

proportions in families of five or more—19 percent among the aged and 45 percent among persons under 65.

Aged men and women are found in families of approximately the same size. Because of differences in marital status, somewhat more women lived alone in 1940 and somewhat more men lived in two-person families. The aged living in their own establishments tended to be found in smaller families; relatively more were members of one- and two-person families and relatively fewer were in families of three, four, or five or more persons.

Data on size of family are available for old-age and survivors insurance beneficiaries from field studies made in 1941-44, but not for recipients of old-age assistance. The insurance data suggest that individuals in two-person families bulk larger among beneficiaries than among the aged as

a whole, with a corresponding greater or lesser deficiency of persons in families of other sizes. This characteristic conforms to the pattern among insurance beneficiaries of a higher ratio of married persons and of persons in their own establishment.

#### Summary

Available information indicates that in several significant respects aged beneficiaries of old-age and survivors insurance and recipients of old-age assistance differ from all the aged and from each other.

Insurance beneficiaries include a larger proportion of men than the total aged population, are more heavily concentrated in urban areas, include fewer nonwhite persons, and are more likely to be married and living with a spouse. A relatively larger number live in private families and in their own establishment; fewer live

alone; more share their living quarters with a spouse only; fewer live in large families.

Assistance recipients have a higher median age than the aged as a whole and include relatively fewer men. Proportionately more live in rural areas; more are nonwhite; fewer are married and living with spouse. Approximately the same proportion as in the total aged population live in private families and in their own households; relatively more, however, live alone, and fewer live with others.

These broad differences reflect in varying degree the selective character of the eligibility requirements of the two programs, the stage of program growth attained, and the impact of the war on the number and characteristics of persons applying for benefits or assistance. In other words, there is nothing necessarily permanent about the differences.

## Commercial Nursing and Boarding Homes in Philadelphia

By Margaret K. Bishop\*

PHILADELPHIA faces a problem with serious implications for the health and welfare of its citizens in the lack of adequate facilities to care for chronically ill persons and for persons who are unable to assume the responsibilities of living alone and do not have relatives or friends willing or able to undertake responsibility for their care. This problem is not restricted to the indigent but touches all but the highest economic level, at which families can afford to care for the ill, feeble, or handicapped person in his own home or in expensive institutions. The group most seriously affected, however, comprises recipients of public and private aid and persons living on a marginal income level, at which any adverse circumstance may necessitate dependence on public assistance.

There are chronically ill persons in every age group, but by far the majority are concentrated in the upper age brackets. In 1940, 7 percent of

the city's population were in the ages 65 years or over, and the proportion is showing a steady upward trend. Moreover, the present lack of facilities for caring for nonacute illnesses of younger persons is developing an increasingly larger group of chronically ill in the older age levels. More than 90 percent of the public assistance recipients in commercial nursing homes are over 65 years. Thus, while the problem of caring for the chronically ill must be closely, but not exclusively, identified with care of older persons, constructive emphasis must be laid simultaneously on prevention of chronic illness by early diagnosis, treatment, and adequate care.

Nonprofit institutions care for only a small fraction of the aged population, because of the scarcity of such institutions and their restrictions on admission. Some of these homes operate on a contractual basis that automatically excludes recipients of public assistance. Many are limited with respect to church affiliation or race. Few will accept nonambulatory per-

sons or persons with chronic or progressive ailments. Philadelphia has only 4 nonprofit institutions for the chronically ill, with a bed capacity of about 500. Practically no hospital accommodations exist for the chronically ill of any age group. The few available facilities are limited to caring for persons suffering from particular diseases, such as rheumatic fever, cancer, and so on.

The shortage of nonprofit homes forces persons in need of sheltered care into commercially operated nursing or boarding homes. The distinction between these two types of homes lies in the degree and kind of care needed by the applicant for admission and in the legal requirement of licensing for nursing homes. Philadelphia has 52 licensed nursing homes accommodating some 1,300 persons; at the time of this study—the summer of 1945—public assistance recipients were living in 31 of these homes and in 42 boarding homes.

