1951.

Age Composition of Home Care Patients

With the exception of the Boston Dispensary Domicilliary Medical Service and the Massachusetts Memorial Hospital's Home Medical Service which provide care for many acutely ill and obstetric cases, almost every home medical care plan is organized to treat patients afflicted with chronic ailments. Roughly half of all patients treated are 65 years of age or over.

In 19 hospital programs studied by the Hospital Council of Greater New York 49 percent of the home care patients were 65 years old or over. Percentages available from records of other programs were

- Kings' County Hospital Extension Service, 66 percent

- Philadelphia Intensive Home Care Plan, 47 percent

- Queens General Hospital Home Care Program, 49 percent

Other plans noted kept no percentage figures but treated predominantly patients over 65 years old.

From all present indications, home care programs in the future will tend to be dominated more and more by people over 65 years of age.

HOUSING FACTORS

In a great number of cases, housing is totally or largely inadequate for a well run home care program. It must be remembered that these programs deal wholly with indigent patients over 50 percent of whom make less than $2,000 a year. (Older patients average even less). Housing which is suitable for home care patients is greatly lacking for people with incomes of this size. Dwellings which have been thought to have the proper toilet facilities, ventilation and light often are grossly inadequate in other respects for home care patients. Neighborhoods often are noisy, smoky, and crowded. Streets are filled with heavy traffic and sidewalks often swarm with playing adolescents. All this presents a potential danger to any aged person - home care or not. The situation may be summed up by saying that even if the housing is adjudged suitable from the physical standpoint, (which is true only part of the time) from the psychological point of view most home care dwellings do little to promote the mental sanguineness, confidence or enthusiasm of the patient.

Most of the present home care programs are selective of patients. For example, in many instances patients who do not have an adequate home environment are not accepted for home care.

The most frequent criticism of home care in the study conducted by the Hospital Council of Greater New York (40) was of the housing of the recipient.

The Hospital Council study found that 10 percent of the housing in which home care patients lived was inadequate for their needs, but in the Gallinger Municipal Home Care Study in Washington, D. C., it was found that home care could be given to "only one in three of those qualifying on purely medical grounds because of inadequacy of environmental factors". (41)

The problem of housing the aged is a complex one. It has long been recognized that it involves other associated problems. In 87 percent of the cases in one study, the matter of suitable living arrangements was involved in one way or another with matters other than the question of shelter alone. With old persons, the question of where to live was usually associated with some other problem, and often the clue to the appropriateness of the proposed living arrangement lay in the degree to which it would contribute to the solution of two or more problems at the same time. Thus, the old person will be likely to need shelter plus some type of service be it medical or nursing care, some degree of supervision or some degree of physical help. He may need only to have his meals prepared or to have a responsible person available in case he should fall or become ill. (42)

In considering the problem of housing and its effect on the health of the patient attention must be given to the psychological aspects. Science, for many years, has recognized the close relationship between the physical and the mental processes. The following quotation by a famous geriatrician is pertinent:

(40) Hospital Council for Greater New York, "Organized Home Care In New York City." 1956.

(41) Shindell, Sidney M., "Preliminary Report On The Gallinger Home Care Study", American Journal of Public Health, Vol. 43, May 1953.

(42) Brunot, Helen H., "Old Age In New York City", Welfare Council of New York City, Bureau for the Aged, 1944.

"The second and really impressive fact to the geriatrician is the influence that general living forces have upon diseases, not merely upon morale. Everyone knows how often heart disease strikes down men who are facing the retirement crisis; the disease was already established, but the shock of lost place, lost usefulness, and changed program activated it. Living on the side lines promotes malnutrition and brings old symptoms into prominence . . . We must experiment with new kinds of homes which old people can call their own because they pay rent; homes where household tasks and shopping can be lightened by the kindness of neighbors or by fees for such services; homes where there are opportunities for physical play, for seeing friends, for exploring hobbies and jobs, for continuing to play a part in community life . . . Therefore, the new style homes will be multidwelling apartment houses - congregate living without institutionitis . . ." (43)

On the other hand, there is an opposite although not necessarily conflicting view that while poor living environment (loss of occupation, run-down housing, etc.) might tend to have this psychosomatic effect on some, it will not necessarily effect a person who has been accustomed to an adverse environment all his life. Thus, lack of occupation cannot effect so seriously an old woman who has been used to a rather inactive existence during her lifetime. Nor will slum living produce any particular effect on a man who has grown up and lived in the slums all his life.

