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ADULT DAY FACILITIES FOR TREATMENT, HEALTH CARE, AND RELATED SERVICES

A WORKING PAPER

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SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

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Prepared by Brahna Trager

PREFACE

High costs of dealing with long-term illness or disability among older Americans—together with growing concern about needless institutionalization of many elderly persons—have caused a growing demand for so-called "alternatives" to expensive institutional care.

That demand, given impetus by the White House Conference on Aging in 1971, has swelled considerably since, not only because of the factors mentioned above, but because of widespread scandals and misgivings about nursing home care in the United States.[1]

But, as the author of the following paper points out, there is some danger in the use of the word "alternatives." It seems to demand a clear-cut, "either/or" division between nursing home or hospital care and all other health or help resources needed in a community. What really is needed, she declares, is a more responsive and comprehensive community-based *system* in which a number of options are available to those who need assistance to maintain semi-independence, in which the full-time institutional bed is there when needed but not called upon unless it is in the patient's best interest to do so.

The author also identifies two trends prevalent in attitudes toward planning community-based services for the chronically ill and disabled:

"One is a desire to define clearly 'health-related' services in order to provide medical care and treatment as a health benefit in an insurance program.

"The second is a growing concern for large numbers of disabled and chronically ill adults for whom life in the community becomes an impossibility when access to health care and the capacity for complete self-care are restricted because both complete mobility and certain of the activities for daily living are not continuously possible."

To make those trends more compatible than they now are, legislators, other policymakers, health and social service providers, and concerned citizens need much more information about the capacities and limitations of programs intended to bridge the widening gap between "complete self-care" on the one hand and total institutionalization on the other.

This committee has already provided two reports[2] on home health care in the United States and has recommended a wide number of actions to encourage further development of in-home service systems.[3]

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[1] See, for example, *Nursing Home Care in the United States: Failure in Public Policy*, 1974; and Supporting Papers, 1974–76, issued by the Subcommittee on Long-Term Care, U.S. Senate Special Committee on Aging.

[2] *Home Health Services in the United States*, committee print report, April 1972 (Cat. No. y4:Ag4.H34/11), and *Home Health Services in the United States: A Working Paper on Current Status*, committee print, July 1973 (Cat. No. Y4.Ag4:EC7/IND).

[3] See, for example, "Recommendations," pp. 48–49, *Developments in Aging: 1973 and January–March 1974*, a report of the U.S. Senate Special Committee on Aging, May 13, 1974.

The author of those two papers, Ms. Brahna Trager, is also the author of this report. She is recognized as a pioneer and respected authority on home health care, having established one such program in San Francisco, having intensively studied such activity in Europe, and having served as consultant to the Department of Health, Education, and Welfare and many other public or private agencies with a concern about this important, but still beleaguered, component of our loosely knit, and very expensive, national health care system.

Ms. Trager certainly recognizes that home health services cannot exist in a policy and systems vacuum, any more than nursing homes and hospitals can.

And so she agreed, when this committee asked for her help, to write this paper because of her great interest in the development of what she describes as the "essential components within the community" for the provision of help *wherever it is most appropriately given:* in the home, in institutions, or in a number of other arrangements which enable the person in need of help to maintain "independent" living quarters while making use of needed services.

Ms. Trager devotes most of this paper, as she was asked to do, to what she calls "Adult Day Health Centers," in which individualized care routines are provided to people who are usually called "participants" rather than "patients" in order to emphasize their ambulatory status and their need for a widely varying mix of services which do not necessarily fit neatly into health/social service categories.

In a very few years, such centers have proliferated and assumed such titles as: "Senior Health Improvement Program," "Health-Care-by-the-Day," "Daily Living Center," and "Senior Health Services Center." In Rhode Island, one such unit is based in a church and is called "Geriatric Day Care," even though its major emphasis is upon social services or socialization.

One reason for the variety of names, according to Ms. Trager, "is precisely to avoid the simplistic application of the child care concept to a set of community services for adults which are as much a part of the health/social care continuum, as essential a component in 'comprehensive' care, as the acute care hospital, the rehabilitation center, or the various 'extended' institutional facilities which make up such a large part of the health care resources in the United States."

If that is what day care centers can avoid, what exactly can they achieve? Ms. Trager provides this broad description:

"Adult day centers provide for group care during the day in a safe, comfortable environment in which selected treatment, personal care services, good food, and social opportunity are offered by professional and paraprofessional staff which has both special training for, and special interest in, the objectives of this method of care and in the individuals to whom it is adapted. A day center for health and related services to adults who have physical and other limitations utilizes the individual's 'own bed' and sustains his relationship to the environment which he considers his home. That home may be with a spouse, with members of his family, with friends or in a group-living arrangement, in a place where he is living alone and, in rarer instances, in a facility

which utilizes the center to provide for transition from an institution to community living."

Ms. Trager performs an important function by reporting on findings thus far of several studies intended to test cost effectiveness, feasibility, and clarification of varying purposes of day health centers. But she also suggests areas for more intensive inspection. And she points out that Federal interest is not only appropriate, but mandatory. Multiple funding is the rule in adult day care, which draws from certain titles of the Older Americans Act for some funding, from title XX of the Social Security Act, and (occasionally and partially) from Medicare and Medicaid. Even revenue sharing and the old model cities program provided support in scattered instances.

It is small wonder that Ms. Trager regards fragmentation of funding sources as one of the most serious handicaps to establishment of centers and to a real exploration of the total contribution that such centers can make. Her other recommendations call for greater testing and demonstration as among those reasonable and manageable steps which can apply and further analyze the adult day health concept.

In addition, Ms. Trager discusses the British "day hospital" model, which provides a full range of treatment and laboratory services for visiting patients, usually in conjunction with a hospital. As in other sections of this report, she makes helpful comparisons of efforts underway in this Nation and in Europe, where virtually all of the services mentioned in this report have been developed, many of them over long periods of time.

Among the other matters discussed in this paper is the "after-care" program provided by a New York hospital to patients who are delivered in small groups to the hospital for afternoons of therapy and social activity; the growing and potential role of senior centers and senior clubs in supporting or providing services which maintain semi-independence; the strategic and logistical problems related to "special-needs" transportation, and the relationships of all components in the "community networks," which Ms. Trager regards as critically hampered by failures in Federal policy and practice.

As to the important matter of cost effectiveness, Ms. Trager feels that a more energetic and cohesive effort should be made to obtain such information.

She also points out:

"The impact of insufficient, inadequate, or poorly organized services upon those who are particularly vulnerable to neglect does . . . measurably affect dependency, and increased dependency where it is avoidable will measurably affect dollar outlays."

In addition, poor services or no services have a clear-cut but immeasurable effect upon life satisfaction. This is no small matter, and it is of concern not only to older persons but—as Ms. Trager documents—to growing numbers of younger Americans, as well.

To Ms. Trager and those persons whose help she acknowledges, we extend our thanks for a timely and useful document. As in her earlier works, Ms. Trager has produced a statement which is encouraging in describing present successes and future possibilities, even while she

warns of the serious practical difficulties that must be overcome if we are to develop a more comprehensive, more humane, and more effective way of providing the help that is needed—where it is needed—for those who cannot live satisfactorily without it.