Workers in social agencies are often faced with the situation of the person who is ready to be discharged from a hospital but needs continuing care; of the elderly couple who have struggled to keep up their home but are no longer able to combat the weaknesses and disabilities of old age; of the lone man who is unable to prepare his own meals or to go out to a res-

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Consequently, recipients who need only boarding care are more frequently able to keep a part of their assistance payment for their own use. As in the case of recipients in nursing homes, the assistance payment in most instances is \$40 a month.

About one-fourth of the recipients have resources in addition to the assistance payment. For a few who are making relatively high payments to the home, relatives or agencies are supplementing assistance to obtain what borders on the type of care offered in a nursing home. The source of income is shown below for all cases.

Source of income	Percentage distribution of recipients
Total	100.0
No income other than grant	73.3
Relatives and friends	14.8
Federal insurance benefits	2.9
Agencies, including churches	2.4
Personal, including part-time employment	3.3
Other	3.3

### General Conditions in Boarding Homes

The 42 boarding homes in which recipients of public assistance were living at the time of the study present the following composite picture. The home is usually under the personal direction of the owner, who frequently has no assistance in its maintenance. Nearly all the homes are located near a physician or hospital, transportation, and recreational centers, such as parks, motion picture theaters, and churches.

In general, the physical condition of the home is adequate or better; houses are structurally sound and suitable for the purpose for which they are being used; bedrooms are not crowded, and beds are of adequate size with sufficient bedding; rooms are kept reasonably clean. Bathroom facilities are fairly adequate, with an average of five persons to each toilet and washbasin and six persons to each tub or shower; inspection of these facilities indicated that satisfactory cleanliness was maintained.

Most of the homes offer a limited number of services in addition to shelter and food. Many care for personal laundry, while a few provide clothing and such services as shopping and mending. Recreational facilities are made available in the form of books, games, and radios, and in access to outdoor space, porches, and living

rooms. In most homes, medical care is provided on a temporary basis, through attendance of physician, visiting nurse, or graduate nurse on call, but in extended illnesses the patient is usually removed to a hospital.

Boarders often share in the work of the home to the extent of caring for their own rooms, where they may usually have their personal possessions, and of performing odd jobs around the kitchen and dining room. There are few restrictions on their activities other than those often experienced in institutions, such as giving notification when leaving the home, returning at a certain hour, and remaining at certain times in designated parts of the house.

Comments made by agency visitors indicate that, in general, recipients are reasonably satisfied with the conditions in the homes and that the relationship between the owner and the guests is friendly and harmonious. One visitor reported:

Mrs. G seems to take a personal interest in her boarders. She says she is specially interested in providing a comfortable home for aged people, and she renders a great many services beyond those expected of a boarding house proprietress. She has nursed several sick boarders back to health and at present has a round-bound boarder whom she seems to attend very adequately.

Complaints tend to center most frequently around the home's charges, which often leave the recipient little or no money for items other than maintenance, and around the quality and quantity of the food provided. Thus a report on a home with seven recipients indicates:

Boarders are dissatisfied with this particular home. They have to clean their own rooms, and most of them are too old or not well enough. They are dissatisfied with the food because of inadequacy of amount served, and because of the way in which it is prepared. The proprietress, Mrs. B, has no help except an 8-year-old child who, she said, helps with the dishes. The boarders do not like Mrs. B's personality and prefer not to have their friends call on them because "Mrs. B makes it too unpleasant."

With respect to another home it was reported:

There have been some complaints that insufficient food is served. Many clients get hungry in the evening and must buy food from the proprietress, thereby leaving them little or no money for incidentals.

### Characteristics of Recipients in Both Types of Homes

Information was obtained for each recipient, 18 years of age or older, who was resident in a commercial nursing or boarding home at the time of the studies. Since only about 10 percent of the total group were Negroes, data are not presented separately for them.