It would be reasonable to conclude that primary emphasis should be placed on removing aged individuals who are newcomers or relative newcomers to the slum environment in preference to finding improved project housing for those who had accustomed themselves to living in tenements throughout the years.

Most aged home care patients prefer to remain in neighborhoods that are familiar to them. They are occasionally able to see old friends and neighbors this way and shop in stores where they are known and which are familiar to them. However, as is pointed out by the Hospital Council study, neighborhoods often change radically in racial and ethnic composition, old friends die and move away, and this condition often succeeds in isolating the home care patient in what once was to him a friendly and familiar neighborhood.

(43) Monroe, Robert T., "Needs and Problems, Where and How Older People Wish to Live" (Chap. III). University of Michigan Press, 1954.

Household Characteristics Of Persons Receiving Home Care

The study of home care by the Hospital Council of Greater New York found that 13 percent of all persons receiving home care were aged persons living alone; 35 percent were aged living with a spouse. The remaining 52 percent of the persons receiving home care lived in families of widely different age groups.

Most of the 13 percent who lived entirely alone were survivors of the husband-wife relationship. In this group, bereavement for the deceased spouse accompanied by great loneliness and loss of social contact is by no means uncommon. Interviews during the Hospital Council study often found that older persons living alone had difficulties with their personal relationships.

Interviewers frequently reported garrulousness, exaggeration and other characteristics indicative of decreasing ability to handle social contacts.

This, it is pointed out, was probably a result of isolation, Housekeeping was also more difficult for the single person than in the case where more than one person was present.

While there were instances of couples who were estranged or hostile, these instances were very uncommon and most couples were able and did take care of one another.

About 50 percent of all home care patients lived in families of widely different age groups. Of this group, 20 percent were oldsters who lived with and were supported by younger people, usually their own children. Where the families were large, the care provided by the family often was adequate since different members of the family took turns in caring for the elderly patient. But, where the family was small, as in most cases, and one or two persons had to do all the work such as changing wet sheets for an incontinent mother or father, conflicts developed. Generally, however, care provided in families was very limited.

Supplemental Services

One of the major problems in home care has been the provision of supplemental services. Generally, nursing and other services were provided for persons living alone, while apparently, the assumption was made that some housekeeping and nursing services were available for those living in families. However, this is not always true. For example, in the Hospital Council study of home care, 38.6 percent of the patients interviewed received no nursing visits. For persons living alone only 10 percent received no nursing services, while 88.7 percent of persons on home care living with family members received no assistance with personal care, bathing, injections, dressings, administration of medicine, bedmaking and massage. Only one percent of those living with families had beds made by family members.

LIMITATIONS ON HOME CARE

In the previous chapter it was suggested that the population segment of the aged to be considered for care in special projects be confined to those who are neither bed nor wheelchair confined, or those who are effectively able to care for themselves. This latter group, in most instances, does not require special facilities with special programs to supplement their housing requirements.

Where home care has been carefully and objectively evaluated, the conclusion always is reached that home care is one tool for dealing with the problems of the sick, and not a pancea. A number of factors limit the application of home care.

Mental State Of Patients

In any home care program for the aged, special attention must be given to mental problems many patients are bound to encounter.

Nearly one in five old people is moderately senile while one in twenty is strongly so. (44) Among a sample of 525 patients who were served by the Instructive Visiting Nurse Association of Baltimore City in 1953 (47.8 percent of whom were 65 and over), it is reported that 21.3 percent of the patients were "confused part of the time", and that 2.5 percent were "confused all or most of the time".

Psychotic patients generally are excluded from any program which allows a patient to be treated in his home. However, it is not always easy to draw the line between a patient who is psychotic, one who is severely neurotic, or one who is disturbed. Gradual and sometimes rapid changes can occur in the mental status of old patients. These changes can take place after the patient has already been placed on home care. Consequently, a home care program for the aged must have provisions for continuous evaluation of the mental capacity of the recipients.

Need For Medical Facilities

"Older People don't have diseases They suffer from a number of disorders of metabolism and circulation which impair their efficiency." (45) Because many

(44) Kutner, Bernard; "Five Hundred Over Sixty", 1956.

(45) Stieglitz, E., "Relation of Gerontology to Clinical Medicine", Problems of Aging, 12th Conference, Feb. 6th and 7th, 1950.

old people do not understand the meaning of their symptoms, because many are inactive both physically and mentally and because a great number are simply lonely and in need of companionship there may be more of a tendency among aged patients toward an increased and unwarranted use of health services. This fact must be fully understood when dealing with aged patients.