FRANK CHURCH, *Chairman,*
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Important data and experience concerning the day hospital was provided by Charlotte M. Hammil and Robert C. Oliver of the day hospital at Burke Rehabilitation Center in White Plains, N.Y. After care was demonstrated and described by George Vagias, RPT, and the staff of the after care program at Montefiore Hospital in New York. William Pothier, executive director of the San Francisco, Calif., Senior Center, member of the board of directors, National Council on the Aging, president, National Institute of Senior Centers, and Florence Vickery, who initiated the San Francisco center, provided extensive information on history and development. Judy LaVor, Office of Assistant Secretary for Planning and Evaluation, DHEW, provided current information concerning medicaid and home health services.

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ADULT DAY FACILITIES FOR TREATMENT, HEALTH CARE, AND RELATED SERVICES

Prepared by Brahna Trager*

PART 1

THE NEED FOR COMMUNITY SERVICES

Chronic disease and/or disability in any age group presents the affected individuals and those involved in their welfare with problems which cannot be resolved by isolated or fragmented measures. For those who must live with limitations imposed by impaired health and physical disability and for those who are intimately involved in their care and support—whether that support is economic, physical, emotional, or all three—the expectation that the traditional self-reliance and independence, which are our cultural conventions, should prevail are bound to be unrealistic.

Changes in the structure of the family and the presence in our population of large numbers of individuals who are limited in their capacity for self-care or for full participation in community life create responsibilities which extend beyond the ability of the individual or the family. The need for services which are required for the health and safety of population groups becomes the responsibility of the community in the largest sense of the word.

> During 1972 an estimated 12.7 percent of the population, or 23,868,000 persons, in the civilian noninstitutionalized population, were reported to be limited to some extent in activity due to chronic disease or impairment. About 3 percent of the population, or 6,031,000 persons, were unable to carry on their major activity (working, keeping house, going to school). About 6.6 percent were limited in the amount or kind of major activity, and 3.1 percent, or 6,279,000 persons, were limited in other activities such as recreational, church, or civic activities. Over the 15 years of the survey, the percentages of the population in each degree of activity limitation have been quite stable. As age increases and income decreases, the proportions of persons with limitations of activity and mobility rose regardless of sex or race. This information is important in estimating the present and future population in need of long-term care. (App. 1, p. 45.)

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Youth, or relative youth, does not provide immunity either from disability or from the risks which disability combined with poverty impose. In the childhood population significant numbers of children are in need of long-term care (as of 1972 over 1 million children under the age of 17) and in the working age population almost 3 million persons are unable to work because of major physical disability and 8 million persons are limited in the amount and kind of work they are able to undertake because of disability. (App. 1, p. 45.)

Along a scale in which multiples of personal distress and economic pressures increase those in the older age group suffer disproportionately when disability and/or chronic disease is a central problem and when economic and personal deprivation call for resources which require a broader base than that which the individual or the family are able to provide. The blessings of the increased longevity which a generally higher standard of living has produced in industrialized societies have not been unmixed. For those in the older age range who are chronically ill and/or disabled; for those in these groups who are also economically deprived, neglect, isolation, the prospect of years spent in an indifferent environment offer few rewards.

More than 4 million people in the noninstitutionalized population over the age of 65 are limited in the amount or kind of major activity they are able to undertake and more than 3 million are unable to carry on major activity.

> The severely disabled especially showed a positive relationship of functional disability to age. (App. 1, p. 45.)

A study of the disabled population under age 65 presents a situation in which "three-fourths of those in the group (of severely disabled) aged 55 to 64 were dependent on others for self-care and mobility." [1]

Economics in all age groups, but particularly for older persons, is a major factor in disability and dependency. The effects of poverty on both the prevention of disability, the potential for rehabilitation by means of adequate environment, decent food, good medical care, and the supplementary supports necessary to achieve these objectives have been subjectively documented repeatedly. Statistical evidence as well indicates that approximately five times as many individuals over age 65 are unable to carry on major activity in income ranges of $3,000 or less as those whose incomes are in the $10,000 to $15,000 range; and major disability occurs in decreasing proportion to increasing income. (App. 1, p. 45.)

The present challenge is one which places, upon planners and organizers of facilities and services, and upon public and private funding sources, the necessity to provide for community based ambulatory treatment, rehabilitative and compensatory supports by means of a multifaceted community-based approach in order to assure to disabled members of the population an equitable share of that societal concern which is the basis of all civilized cultures.

Isolated examples of resources and services geared to the long-term needs of high-risk members of the population have been demonstrated

[1] Allan, Kathryn and Cinsky, Mildred E., "General Characteristics of the Disabled Population. "Social Security Bulletin, August 1972. U.S. Department of Health, Education, and Welfare, Social Security Administration, DHEW Pub. No. (SSA) 73-11700, p. 8.

in the United States; the needed comprehensive network of services has not, either in fact or as public policy, yet been developed.

The examples of noninstitutional services which provide treatment, health supervision, safe maintenance, social opportunity, and mobility for those whose need for such services may extend over long periods or over a lifetime are described in this report, along with some indication of their potential usefulness in such a network.

Major emphasis is placed upon older age groups in the services described. Planning for these groups has become a central concern because of rising costs in existing approaches to care, and because growth in this age range points to a pressing need for rational planning. The same need exists in large numbers of younger persons—adults, children, and infants for whom neglect carries the same implications. (App. 1, p. 45.)

STILL AT EARLY STAGES IN UNITED STATES

Many of the services described are new only in the United States, although in some instances they have been planned and demonstrated here with considerable sophistication and imagination. The comparative numerical count and population coverage are small here, however. In other industrialized countries which still have their roots deeply imbedded in concern for the protection of family and community relationships the deemphasis on institutional approaches and the development of community services probably represent a continuity of cultural understanding of, and interest in, the preservation of these aspects of individual life as much as they represent the search for economical solutions to a growing population need for long-term care resources. Community efforts have, in other countries, been directed toward the replication of what may previously have existed for the individual: the home, as a natural base which supports personal identity; the nuclear and extended family (now rapidly disappearing); participation in the broader aspects of social and community life. The use, in these approaches, of such a replication in a variety of organized community, individual, and group care services is thus intended to support or restore individual identity, physical, psychological, and social functioning with a view to maintaining a humanistic social ideology in public policy—but with an equally important emphasis upon economics—upon approaches to prevent or delay total dependency in a growing section of the population—and to avoid institutional approaches—thus reducing the need for patterns of care which become increasingly costly to create and increasingly difficult to support and maintain decently.

The social ideology upon which such approaches are based also exists in the United States, confused, perhaps, by an unrealistic understanding of what is happening to family resources which in the past have been judged on the basis of initiative and foresight; and perhaps even more by an overriding interest in efficiency and an almost ingrained disdain for obsolescence of all kinds. Institutional care may be seen as an "efficient" method of care, and decreased individual productivity, real or imagined, as a form of human obsolescence. On the positive side of the American culture there coexists a very real sense of societal responsibility for the weak and the helpless, and a real interest in the extension of the talent for efficiency to prompt recognition of what, in business or in care, has ceased to function effectively as a method and has therefore become uneconomical.