Sixty-three case records of recipients living in homes were read. These people vary widely with respect to their family composition, disabilities, temperaments, and reactions to their inevitable dependence; but the core of most of the situations is essentially the same. Most of them have subsisted on marginal or near-marginal incomes. They have been able to manage through earnings or support by relatives until the disabilities of age have made it impossible for them to live alone or too difficult for relatives to care for them. There is practically universal reluctance toward leaving their own homes, even when living alone or having insufficient care from others becomes highly unsatisfactory and precarious. Frequently hospitalization provides the turning point, when it becomes obvious that convalescent or continued care will be needed or when landlords or relatives refuse to permit return to their homes. Acceptance of or resistance to life in a home is related primarily to the personality, attitude, and previous standard of living of the individual and only secondarily to the character of service offered by the

Table 3.—Age distribution of recipients in nursing and boarding homes, for each sex and type of home

Age group	Percentage distribution of recipients in—					
	Nursing homes			Boarding homes		
	Total	Men	Women	Total	Men	Women
Total recipients...	346	138	208	210	90	120
Total percentage...	100.0	100.0	100.0	100.0	100.0	100.0
Under 40.....	.3	.....	.5	.9	2.2	.....
40-49.....	1.5	2.1	1.0	.9	1.1	.8
50-59.....	3.1	3.6	2.9	3.3	3.3	3.3
60-69.....	12.4	14.5	11.0	12.4	11.2	13.3
70-79.....	46.2	50.1	43.7	44.8	44.4	45.0
80-89.....	32.4	28.3	35.1	35.3	37.8	33.4
90 and over.....	4.1	1.4	5.8	2.4	.....	4.2

Table 4.—*Marital status of men and women recipients, for each type of home*

Marital status	Percentage distribution of recipients in—					
	Nursing homes			Boarding homes		
	Total	Men	Women	Total	Men	Women
Total recipients.....	346	138	208	210	90	120
Total percentage.....	100.0	100.0	100.0	100.0	100.0	100.0
Single.....	32.1	40.6	26.4	32.4	33.3	31.7
Widowed.....	59.8	45.7	69.2	55.2	47.8	60.8
Separated.....	7.5	13.0	3.9	8.6	14.5	4.1
Divorced.....	.3	.7	.....	2.4	3.3	1.7
Married.....	.3	.....	.5	1.4	1.1	1.7

home. Some recipients have moved from one home to another, expressing dissatisfaction with each. Others, living in the same homes, are able to adjust themselves in spite of their natural desire for homes of their own. One old man commented that he had "enough to eat, and a good place to sleep, and no one could ask for anything more."

#### Age and Marital Status

Persons seeking nursing and boarding home care are predominantly an elderly group; more than 90 percent of the recipients in both types of homes are over 65 years of age (table 3).

Nearly half the recipients living in nursing homes at the time of the study, and nearly two-thirds of those in boarding homes, are lone individuals; many others have close relatives who are not interested in their welfare or are so overburdened by the needs of their more immediate family that they are genuinely unable to assume any further responsibilities. The disabilities of these persons create a situation which is completely insuperable to the lone person and often too onerous for families, and make sheltered care practically imperative.

Most of the recipients living in homes are single or widowed (table 4). Although very few married persons were living in the commercial homes at the time of the study, a very real social problem is presented by elderly couples who are not able to care for themselves completely and are not able to pay for continued and expensive care. Some other cities have taken cognizance of this situa-

tion by building apartment houses with small quarters especially designed for elderly persons and common services available at low cost. This arrangement permits privacy, independence, and comfortable living, pending the day when nursing care becomes necessary. It means a prolongation of home life for elderly people who are unable to cope with the expense and difficulty of maintaining their homes under the usual ill-adapted conditions of the ordinary rented house or apartment.

#### Period of Dependence on Public Assistance

Most of the recipients of public assistance in commercial homes are long-term dependents. Some have been able to interrupt their public dependency by periods of self-support, but the majority have been receiving aid continuously from the date of their first application (table 5).