In 1955, a study was made of two groups of heart disease patients. (46) One group was placed on a hospital based home care program and the other group (a control group) was treated within the hospital. When the results of this study were tabulated, it was found that home medical care reduced markedly the rate of hospitalization for heart disease but the average patient was nevertheless, often forced back into the hospital for ailments which were non-cardiac in nature. In this study, it was found that "the factor of advanced aged introduced the problem of multiple concomitant disease". This means that when aged heart disease patients were examined many were found to be suffering from ailments other than the original heart disease condition for which they had been placed on home care.

The effectiveness of home care can be improved and the problems simplified if the patient has easy access to a hospital both for inpatient service and for diagnostic services and complicated treatments that can not be provided at home.

Resistance To Change

According to the 1950 census, 7.2 percent of persons over 65 moved during the preceding year. This compares with a total of 12.6 percent for the entire population of the State of New York. While this may actually reflect the resistance to moving by persons over 65, there appears to be some evidence that the problem of moving the aged from one place to another is not as great as has sometimes been indicated.

A study in a typical midwestern city in 1942 showed that of the people aged 59 and over, 40 percent moved at least once during the ensuing six years and almost half of these moves involved change of residence to a different community. Those who had moved, it was noted, seemed to be as well adjusted to their new communities as those who had remained in their old ones. (47)

(46) Bakst, Henry J., "Home Care For Cardiac Patients", American Journal of Public Health, April 1955,

(47) Donahue, Wilma, Ph.D.; "Where And How Older People Wish To Live", (See Chapt. III), University of Michigan Press, 1954.

Housekeeping

In nearly all studies of home care emphasis was placed on the importance of providing adequate housekeeping in order to achieve the maximum results from the home care program.

Personnel

There is, at present, in most areas, a real shortage of medical and other specialized personnel to run an adequate home care program in terms of the medical and social services which have been deemed necessary. A House staff shortage, plus a lack of social workers, nurses, housekeepers, and therapists in most home care programs has meant that many patients on home care have not been receiving the attention they require.

Travel Time

One of the important factors that influence cost and affect the attitude of the physician involved in the home care program is the distance that the physician must travel to reach the home care patient. A detailed study was made of the time spent by 11 different physicians in travel on home care visits. The time varied from 56 percent of the total working time to 18 percent. The maximum time was spent by a physician whose home care patients were widely scattered and the minimum time by a physician whose patients were concentrated within a radius of six blocks.

SUMMARY

While there are a myriad of problems that make home care inappropriate in some cases and reduce its effectiveness in other instances, the most important problem, and one that influences many other problems is that of housing. A study by the Welfare Council of New York City (48) reviewed 1,935 case histories of aged clients. It then examined the 4,007 problems mentioned in these case histories. Following are the results:

(48) Brunot, Helen H., "Old Age In New York City". Welfare Council of New York City Bureau for the Aged, 1944.

Problems Of The Aged

Problem Area	Number Of Times Mentioned
Physical illness or disability	1,007
Mental illness or disability	352
Economic need	623
Family relationships	260
Living arrangements	1,694
Employment, recreation, etc.	71

The Welfare Council concluded by saying,

> "The most frequent combination (of problems) was that of health problems requiring specialized care which, in turn, involved some adjustment in living arrangements."

V - CONCLUSIONS AND RECOMMENDATIONS

This chapter summarizes the major conclusions reached from the material presented in the previous chapters. Specific recommendations are proposed.

CONCLUSIONS

1. The incidence of chronic disease is in direct proportion to the age distribution of the population. The older the person the greater the probability of the person having a disabling chronic disease.

2. One of the major differences between acute illness and chronic illness lies in the resources needed to care for the patients. For acute illness the patient may be cared for adequately in the general hospital. The patient is then discharged to his home and, after a short convalescence, can resume his pattern of living. For the chronic patient, a number of the resources of the community must be marshalled for his care. He may need a complete work-up in a general hospital; further care in an infirmary, nursing home, or other institution; re-training for his occupation; and re-education to fit him to a new pattern of life.

3. In order to provide effectively for the medical care needs of the aged a wide range of facilities and programs are essential. The services provided must range from those that supplement in only a limited degree the resources of the individual to those that provide complete care. Home care is only one of many resources that must be available to achieve a total program for the care of the aged, a large number of whom have disabling chronic diseases.

4. There is a direct relationship between the need for hospital care and the adequacy of housing for the aged. A study of patients over 65 in six general hospitals indicated that only 28 percent of these patients had housing which met their specific needs. One out of five patients over 65 in these hospitals could be discharged if adequate institutional or home facilities and services were available.