QUESTIONS ABOUT "ALTERNATIVES"

The concept of "alternatives to institutional care" which has become so common in all discussions, research, planning, and in attempts toward program development is perhaps an expression both of this sense of social responsibility for a numerically growing population in present or potential need, and an increased recognition that economic considerations will become increasingly important in meeting this need.

This use of the term "alternatives to institutional care" to describe a relatively small number of community approaches is unfortunate since it seems to imply either/or solutions with, more often than not, an implied rationale based entirely on economic considerations. In fact, what could emerge from sensible community development might be a combination which represents personal choice—appropriateness and economy—in the long run. It may be impossible to demonstrate substantial cost savings during the initial developmental period of such new approaches; it is demonstrably impossible to compare the cost of one method of care with another which is totally or even partially dissimilar, or of a different level of quality; it is difficult to compare the cost of an hour or a day or a week of a given method of care with one which spreads such costs over a month or a year. The use of the term "alternatives to institutional care," therefore, appears to be an attempt to express the search for services which make the combination—personal choice-appropriateness-economy possible and this does not exclude the use of the long- or short-term institution; it represents an *addition* of care components which allows for greater dilution in some approaches and greater concentration in others—*with appropriateness as the decisive factor.*

PART 2

"NEW"[2] APPROACHES IN THE UNITED STATES

The programs which are described here represent a variety of community approaches: "After-care"; the "day hospital"; "adult day care centers" (variously labeled by providers); "socialization and nutrition centers"; and "senior group centers." Related to these are elements in a "community network" which either supplement, enable, or support them or which they, in turn, supplement, enable, or support: "Home health services," "meals-on-wheels," "special needs," transportation, and related community services focused on socialization and surveillance, assistance in the location of appropriate services, education and information for those in need concerning existing or non-existing resources.

In all of the components of community-based care described, there are both an expressed conviction that a basic community network of services is essential to the full realization of the potential of the individual components as a system of care, and the realization that effective utilization of the services will be limited when needed elements which are essential to the system are inadequate in kind and quality, limited in coverage, or unavailable.

I. "ADULT DAY HEALTH" CENTERS

Most providers of day care services for adults prefer to avoid the use of the term "adult day care" when they describe their facilities. This resistance is apparently based upon an unwillingness to allow a set of progressive, specialized, community facilities and services to become identified by planners, consumers, and in general public understanding with the "child care" center concept of which they are most certainly not a prototype. If these adult service centers are variously titled "senior health improvement program," "health care-by-the-day," "daily living center," "adult day health center," "senior health services center," it is precisely to avoid the simplistic application of the child care concept to a set of community services for adults which are as much a part of the health-social care continuum, as essential a component in "comprehensive" care, as the acute care hospital, the rehabilitation center, or the various "extended" institutional facilities which make up such a large part of the health care resources in the United States.

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[2] Virtually all of the services described have been developed in other countries. Many of them have existed over long periods of time and have been built into community health and welfare services with substantial government support. Essential linkages continue to develop between various methods: between mechanisms for early discovery, levels of care, varieties of care, and provision for coordination and movement between institutional and community or in-home services, and between long- and short-term care systems. This coordination and the availability of the essential components within the community are recognized by innovators and providers of such care in the United States as well as in systems in other countries as essential to effective long-term care.

> We object to the comparison to child care because it is inaccurate. We are not a place where people are left in safety as children are left, until someone is ready to "pick them up" again. Our services have an objective, and those who are consumers are not children. They are adults who may be limited for shorter or longer periods of time in their capacities for total self-care—but they are participants in their own care programs with everything that the term implies.[3]

There is, as a first attribute of these centers, a firmly established unwillingness to accept the stereotype equations: aging-debility-senility; or, physical fragility-limitation in self-determination—in fact, most of what the term "patient" has come to mean particularly when it is applied to older and/or disabled individuals. Most adult day health facilities refer to consumers of their services as "participants," [4] and the term is apt since the services provided involve choice and full participation in individualized care routines.

As a part of the current interest in "alternatives" to institutional care, the "day care option" is being tested with respect to cost effectiveness, to feasibility, to clarification of its various purposes to delineation of "health-related" versus other models.

Although such testing does have relevance in the United States, the concept of facilities for adult health care in community day centers did not originate in the United States. In Western European countries, and in Great Britain particularly, group care centers of various kinds developed naturally out of attitudes toward health and social care which differ substantially from those in the United States. The services are not seen as "alternatives" or "options," but rather as a basic component in community services in systems which contain very few long-term care institutions; and where there is a tendency to limit acute care institutions to very specific uses, community resources are expected to provide for a range of health and social needs, particularly for the chronically ill and disabled which, in the United States, might be considered feasible only in 24-hour institutional settings. In the resources of the local health authority, in the very extensive use of "home helps," of day care centers and "social clubs" which offer more than "socialization" and of intermittent 24-hour care for social as well as health needs, the services are considered effective as measures which are usually provided in proportion to the level of need.

A distinction which is even more marked is an attitude in planning which recognizes responsibility for long-term care and for the provision of such care in the community as possible and capable of realization. Such community services are intended to offer resources which may maintain more or less disabled individuals for very long periods of time, or for a lifetime, without necessitating radical adaptation to changes in the essential personal environment.

Early developments in adult day care, both abroad and in the United States, stressed care which could meet the needs of psychiatric patients:

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[3] Lupu, Marian. "Areawide Model Project on Aging," Pima Council on Aging, interview May 1975.

[4] Transcentury report, "Adult Day Care in the United States." A comparative study. Prepared in accordance with provisions of contract No. HRA-106-74-148, awarded by the National Center for Health Services Research, Health Resources Administration, PHS, DHEW, June 30, 1975, p. 14.

All of the well known initial programs were concerned with psychiatric care. Day care services for *geriatric* patients are believed to have started at the Crowly Road Hospital in Oxford, England, in 1958. Great Britain took a lead in expanding such services by also including younger adult patients. They set up two types of programs: that is, "Day Centres" and "Day Hospitals." A day center, according to Brocklehurst, would ". . . provide social facilities—company, a cooked meal, possibly a bath and chiropody, but none of the remedial services found in the day hospital." He further defined a day hospital as ". . . a building to which patients may come, or be brought, in the morning, where they may spend several hours in therapeutic activity and whence they return subsequently on the same day to their own homes."

In 1969, there were at least 90 day hospitals operating in the United Kingdom. Since that time, numerous other facilities of this kind have been opened in that country. In contrast, by November 1973, there were only 15 day health centers operating in the United States, exclusive of psychiatric day care centers. It is indicative of the embryonic state of systematic health care in the United States that a county such as Great Britain, with about one-quarter the population and significantly smaller economic resources, has established at least six times the number of day care facilities to improve adult health.[5]

Differences in Definition

The above description of services is not entirely accurate when it is applied to adult day health centers in the United States. Most therapeutic services described by Brocklehurst as appropriate to the "day hospital" in England are being provided in adult day health centers here. Robins indicates that the English programs are attempting to differentiate between those participants requiring a therapeutic level of care in the day hospital and those whose need is primarily for "social care":

> Admission of patients for primarily social care in day hospitals or maintaining such patients after the need for rehabilitation is past is a controversial issue in Great Britain. . . . In Brocklehurst's view, the provision of social care may be seen as an extension of the geriatric hospital service into community and preventive medicine. He strongly recommends the use of social day centers for many patients discharged from day hospitals. (App. 3, p. 63.)