Records of long-term cases show clearly the reason for continuous dependency. Recipients are solitary persons or have relatives who cannot assist them, and they are incapable of any effort in their own behalf—as, for example, an elderly woman whose only relative is a daughter in the Home for Incurables; a lone senile woman of 85; a diabetic woman who has had one leg amputated, is so senile that she fails to realize that she is a recipient, and

Table 5.—*Interval since first authorization of public assistance, for each type of home and continuity of assistance*

Interval since first authorization	Percentage distribution of recipients in—					
	Nursing homes			Boarding homes		
	Total assistance	Continuous assistance	Intermittent assistance	Total assistance	Continuous assistance	Intermittent assistance
Total recipients.....	346	246	100	210	163	47
Total percentage.....	100.0	100.0	100.0	100.0	100.0	100.0
Less than 1 year.....	1.7	2.4	.....	1.9	2.5	.....
1-2.....	12.4	17.1	1.0	11.5	13.6	4.4
3-4.....	12.2	13.0	10.0	14.9	15.4	13.0
5-6.....	17.9	17.9	13.0	16.8	17.3	15.2
7-8.....	20.2	21.5	17.0	18.3	17.9	19.6
9-10.....	19.7	15.5	30.0	18.3	19.1	15.2
11-12.....	10.7	8.5	16.0	12.0	10.5	17.4
13 or more.....	5.2	4.1	8.0	6.3	3.7	15.2

Table 6.—*Length of residence in homes, for each type of home*

Length of residence	Percentage distribution of recipients in—			
	Nursing homes		Boarding homes	
	Residence in homes (present and previous)	Residence in present home	Residence in homes (present and previous)	Residence in present home
Total recipients.....	346	346	210	210
Total percentage.....	100.0	100.0	100.0	100.0
Less than 6 months.....	24.6	30.1	18.1	31.4
6 months-1 year.....	18.5	18.2	12.8	21.4
1 year but less than 2.....	24.6	24.0	16.7	16.7
2 years but less than 3.....	15.6	15.0	13.8	11.9
3 years but less than 4.....	5.5	7.5	12.4	9.1
4 years but less than 5.....	5.5	2.3	6.2	2.4
5 years but less than 6.....	2.0	1.4	6.7	2.4
6 years but less than 7.....	2.0	.9	4.7	1.4
7 years or more.....	1.7	.6	8.6	3.3

has only one relative, a son with a large family who is usually unemployed or earns very little; a lone man, whose adopted daughter does not give him any financial help.

#### Period of Residence in Homes

The scarcity of commercial homes and the progressive disabilities of the recipients living in them are probably the principal reasons why individuals stay as long as they do in the homes they enter first. While some records show a history of repeated moves, more show a prolonged stay in one home, motivated in some cases by a senile indifference to surroundings, in others by an acceptance of the inevitable, and in a few by a real appreciation of what the home offers.

#### Health

Poor health prevails among inmates of boarding and nursing homes. One-fourth of the recipients in boarding homes are reported by the agency visitors to have no particular disability; this statement probably implies the absence of a diagnosis known to the visitor, rather than a clean bill of health. Most of the ailments listed are chronic or progressive and are related to the infirmities of age and senility. Specifically, heart and circulatory disturbances, nervous and mental disorders, and disorders of the bodily framework are the most frequently reported. The effect of ill health on the

Table 7.—*Mobility of men and women recipients, for each type of home*

Degree of mobility	Percentage distribution of recipients in—					
	Nursing homes			Boarding homes		
	Total	Men	Women	Total	Men	Women
Total.....	100.0	100.0	100.0	100.0	100.0	100.0
Bedridden....	23.4	13.0	30.3	4.8	1.1	7.5
Room-bound..	35.3	37.0	34.1	8.6	12.2	5.8
House-bound..	15.9	14.5	16.8	17.1	11.1	21.7
Ambulatory..	25.4	35.5	18.8	69.5	75.6	65.0

mobility of recipients is indicated in table 7.

### *Life in the Homes*

Description of the facilities in the homes and of the potentialities of the inmates paints a picture of a largely vegetative life. The patients lie in bed or sit side by side with little or nothing to entertain or interest them. Some listen to radios, read books or newspapers, or visit with the other inmates. Many are too advanced in senility to participate in any social activities, while others, through long disuse and idleness, have lost the initiative to seek diversion. Moreover, lack of money strictly curtails possible activities. If every penny of the assistance payment is turned over to the home, the individual without other resource cannot purchase even a newspaper, stamps or stationery, material for handwork. In some homes the proprietress returns a small amount for such incidentals or herself supplies them, but often the recipient receives literally nothing but maintenance and minimum care. The more active move around the home—to living rooms, porches, and grounds—take short walks, and occasionally visit the homes of friends and relatives, attend church or the movies, or go to libraries. Several homes require boarders, when physically able, to take care of their own rooms. A small group of recipients do odd jobs around the home, such as cleaning, helping in the kitchen, and mending, either for slight recompense or "just for something to do." A few do their personal laundry.