5. It is estimated that there are:

- 1,543,000 persons in New York State over 65 years of age

- 588,000 persons over 65 with insufficient income to meet a minimum budget. This represents 177,000 couples and 234,000 single persons.

6. The need for special facilities for those neither bedridden nor able to care completely for themselves, over 65, is estimated to be:

- 60,840 single units

- 46,000 double units.

7. In addition to basic housing requirements, the principal needs of those over 65 not completely able to care for themselves include:

- Medical assistance which can largely be provided by home care - an extension of the hospital services into the patient's home

- Supplemental services such as housekeeping, shopping and transportation.

8. Major problems that restrict expansion of home care programs are:

- Inadequate housing and other environmental deficiencies of persons who are appropriate medical subjects for home care

- Distances that medical staff and other hospital personnel must travel to reach home care patients.

RECOMMENDATIONS

1. That A Pilot Program Providing Housing And Supplemental Facilities For The Aged Be Undertaken

Such a program might well provide demonstration projects both in New York City and upstate to meet differing situations.

The building of these projects adjacent to hospitals would provide home care to the aged requiring this service. Where feasible, the inclusion of these projects as part of an urban renewal program would be desirable. In a special study undertaken by the New York State Division of Housing it was found that 54.7 percent of the hospital beds in Manhattan were within substandard housing areas as defined by the City Planning Commission or within a radius of two blocks of such substandard areas. (See Appendix A for a summary report of this special study.)

The following specific proposals should be considered:

a. In addition to his present powers to approve the development of low rent and limited profit housing with special consideration being given to the aged, the Commissioner of Housing should consider developing with the local housing authorities the means by which land adjacent to a hospital might be cleared and provided to the hospital for the inauguration or expansion of facilities from which a home care program will be conducted. The agreement between the hospital and the housing authority could call for the hospital to perform services which include outpatient care and home care to the residents of the special housing facilities for the aged for a stated period - for example, five years. The participating hospitals would also agree to maintain records from which actual cost of care of the residents of the special housing facilities can be computed. Such records might serve as a basis for future compensation to the hospitals for providing such care after the initial five-year period.

b. Supplementary services to be provided by community resources would depend on location, arrangements with relatives or friends, and other factors which experience would demonstrate. It is important to let the aging do as much for themselves as possible from a mental as well as a physical standpoint before providing services which may be necessary, such as housekeeping, shopping and transportation.

One of the ingredients necessary for an effective program is a coordinator - a person who continually visits the older residents to determine their needs and general condition. We might call this a Hostess Service which could resolve the needs of many people cooperatively and call in the outside services when necessary.

Another service may be provided by a cafeteria. It may not be necessary to have a cafeteria in each project. In one or two projects it should be included on an experimental basis.

c. While proximity to a hospital is important in the planning of the special apartments for the aged, particularly those chronically ill, it does not mean that they should be exclusively so occupied. It is important that the aged live in an environment which does not remove them from the community. In the selection of chronically ill, aged tenants, consideration

should be given to those who appear able to care for themselves best with the medical care and supplemental services available.

d. The Commissioner of Housing should continue to encourage or approve construction of all types of housing in the total complex. Such additional housing could include· private housing, a percentage of units being available for those over 65 who are able to care for themselves; low income housing and limited profit housing. Such additional units contribute to the normal environment of the total complex which would include special units for the aged requiring supplemental care.

2. That Continuous Evaluation Be Made Of The Operations And Effectiveness Of The Pilot Projects After Their Completion

Careful analysis should be made of the total pilot program. Evaluations should include:

- Criteria for selecting applicants for the special housing facilities

- Costs of maintaining supplemental services such as housekeeping, shopping and transportation

- Need for and use of cafeteria and other services

- Scheduling and use of hospital and other medical facilities, including home medical care

- Assessment of design and planning, particularly of special features for the housing of the aged.

3. That Consideration Be Given To Other Related Housing Programs

Particular consideration should be given to extension of the Mitchell-Lama Act to

- Include in the development of a project, the provision of single units for the housing of graduate nurses and residents. Not only would this afford them the housing needed close to a hospital, but would permit the aged an added measure of security with this additional staff,

many of whom would be used in the home care program.

- Encourage nonprofit organizations to construct low-cost housing for the aged. For example, this program, if tied in with urban renewal, might provide relatively low-cost land to a hospital or other nonprofit organization in an urban renewal area for construction of limited housing.