In the United States, the adult day care center under its several titles has been variously defined as to purpose, function, services:

> It is a part-time living arrangement for those whose disabilities require special care in which services are adapted to individual need in terms of concentration of services or duration of services.

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[5] Mehta, Nitin H., and Mack, Christopher, "Day Care Services: An Alternative to Institutional Care," Journal of the American Geriatrics Society, vol. XXIII, No. 6, June 1975, p. 281.

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> It is a social living arrangement which enables individuals to remain in contact with others in ways which are normal and acceptable.
>
> It enables family members to work, to have relief from care responsibilities—at the same time providing for therapeutic services without the necessity for multiple treatment visits or institutionalization.[6]

These purposes express a strong emphasis on the "living arrangement" which supplements the personal environment and which concentrates social and therapeutic services in a single setting.

Another view emphasizes assessment:

> The day care setting has as one of its major functions the assessment of an individual *prior* to institutionalization; over a period of time it allows for observation: of physical and mental functioning, capacities for adaptation, attitudes and character traits, care needs, and potential capacities.
>
> It provides for necessary tests which lead to assessment of the whole person and these can be a part of a day care routine rather than in a fragmented and artificial approach found when assessment and decisions are made in the physician's office. When and if placement is made, it can then be appropriately planned.[7]

More officially, major stress is placed on the alternative features of adult day care. The Transcentury study is explicit in its definition:

> Within the last few years . . . a search for alternatives has been set as a national objective for long term care and research . . . among them is adult day care envisioned as a coordinated program of services provided in ambulatory settings.[8]

And in response to legislation providing for research which would test the validity of this method,[9] a definition has been developed to serve as a draft regulation to be used in studies of selected day care centers:

> "Day care" is a program of services provided under health leadership in an ambulatory care setting for adults who do not require 24-hour institutional care and yet, due to physical and/or mental impairment, are not capable of full-time independent living. Participants in the day care program are referred to the program by their attending physician or by some other appropriate source such as an institutional discharge planning program, a welfare agency, et cetera. The essential elements of a day care program are directed toward meeting the health maintenance and restoration needs of participants. However, there are socialization elements in the program which, by overcoming the isolation so often associ-

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[6] References cited in footnote 3.

[7] Theodore Koff, Ed. D. associate professor, P.A., project director, retirement housing administration, department of public administration, College of Business and Public Administration, University of Arizona. Interview, May 1975.

[8] Reference cited in footnote 4, introduction, p. 1.

[9] Public Law 92-603, sec. 222(1)(b)(H).

> ated with illness in the aged and disabled, are considered vital for the purposes of fostering and maintaining the maximum possible state of health and well-being.

This definition allows for a good deal of flexibility of interpretation as to the service requirements of programs to be admitted to the study:

> Procedures and agreements describing working relationships with a hospital and/or a rehabilitation center and a mental health facility (which provides inpatient or outpatient care) and other health agencies so that participants may obtain any additional health care services needed.
>
> Personnel policies that specify the educational and experience qualifications for each position category of the staff of the day care program.

And as to the definition of individuals considered eligible:

> "Impaired adult" means a chronically ill or disabled adult whose illness or disability may not require 24-hour inpatient care but which, in the absence of day care services, may precipitate admission to or prolong stay in a hospital, nursing home, or other long-term care facility.[10]

What is particularly apparent in the draft regulations and in the definitions which they contain is the stress upon institutional care—present as much in the expressed desire to avoid it as it might be if it were emphasized. The threat of increased beds, increased admissions, increased costs seems to overshadow good intentions, vis-a-vis, the positive potential of a community based system per se. The search for "alternatives" seems to narrow the field of eligibles to members of the endangered species "whose illness or disability in the absence of day care services . . . may precipitate admission . . . to an institution."[11]

Such an approach, while it may seem to solve the immediate problems of continued and costly construction and maintenance of institutional facilities and the prospect of financing care for the increasing numbers who must be maintained in them, does not focus upon the needs of those for whom treatment and care of good quality must be realistically planned. "Care of good quality" is not exclusively bound up with the avoidance of institutionalization nor is the consideration of "effectiveness" exclusively tied to considerations of cost.

Care for the population which the day center might potentially serve is primarily concerned with positive objectives: effective treatment, maximum rehabilitation, physical and social supports to supplement limited function in chronic disease and disability—services which bring into the "comprehensive care continuum" or into the "mainstream of health care" that section of the population for which the institution is not appropriate. Such care includes, as well, consideration of the possibility that within the continuum the institution may be eliminated as the sole resource for significant numbers in that population, to be replaced by services in the community which might be effective over long periods of time—for some, throughout a lifetime.

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[10] Draft regulations prepared for use with experiments in day care conducted under Public Law 92–603, sec. 222.
[11] Ibid.

"Cost effectiveness," in the sense that it represents the avoidance of long-term institutional costs, becomes a byproduct in this context and the adult day care, treatment, or health improvement center becomes an essential component in community services.

Such a positive approach places many of our long-term care objectives in a different light. "Rehabilitation" may mean many things. It may mean protection of a given state of functioning; the arrest, or at least a retardation, of physical and psychological disability. It may mean treatment which restores relatively simple but essential self-care capacities. It may also mean full restoration of those functions which enable the individual to return to independent living.

> Cost alone should not determine whether day care is a viable alternative to institutional care. More important should be the issue of the person being served and the ability to keep him a part of the community as long as possible.
>
> The self-respect of the individual who knows that at the end of the day he will be returning home is another great factor in support of day care. Institutionalization for many means the end of the line. Day care still offers hope.[12]

Interdependence of Components

Providers of care in adult day centers are unanimous concerning the interdependence of all care components. They stress the need for a "system" of care services, a "continuum" in which the effectiveness or usefulness of any single setting will depend upon the availability of other services. This, they say, is particularly true of the adult day center. The individual in need of the center services will be unable to make use of them if transportation is not available; the use of the center facilities will not be possible unless those services are supplemented by home delivered meals or home health care for those who live alone or who do not have family members capable of supplying essential care in the home; movement in and out of the center to more appropriate settings such as nutrition and socialization centers and/or the multipurpose senior center must be possible when these more closely meet the need of the consumer (such movement avoids the creation of a static group fixed in a setting which may become inappropriate to his needs) ; the availability of acute care treatment and 24-hour facilities increases the usefulness of each of the services in the continuum. Providers also stress the need in such systems for firm linkages between care components in order to coordinate and adapt services so that care, regardless of setting, may be provided in the uninterrupted sequence which the term "care continuum" implies.

A. The Adult Day Center, General Description

Broadly described, adult day centers provide for group care during the day in a safe, comfortable environment in which selected therapeutic and personal care services, good food, and social opportunity are offered by professional and paraprofessional staff which has both

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[12] Lamden, Richard S., director, Handmaker Jewish Nursing Home for the Aged of the Tucson Jewish Community Council, Tucson, Ariz.; letter, August 7, 1975.

special training for and special interest in the objectives of this method of care and in the individuals to whom it is adapted.

A day center for health and related services to adults who have physical and other limitations utilizes the individual's "own bed" and sustains his relationship to the environment which he considers his home. That home may be with a spouse; with members of his family; with friends or in a group living arrangement; in a place where he is living alone; and in rarer instances, in a facility which utilizes the center to provide for transition from an institution to community living.