Needs of the recipient other than maintenance and care are met in a variety of ways or are completely un-

met. Clothing is considered to be included in the nursing home's charges to about one-third of the recipients and is supplied in a few instances by the boarding homes. The assistance payment usually includes allowance for clothing. When the home does not receive the entire assistance payment the recipient may be able to meet his clothing needs from the remainder. Relatives and friends also help with contributions of clothing. Laundering of personal apparel is taken care of by most of the nursing homes and a few of the boarding homes. Sometimes friends and relatives perform this service for the patients, and a few recipients are able to do their own laundry. Incidental items, such as tobacco, toilet articles, and reading material, are supplied in relatively few cases, and usually by relatives and friends. The area of unmet needs embraces practically all other items.

The nursing and medical care available to recipients varies in kind and extent from one home to another. In general, the nursing homes afford nursing care to all inmates, with day and night bedside care for those patients who require it. In a rather surprising number of instances, boarding homes are giving general nursing care to boarders, probably more often at intervals rather than as a continuing service. Several proprietresses of boarding homes are nurses and are qualified to give nursing care in emergent situations. The most frequent plan with respect to medical care is to use a physician in attendance on the home, financed through the agency's medical program. A few recipients also use hospital clinics and the services of visiting nurses.

Life in the nursing and boarding homes is ordinarily a restricted existence, with little that is constructive or even pleasurable and entertaining. In present circumstances, however, the homes are performing a real function. While it is easy to criticize the operation of the homes, and there is undoubtedly much that is subject to valid criticism, the following points should be kept in mind: (1) The standard of living of the home is definitely higher than that of the former scale of living of many recipients. If it were not for the commercial homes, many persons would be

receiving little or no care in conditions of real squalor. (2) The homes are not philanthropic institutions but business enterprises. The homes that cater to public assistance recipients cannot afford to offer a very high standard of living for \$40 a month per person. Certain obvious abuses that exist currently could be corrected, however, if community pressure were exerted to improve standards and supervision. (3) If the ill or disabled person is forced to live in the unconventional surroundings of a commercial home, it is because the community has not made provision for this particular group of its members.

### *Need for Nursing and Boarding Care*

Analysis of the characteristics of persons in need of sheltered care reveals no significant difference between this group and those persons already resident in the homes. Sheltered care would undoubtedly benefit many recipients who are now living alone and are dependent on the care given by landlords, other tenants in the house, or friends, or who are receiving no care at all. The reasons for their refusal to consider commercial home care are of interest.

First in importance is the natural feeling of people for their own homes, however poor and humble, and the reluctance to admit they cannot manage alone. Their need of sheltered care is often much more obvious to others who are interested in them than to themselves. Such a case was that of a lone woman nearly 80 years of age, suffering from recurrent cancer. She lived in a single furnished room in a private home which she refused to vacate even when her landlord moved and other tenants rented the house. She could do little for herself and was dependent on a neighbor for food and laundry and on a visiting nurse for baths three times a week. She violently rejected the idea of entering a nursing home.

An allied reason for rejecting the plan of entering a home is the frequently expressed belief that the restrictions imposed by the home would prove burdensome. Actually, most of the homes do not attempt to regulate the lives of their inmates beyond the point of compatibility with communal living. A few have restrictions which

are definite sources of unhappiness to their boarders, such as rules against use of porches and grounds, limitation of boarders to one floor of the home and to their own rooms at night, a required bedtime of 6 p. m. Many people value their independence so highly that they will go to extremes to preserve it. Thus, an elderly man is living by himself, eating in restaurants, and sending a boy for his meals when he is unable to go out; another man is confined to his room, is alone all day when his landlady goes to work, and receives only two meals a day prepared by his landlady before she leaves the house and when she returns at night; a third recipient, with no proper cooking facilities, is subsisting largely on canned foods purchased by friends and neighbors.