4. That Coordinating Studies Be Undertaken

These studies are needed to determine

- How, organizationally, to develop the program. The cooperation of various interested agencies would be enlisted, including: Housing; Public Health; Welfare; Hospital, (including Joint Hospital Survey and Construction Commission) and Mental Health

- The hospitals to be included in the proposed initial pilot studies. In this determination, consideration should be given to

  - Existing or planned programs and resources of the hospital. For example, preference should be given to a hospital with an intern and resident teaching program over a hospital without such a program

  - Activity and interest of the hospital not only in home care but also in related programs

  - Community resources available in the area. Existing housekeeping, transportation and other services provided by agencies should be utilized in preference to establishing new services

  - Recreational and related programs and activities in the immediate area

- Number of eligible persons in the community

- Location of the hospital in terms of urban renewal.

- Methods for selection of tenants to take into consideration besides economic eligibility, those characteristics which will affect adjustment

- The extent to which special facilities, recreational, therapeutic, etc. may be provided in light of construction and operating costs.

APPENDIX A

HOSPITAL BED DISTRIBUTION RELATED TO SUBSTANDARD AREAS IN NEW YORK CITY

Prepared By

New York State Division of Housing
Bureau of Research and Statistics
July 1957

APPENDIX A - HOSPITAL BED DISTRIBUTION RELATED TO SUBSTANDARD AREAS IN NEW YORK CITY

As a part of the comprehensive study of the potential need for home care facilities in housing by John G. Steinle and Associates, information was gathered by the research staff of the Division of Housing on the ratio of hospital beds in New York City that are located in and near substandard areas. All hospitals and related facilities in New York City listed in the 1956 directory of the Hospital Council of Greater New York were considered, except those operated by the State and Federal governments. Bed capacity rather than the number of beds presently set up was taken as the criterion of hospital facilities. The areas reviewed were those sections of New York City designated by the Master Plan of the City Planning Commission as "containing substandard and insanitary areas suitable for clearance, replanning, reconstruction and rehabilitation for predominantly residential use." Near substandard areas are, by definition, a two-block belt surrounding the designated substandard areas.

It was found that 12.1 percent of the hospital bed capacity is located in substandard areas. When hospital facilities within two blocks of the substandard areas are counted, the proportion becomes more than a third (36.4 percent).

The boroughs of Manhattan and Brooklyn have the largest proportions of hospital bed capacity in substandard areas in the city; 15.3 percent and 15.7 percent, respectively. However, when the areas analyzed are expanded two blocks, the borough of Manhattan stands by itself with over half (54.7 percent) of its hospital bed capacity located within such areas.

Voluntary hospitals are the most prevalent in and near substandard areas with 16.4 percent of their bed capacity within substandard areas and half, 50.8 percent in or within two blocks of substandard areas. In Manhattan, over two-thirds (67.7 percent) of their bed capacity is in or within two blocks of substandard areas. The percentage for proprietary hospitals throughout the city is 3.1 percent.

These data are presented in detail in the table on the following page. The results of this study appear to bear out the suggestion that many areas adjacent to or near hospital facilities present redevelopment possibilities.

HOSPITAL BED DISTRIBUTION RELATED

TO SUBSTANDARD AREAS IN NEW YORK CITY

	Total Hospital Bed Capacity	In Sub-Standard Areas	% of Total in Sub-Standard Areas	Within Two Blocks of Substandard Areas	% Within two Blocks of Substandard Areas
Manhattan	22,191	3,400	15.3	12,147	54.7
Voluntary	11,845	2,216	18.7	8,016	67.7
Municipal	8,905	1,184	13.3	4,131	46.4
Proprietary	1,441	-	-	-	-
Bronx	7,467	696	9.3	1,668	22.3
Voluntary	3,661	696	19.0	1,221	33.4
Municipal	2,823	-	-	404	14.3
Proprietary	983	-	-	43	4.3
Brooklyn	12,322	1,938	15.7	4,223	34.2
Voluntary	7,238	1,236	17.1	3,521	48.6
Municipal	4,238	588	13.9	588	13.0
Proprietary	846	114	13.5	114	13.5
Queens	6,521	100	1.5	100	1.5
Voluntary	2,503	100	4.0	100	4.0
Municipal	2,327	-	-	-	-
Proprietary	1,691	-	-	-	-
Richmond	2,066	-	-	256	12.4
Voluntary	580	-	-	256	44.1
Municipal	1,436	-	-	-	-
Proprietary	50	-	-	-	-
New York City	50,567	6,134	12.1	18,394	36.4
Voluntary	25,827	4,248	16.4	13,114	50.8
Municipal	19,729	1,772	9.0	5,123	25.2
Proprietary	5,011	114	2.3	157	3.1

Source: 1956 Directory of Hospital Council of Greater New York.

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