Very few of the centers in the United States have been able to make use of facilities which have either been intended for such use or which have been initially well adapted to the needs of the groups they are serving. The adaptations have been made, frequently surprisingly well. Centers have been established in church halls, in unused school buildings, in gymnasiums during "off" hours, in loaned institutional space—nursing home recreation rooms, hospital waiting rooms, rented private houses, recreation centers—in fact in almost any space which could, with ingenuity, be adapted to the health and safety of participants and to the essential services which they require. Emphasis is placed, in the selection of sites, upon the availability of emergency medical care facilities and/or treatment services not available within the center itself (physical therapy, occupational and speech therapy, access to recreational therapy). When possible, they have been located in those districts which have the largest number of potential participants. An important feature of some centers has been the development of multi-site centers: centrally administered with sites strategically placed to meet the needs of various population groups, to adapt to neighborhood characteristics, and to reduce transportation time. (An advantage in specialized staff deployment is realized by bringing services to the center on an itinerant basis rather than by transporting the participant to the service.[13])

When possible toilet facilities have been restructured for wheelchairs, wheelchair ramps have been installed; some centers have adapted bathing and shower facilities; centers either prepare hot meals, rely upon delivered food or combine with available nutrition centers (title VII of the Older Americans Act). A great deal of attention is given to light, heat, and whenever possible, access to a garden or outdoor area. Much of the equipment and most of the furniture is donated or ingeniously manufactured by the staff. There is great stress, however, on a general atmosphere of cheerfulness, of comfort, of safe space which encourages movement; on treatment areas which protect privacy. Where possible outdoor space is protected and work space for the pursuit of hobbies and crafts—structured as much as possible to occupational therapy goals—is provided. The atmosphere is usually informal and relaxed with structured routines flexibly adapted to individual participant needs.

THE SERVICES

> A tendency, on average, to give appropriate care is a special strength of adult day programs . . . programs studied have

[13] San Diego Senior Adult Day Care Center; Tucson Senior Health Improvement Programs.

> developed an amazingly close match between staff health care capability and the needs of the participants. Programs with the most impaired and dependent participants have the highest ratio of health care services, especially emphasizing therapies.[14]

Conversely it might be stated that when day care programs *offer* a high ratio of health care services they will attract and be useful to larger numbers of impaired and dependent participants—the corollary being that increased numbers of participants might then be enabled to continue to use their own beds when a broad range of services is available for their use in the day center.

Services provided can be classified in general categories, each utilized in varying amounts and emphasizing aspects of care considered important in center objectives:

Health care services.—Medical, nursing, diagnostic, pharmacy, psychological, physical therapy, occupational therapy, speech therapy.

Supporting services.—Social work services, recreation, food, diet counseling—related paraprofessional services.

Supportive enabling services.—Special needs transportation, home health services, home delivered meals.

Centers differ in the amount of time and staff devoted to specific health care activities. In 10 programs studied by the Transcentury group, staff time invested in health care activities ranged from 9.4 percent to 56.6 percent—with an average of 33.4 percent.[15]

Some centers are limited because professionals are not always available to administer medication. Nonprofessional staff can "remind" but not administer; other centers organize the administration of all medications with routines parallel to those in well-run institutions.

Services described as "supportive" are related in large part to personal care, activities of daily living intended to increase the capacity for self-care, personalized counseling and health education directed toward maintaining or restoring individual security and a sense of personal identity; recreation adapted to the interests of the participants including organized crafts and the pursuit of hobbies, field excursions, and social activities. "Adult day care is much more than simply health care services. . . . Most programs have a professional trained staff member in charge of social services and some centers separate social services and recreation and have a staff member in charge of each. . . ." [16] "The cost for *supporting* health activities in most of the programs studied is higher than that for *health activities*," [17] and this should not be surprising nor should it categorize day centers as not health oriented. Distinctions concerning what is, or is not, "health related" are difficult to establish, particularly for the chronically ill, and many of the services in this category do, in fact, contribute largely to the health status of the recipient. Direct treatment in acute care institutions also utilizes a relatively small portion of the time spent in them and analysis of relative costs might support a similar conclusion.

Providers of adult day care emphasize the importance of "participant centered" services. The program of the center, its staffing pattern, the relative emphasis upon the use of professional and paraprofes-

[14] Reference cited in footnoote 4, pp. 9–10.
[15] Reference cited in footnote 4, p. 18; also table 15, appendix 2, p. 61.
[16] Reference cited in footnote 4, p. 55
[17] Reference cited in footnote 4, p. 63, table 23.

sional staff, the structure of the activities program are related to the assessment and related care plans of the individual participant. Service emphasis within the centers is structured on the concept of the "care continuum," and the needs of the community itself affect the service patterns and activities of the center—or centers—which serve the community.

When the capacity for self-care is limited even for short periods of time, this limitation is one which frequently precipitates the need for institutional care. "Personal care" services vary from center to center. Some centers are equipped to provide baths, shampoos, barbering, and most provide assisted toileting—toilet facilities equipped for wheelchairs and with adapted equipment; one at least provides laundry facilities so that participants may bring laundry to the center. The capacity of the center to provide such services determines their usefulness: Those with the broadest range of services can extend services to a more disabled group—to those who are chairbound, for example. When there is equipment for bathing and personnel trained in transfer activities, the need for personal cleanliness and comfort, and incidentally skin care, need not be factors which are decisive in making radical changes in personal living arrangements. A very simple equation which is related to the concepts of "quality-need" versus "alternatives" is the provision of those services which preserve a personal life style in an optimum environment.

Food.—Participants in day care invariably receive hot meals. Although there is considerable emphasis on sound nutrition—one center serving two different ethnic groups provides *four* special menus: Two which are ethnic "special diets"; two ethnic "normal" diets—the attitude toward food is comfortable, sociable, and relaxed. Food appears to be generally available—for breakfast if it has been missed at home or a second one is wanted; and hot lunches. Evening meals may be served or sent home in containers for participants who live alone; a multisite center provides weekend food packages; another combines with community delivered meals-on-wheels for food service and another with a nearby "nutrition and socialization" center so that there is an opportunity for a social "mix" at mealtimes. There is a conscious effort to restore and maintain normal routines with respect to a vital source of human pleasure.

Social services.—Social services, both formal and informal, are central in all day centers. Every staff member is involved in a continuing effort to provide the psychological support to every participant in order to make the utilization of the services effective. Psychological counseling, planned recreation, concern with family relationships, with housing problems are invariably a part of the services of the centers. Home visits, attention to continuity of medical care, telephone contact with participants who are absent for illness or other reasons are also considered center responsibilities. Most centers have established firm working relationships with community health and social agencies and use them effectively. "At every step in the program, interaction among participants and among staff and participants is considered an important service." [18] The emphasis, whether the center is

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[18] Reference cited in footnote 4, p. 55.

primarily "health oriented" or "socially oriented" is upon a strongly individualized approach.

Utilization.—In general, and probably because center objectives emphasize individualized care, providers tend, both in the United States and abroad, to stress the small group. The optimum size in relation to maximum participant benefit and staff utilization has not been fixed. In general the average daily attendance ranges from 11 to 47 participants with most centers caring for daily groups of 20 to 25 participants.[19] There is considerable variation in requirements for frequency of attendance, related to some extent to factors such as service objectives, transportation, living arrangements—with or without families to assist in interim care.