Several recipients have expressed their unwillingness to leave the neighborhood in which they have lived for many years and their reluctance to share a room with others, which would usually be necessary in a home at the price which they could pay. Others have spent some time in a commercial home and, on the basis of an unpleasant experience, are adamant in refusing to try it again, despite the undesirable factors in their present way of living.

It is very difficult or impossible to obtain any real measure of the need for commercial home care among the recipient group. Expression of the need would necessarily have to come from the individuals concerned, since no outsider, however well-trained or well-meaning, could have complete awareness of all the factors involved—physical, social, and psychological. The recipient's admission of the need is blocked by the reasons that make him unwilling to face the issue squarely until complete incapacity forces him to do so. Moreover, the present low caliber of many of the homes is well known to most recipients, and it is impossible for them to conceive of sheltered care except at the familiar level. If more adequate and more attractive facilities were developed, it is extremely probable that many recipients who cling to their own unsatisfactory scheme of living would be more than glad to avail themselves of the opportunity to receive nursing or boarding care.

## Conclusions

Probably few single needs are more pressing, more vital to the national welfare, and more neglected in most communities today than the need for care of the chronically ill. There has been little tendency to come to grips with this problem on any basis correlative with the actual need. Moreover, in planning for the future there is little recognition that this is a steadily increasing need, inasmuch as it is closely related to the rising proportion of older persons in the population and to the cumulative results of years of inadequate care of persons with potentially chronic conditions.

Philadelphia has many thousands of chronically ill persons, some of whom need only simple custodial care while others require active medical care or skilled nursing. Additional thousands, although not chronically ill, find it difficult to perform the routine tasks of daily living without aid. Many of these persons depend on public or private aid or are members of families with marginal incomes that cannot extend to the provision of medical care. To meet this need, Philadelphia has nonprofit institutions caring for 500 persons, commercial nursing homes with a capacity of 1,300, and various hospitals and a home for the indigent that are forced to give care to a minimum number of chronically ill persons, although such care is definitely not within their function.

The dilemma of the indigent chronically ill person occurs so frequently as to form an almost standard pattern. Acute manifestations of the disability bring the patient to the hospital, where treatment restores him to his "normal" condition. At this point the hospital is anxious that he should be discharged, so that his bed will be available to a person in need of active medical care. Because of the patient's need of continuing nursing or custodial care, his lack of resources, and the inadequacy of facilities to meet his needs, he is frequently kept in the hospital beyond the point of need for hospitalization. A vicious circle then develops. Overcrowding of hospital facilities sometimes limits the admission of incipient cases that cannot be treated until the period of therapeutic possibilities has

elapsed, tending to create a new group of the chronically ill. Such procedures are obviously uneconomical, both financially and from the standpoint of human values. The obvious solution lies in the provision of adequate facilities for the care of the increasingly large population of senile persons, the chronically ill, and disabled persons of all types and age groups.

When the discharged patient is finally forced to leave the hospital, the plans for his care are usually the responsibility of his relatives, if any, the hospital social worker, and the representative of the public or private agency which will be charged with his maintenance. If care cannot be provided in his own home or by relatives, little remains except to place him in a commercial home. There, again, usually little choice is possible in selecting the home, if the assistance payment is the total resource. Thus, the worker must recommend placement in any available vacancy whether or not it provides the type of care the recipient needs.

Commercial facilities cannot alone provide the answer to the need for care of the chronically ill. The function of such homes would seem, ideally, to be related to the care of persons who can afford to pay adequately for services. If only this group were to be accommodated, it should be possible to set high standards which should be rigidly enforced. In such circumstances, proprietors could derive a reasonable profit and, at the same time, meet a very real need in the community.

The presupposition would then be that the needs of indigent persons or of those who could not afford to meet medical costs would be met on a non-profit basis. The particular form which such a plan would take would, of course, depend on the needs and desires of the community. It might include a large hospital for the chronically ill, subsidized small homes for groups needing only custodial care, tax-supported homes for groups requiring skilled nursing and medical care, supervision by hospital physicians of persons in their own homes, or any other of a number of plans or combination of plans.

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