Eileen Lester [20] reports, both in observations on the Transcentury study and in the current series of research demonstrations on day care-homemaker services (Public Law 92–603, section 222) with respect to attendance that:

> The chronically ill and physically limited individual is not invariably capable of meeting a regular day center routine. There are mornings when, even with help, the task of getting dressed and out is too much; the transportation becomes a strain; the time spent in the center seems too long. Intercurrent illness, even minor or short term, becomes a barrier to movement out of the home and the less frequent attendance rate on the average probably reflects these facts.

She further comments that for these reasons flexible attendance requirements are important:

> The center cannot invariably be the sole effective resource except for those who are minimally limited and sometimes even not for them. For those who are more limited, center services will need additional community care services brought to the home.

Attendance at least 1 day a week is usually required; some centers encourage daily attendance. Average attendance, however, is usually 2 to 3 days a week.[21]

Duration, or length of stay, i.e., "discharge" or discontinuance of service, appears to be very flexible and long stays for center participants appear to be a general pattern. In some centers, participants have continued to participate since the inception of the services, that is, for several years. If an important criterion in assessment of the centers is consumer satisfaction this fact could support the conclusion that such centers meet a consumer need; other factors also affect length of stay, the most important being the deemphasis on rehabilitation or the "maximum usefulness" standard—one which is sometimes applied in other service organizations as a rationale or policy governing discharge from service. It is not as reliable as a standard in long-term care as it is in acute care services.

Certain of the centers provide services on days of nonattendance and weekends—offering homemaker-home health aide services, meals-

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[19] *Preliminary Analysis of Select Geriatric Day Care Programs,* prepared by the Levindale Geriatric Research Center, funded by the Division of Long-Term Care, Health Resources Administration, DHEW, June 1974, p. 41.
[20] Interview, June 1975.
[21] Reference cited in footnote 4, p. 13.

on-wheels, and telephone reassurance services during the intervals. At least one center program offers the services of a homemaker-home health aide for assistance to the participant who requires help in getting dressed and ready for the center program in the morning.

Flexibility with respect to days of attendance, supplementary services to participants at home and the "open ended" approach to the utilization of the centers over long periods of time is one of the most important attributes in planning and delivering effective long-term care services. Long-term care, by the very nature of the need, cannot be defined in terms of arbitrary time limits or arbitrary combinations of services. The "as needed" approach based upon individualized professional assessment is the key factor in the effectiveness of community services which have as their focus the most appropriate services delivered at the time when they are needed in order to avoid the use of less effective or less appropriate and more costly measures of care.

B. Variations in Current Day Center Objectives

In studies which have been made of selected day centers, there has been a tendency to divide, or describe them in terms of "models," depending in part upon whether the objectives of the center are primarily oriented to treatment, to rehabilitation, or physical restoration—the so-called "medical" model—or whether their objectives tend primarily to emphasize supervision and support—the so-called "social" model. In the Transcentury report, "Model I" has been described as a center which has "a high ratio of registered nurses and professional physical and occupational and speech therapists . . ." serving participants who have recently suffered serious illnesses and need rehabilitation care. An average of 48 percent are paralyzed to some degree. Many use wheelchairs and most are dependent in *three or more activities of daily living.*

"Model II" provides a smaller proportion of professional staff with greater use of paraprofessionals for those who "suffer the infirmities of old age and are *less apt* to be in a rehabilitative stage of chronic illness. An average of 16 percent are paralyzed to some degree, but most are dependent in fewer than *two activities of daily living* and many are independent." [22] (Emphasis supplied.)

An earlier study classifies the objectives of day centers in three ways:

> *Rehabilitation-orientation* referred to programs with a dominant service leading to rehabilitation and restoration, because the primary pathological condition of the population showed the potential for measurable improvement in functional capacities if medical and medically related therapies were provided on a regular basis.
>
> *Maintenance-orientation* referred to programs in which a dominant service objective was to enhance the ability to maintain a person in the community and increase access to recreational stimuli where the target population showed slight possibility for limited improvement in functional capacities, but current levels could be contained and unnecessary deterioration prevented if nursing and social service activities were provided on a regular basis.

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[22] Reference cited in footnote 4, p. 9.

Combined-orientation referred to those facilities which considered the dominant service objective and target population to include both of the above service goals and types of client needs.[23]

In her report on day care centers in the United States, Edith Robins notes four models of day care:

> Each . . . has certain commonalities such as phychosocial activities to improve and maintain mental health; health supervision and supportive services; nutrition services, including the noonday meal and snacks, and transportation.
>
> Distinguishing characteristics are two models related to a time limited therapeutic regimen to acutely ill patients with the ultimate goal of restoring them to independent living or to permit them to be transferred to a less intensive form of care . . . and two models which provide long-term maintenance services designed to permit the individual to remain in the home setting as long as possible. . . .
>
> The health status of the long-term patient . . . who has multiple diseases is subject to frequent change. The necessity for periodic transfer from one module of care to another can thus be anticipated. (App. 3, p. 63.)

Such distinctions become difficult to apply, given the current state of development of the adult day center in the United States. Two very important trends are prevalent in attitudes toward planning community based services for the chronically ill and disabled. One is a desire to define clearly "health related" services in order to provide medical care and treatment as a health benefit in an insurance program. The second is a growing concern for large numbers of disabled and chronically ill adults for whom life in the community becomes an impossibility when access to health care and the capacity for complete self-care are restricted because both complete mobility and certain of the activities for daily living are not continuously possible. An individual whose ambulation is somewhat restricted might well have the capacity to continue to direct his own affairs, to reach needed resources for health and medical care, to participate in community life and still be unable to manage three meals a day every day; to achieve enough mobility to have the kind of social contact and support that is essential for normal life.

The development of centers which set policies and objectives in the context of treatment and physical restoration may tend to exclude those in need of some, but not all of these services. For those who are considered candidates for supervision and socialization, there may be a tendency to ignore essential health related services. Facilities which are treatment oriented may also tend to take on institutional characteristics and to make a "patient" of the participant—an aspect of institutional care which often is counterproductive in terms of the objectives of treatment. On the other hand, major emphasis on a supervision-socialization policy excludes consideration of restoration and rehabilitation possibilities which may appear to be relatively limited but are of great importance to the participant and such facilities might take on the characteristics of current institutions which are "holding facilities" and ignore essential health needs.

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[23] Reference cited in footnote 19, p. 5.

Such distinctions and definitions also become extremely difficult when they are related to the real needs of the participants in day centers and of services currently provided in many centers. On paper, the participants appear to be a group of adults whose major characteristics seem to be that they are more or less dependent. This does not describe chairbound participants who work aggressively and painfully with intensely interested professionals and paraprofessionals to leave their wheelchairs for walkers, to leave their walkers for canes, to take their first steps without assistance, and who may ultimately walk out of doors to the garden or patio of the center. It does not describe the willing participation in a set of tedious arm and hand exercises applied for simple purposes which may either be ignored in the "social" model or overstressed in the "medical" model.

> My major objective is to make every movement useful. If I can help that woman extend her arm and grasp with her hand, I'm going to make it possible for her to extend her arm and grasp a can of beans.[24]

It does not describe the pleasure of a participant at a standing table as he makes a macramé flowerpot hanger or the total psychological restoration of a previously profoundly depressed, severely limited participant with cardiac disease as she works on a hooked rug and chats with members of the group who work with her, teaching them a skill that she has recovered.

There is as yet too little known about the potentials of the groups with which such centers should be concerned. Fluctuation in physical and psychological states have not been as carefully examined as they might be. Understanding of the influence of cultural and social expectation and of sensory stimulation upon these potentials is emerging but not yet realized. It is probable that a key factor in the success of day care facilities is the very fact that they are "day care"—that there is a certain purposefulness in the "coming to" care, and care services, and that there is, during the hours of a day spent in the center, a great deal of "care" which is a byproduct of the life activities of the day, the continuous awareness of both staff and participants that relationships are based upon mutual trust, interest, concern, and purpose. These elements have yet to be tested and evaluated adequately.

Other factors related to the practical aspects of day care "models," their organization and administration, and their position in the community are also important in the present stages of their development. Small communities, districts in larger communities, areas in which funding is limited, may find in a more flexible approach to services and objectives a better opportunity to test the needs of the population, at least at the outset, by offering a broad range of services, both "health related" and "social" models, allowing for a care continuum and the possibility of progression or movement between various concentrations of service in a single setting. It may be too early in the history of these centers to establish clear cut and potentially rigid definitions based upon what is, or is not, a "health related" or a "social" model.

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[24] Interview with Sharon Naughton, occupational therapist, Tucson Senior Health Improvement Programs, May 1975.

FACTORS AFFECTING UTILIZATION

The participant in need of the services of a day care center must rely upon those who are in the home, upon the center, or upon the community for the necessary transportation to and from the center. None of the participants is sufficiently ambulatory to come to the center without assistance; many are in wheelchairs (in some instances, 50–75 percent); others are in walkers; in "most . . . programs (partially or totally) paralyzed participants make up one-tenth to one-third of the participants." [25]

Such physical limitations and disabilities establish the need for day care. They also make participation in the day care facility impossible unless the services can become accessible. Centers which must rely on relatives, neighbors, friends, or volunteers to provide transportation cannot assure needed continuity. They must then, limit their service policies to those who have such resources or offer care only to those whose disabilities are less severe.

THE PARTICIPANTS

Age as a factor: Although most of the participants in day care programs recently studied are elderly (the average age in the centers studied is 71 with approximately one-third over the age of 80 in most of them and a surprising 7 to 10 percent over age 90 in many of them [26]), it has been stressed that it would not be "wholly accurate to view day care as a program exclusively for geriatrics. . . ." [27] The facilities, the services, the approach to care are equally well adapted to any age group when short- or long-term disability requires this pattern of care. Disability and dependency in the 40–60 age range present the same problems, often with greater limitations in resources since insurance coverage in general does not extend to long-term services even when maintenance of existing function or limited but essential restoration of function might be possible, and the social pressures are as severe (app. 1, p. 45). The current emphasis on services to the elderly is related largely to the need for ambulatory care services for the growing numbers of older persons for whom an "intermediate" community care sequence is not available—a sequence of services which fills the vacuum between total family or self care at home and long-term care in an institution.

Although they have a very real potential for services to the disabled in all age groups, centers which have been established have tended to serve those in the older age ranges, probably because funding sources have been more available for these groups. Those with a stronger emphasis upon rehabilitation and physical restoration have tended to serve a somewhat younger population; [28] a recent study indicates that "on the average, adult day care participants are about a decade younger than the 82-year average of nursing home residents." [29] There are, however, significant numbers of older participants in the center programs.

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[25] Reference cited in footnote 4, p. 18.
[26] References cited in footnote 19, p. 21 and footnote 4, p. 15.
[27] Reference cited in footnote 4, p. 14.
[28] Reference cited in footnote 19, p. 21.
[29] Reference cited in footnote 4, p. 16.

Feasibility with respect to living arrangements: Day care centers have demonstrated that such care is possible, whether the participants live alone or with families (in one of the centers studied, for example, more than 52 percent of the participants do live alone [30]) ; the Transcentury study notes that "most participants live with someone else, often a spouse." [31] With respect to the question of feasibility of day care in relation to living arrangements two comments have been made:

> Day care centers are designed to accommodate diverse community living arrangements. For this large (52 percent) proportion that lives alone, the supervised, protective setting of day care encourages a higher degree of independence. Other research conducted . . . established that day care provides an excellent arrangement for the caretaker. It reduces the constant dependency of an impaired family member when 24-hour care is the responsibility of the spouse or another family member. . . .[32]
>
> The day care population is not that different from the nursing home population. It is not so much whether the participants have families or not, as far as using day care is concerned. It is that neither the family nor the individual is always capable of knowing what the possibilities for care in the community might be before making a choice.[33]

This stress upon the usefulness of day care to those for whom it is appropriate, rather than upon those whose social, economic, or living situation impose arbitrary choices, places a heavy responsibility on the planners, the policymakers, the programers of services—particularly for disabled or chronically ill older people, who are living alone or with similarly disabled family members in the same age range. For them, the accident of a "living arrangement" may restrict options to a single choice—the institutional choice, in the absence of available community services.

Disability status: As in the nursing home poulation and the population served by home health services, chronic diseases usually in multiples of diagnostic groups are basic problems for the participants in day care, ranging from an average number of 2.0 to 4.8 per participant in the various centers studied. (App. 2, p. 58.) The presence of chronic disease, even when multiple diagnostic problems exist, is not an index of the need for any of the possible community services for individuals affected, although it may place them in a "high risk" category. Combinations of diagnostic problems occur in very large numbers of individuals, even in the older age ranges, who continue to work and to function in the ordinary routines of life. Short-term or long-term limitations in the capacity to function, which may occur as a result of chronic disease, does demand organized services, and when needed short- or long-term treatment, supplemented by essential life-supporting services, are not available the "high risk" becomes a threat to recovery and to independence.

The disability status of day care participants when it is viewed statistically is instructive in terms of what is possible in community

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[30] Reference cited in footnote 19, p. 19.
[31] Reference cited in footnote 4, p. 14.
[32] Reference cited in footnote 19, p. 19.
[33] Reference cited in footnote 24.

based services. Admission policies and program resources affect admission with respect to health status:

"Some wheelchair use occurs at every center studied"[34] (an average of 23 percent of participants); partial or total paralysis is present in 23 percent; an average of 28 percent have neurological disorders; 43 percent hypertension. Dependency because of inability to undertake activities of daily living, while this need does not have a high correlation with medical diagnosis (a fact demonstrated by large numbers of individuals in the general population who continue with their normal routines in spite of multiple medical diagnoses), is an important factor in the need for day care, as in other community services; in all of the centers,[35] dependency related to the ability to undertake activities of daily living is present in participants, with the need for both assistance by others and assistance of equipment occurring in participants in a significant number (a factor in arriving at activities of daily living scores is, as with other characteristics, affected by the capacity of the center to provide such assistance).

Financial status: Presumably such services can more readily be procured by those whose incomes make such procurement possible. Whatever the quality of such care may be, those in the upper income levels are not predominantly participants in day care services.

> Eighty percent of the entire . . . group . . . have an annual income of $2,000 or less and 98 percent have incomes under $6,000. This finding supports the . . . hypothesis that the majority being served are poor.[36]
>
> Eight of the programs (studied in a series of 10) have participant charges. Most are nominal, often only the cost of a meal. Since most of the programs serve primarily lower income elderly, there is virtually no possibility that this source could cover more than a fraction of the costs of the program.[37]

The day care participant profile: Participants in day care currently can be described in terms of several factors: They are in the older age ranges, although younger, even young individuals with similar needs, may also be served appropriately by such centers; chronic disease or situations associated with chronic disease has limited their mobility and/or self-care capacity, and their access to health care, and may also have affected the capacity of family members or those associated with them to provide total care; they may, in spite of limitations in this capacity, be capable of participating in treatment, of making the choice to remain in the community, and be capable of directing their own lives; they may be maintained in day centers for long periods of time; they may be brought to improved states of functioning; they may be restored to relatively better levels of self-care; they appear to be almost invariably poor—although there is no evidence that day centers could not profitably serve those with similar limitations whose incomes are adequate to provide for their needs.

The services provided in centers recently studied are considered appropriate to individual need although there is variation in services,

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[34] Reference cited in footnote 4, p. 18.
[35] Reference cited in footnote 4, p. 30.
[36] Reference cited in footnote 19, p. 20.
[37] Reference cited in footnote 4, p. 136.

facilities and in the kind and amount of personnel available. This variation, supported by rationalized policy with respect to program objectives, is largely affected by budgetary considerations. It is affected by related problems such as housing limitations and availability of equipment and facilities, and by the presence or absence of resources such as special needs transportation, interim home health and/or homemaker-home health aide services (since daily attendance is not the rule and may not even be the most effective pattern of care). Policy is also affected by the fact that clear definitions of the emphasis needed in center programs have not yet emerged (app. 3, p. 63); the distinctions between the several "models" required by the population at risk and the question of overlapping need; and between a rationale which separates components of service according to defined eligibility for both services and funding and one which stresses a more inclusive approach.

In general, the participant profile both in the centers studied in the United States and those providing similar services abroad presents a picture of potentially effective services to chronically ill and disabled persons, many of them with severe limitations which would make institutional care a necessity if such services were not available to them.

C. Funding Sources

Multiple funding is the rule in day care centers as in most other community services. Three titles of the Older Americans Act (III, IV, VII) have provided funds for some services in some centers through Federal, State, and local levels of government; three titles (VI and XVI and more recently XX) of the Social Security Act; Model Cities and revenue-sharing moneys have been tapped; medicare and medicaid have paid for eligible services; a variety of community organizations—United Way, in some instances private insurors—have paid for services; and in-kind and volunteer services have been utilized. Participant fees make up a relatively small proportion of revenues. (App. 2, p. 58.)

This roster of funding sources represents an overwhelming burden in terms of meeting the wide variety of title regulations, grant applications, requirements, the proliferation of paperwork, the multiple reporting and claims presentation, placed upon relatively small administrative and professional staffs. The uncertainty with respect to continuity in employment and the support of service components considered essential to quality care places pressures upon the center personnel which make the achievements of the center programs a miraculous combination of devotion, energy expenditure, and legerdemain.

PROGRAM COSTS

The per diem or per patient costs vary as widely as policies and services and are, of course, the result of this variation. Centers which are classified by the Transcentury report as "Model I," that is, those stressing "health related" or "rehabilitation" services are about twice as costly as these in "Model II," which also provide some "health related" services but with a less intensive approach or a narrower range of professional services.[38] Inclusion in costs of special needs

[38] Reference cited in footnote 4, p. 73.

transportation when it is available also affects current reporting in this study which presents a range in programs studied of approximately $11 to $33 per diem (excluding a day hospital program with higher costs).

Another report (Levindale [39]) which divides programs into three "models," one of which is a grouping which excludes therapies, placed the range at approximately $7 to $22 when therapies and special needs transportation were included. The lowest per diem range without therapies but including transportation was $3.50 to $13.90. These figures were based on a study made approximately 2 years earlier than the publication date including some centers which defined service objectives differently from those stressed by the Transcentury report.

Summary and Recommendations

The development of adult day centers as a community service is relatively new in the United States and has presented a variety of approaches affected by funding, by what has been seen as the first priority in community need and by the availability of community resources. Emphasis on treatment or rehabilitation occurs in varying degrees; "health related" services are variously interpreted as well. Virtually all centers which have been reviewed formally do, however, stress effective services which support and maintain the participant through personalized assessment, interaction in socialization, the preservation of individual identity, and attention to essential services in nutrition, hygiene, mobility, and a general approach to health oriented rather than sickness oriented services. The profile of participants in almost all centers indicates that individuals whose handicaps are severe enough to require a variety of coordinated services can be maintained in the community—many of them in age ranges and with physical and psychological limitations which might otherwise require institutional care which is not as well adapted to their needs, to their preferences and to the preferences of their families. The effectiveness of the centers in maintaining such individuals in the community for long periods of time has been demonstrated in centers recently studied, and this effectiveness has been achieved in relatively simple facilities and with efficient utilization of professional and paraprofessional staffs. Cost ranges in relation to effectiveness have not been exorbitant and it is probable that they would not be excessive in long term care even with the addition of supplementary community services which would increase utilization and enhance their potential usefulness.

The fragmentation of funding sources and in many instances funding limitations are a serious handicap to the establishment of centers and to a real exploration of what the center program could do in providing effective noninstitutional services to that section of the population which is at risk because of major chronic disease and disability.

A second handicap is the lack of clarity concerning the most effective pattern of service, and the methods by which need may be assessed and met; which groups may best be served by the various combinations of service and how such services may be most effectively developed, delivered, and related to other necessary community services.

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[39] Reference cited in footnote 19, p. 35.

Recommendations for adult day care should involve, first of all, an affirmation of public policy which supports such programs as a means of protecting the health and safety of those persons whose disabilities require the services provided in such centers. Implementation of this policy will involve an investment in furthering the development of such centers and clarifying their functions and purposes in the following ways:

—*Through a series of demonstrations adequately funded over sufficient time which will test and evaluate the various service combinations and their appropriateness to various population groups in different geographic and community settings.*
—*Through an organized approach to the development of administrative methods, program size, program organization, and program policies utilizing the expertise of those who are presently involved in delivering such services.*
—*Through research approaches focused upon utilization patterns, longitudinal studies, and projected costs in various service combinations.*
—*Through the provision of organized training opportunities in adult day care for members of the medical profession and other health professionals as well as paraprofessionals.*
—*Through the development of a rational funding pattern which will eliminate current fragmentation of funding sources and an initial approach to guidelines which may be developed as mandates to States and communities.*
—*Through the development of materials which will assist communities in the organization of such centers and interpret their function to the professions and to the public at large.*

II. THE "DAY HOSPITAL"

It is impossible to discuss the potential of the day hospital for the United States without reference to the development of such facilities in Great Britain where they originated and where they have proliferated rapidly since 1946 when the first day hospital was established in London. The British system, however, makes certain distinctions between the day hospital and the day care center which have not been applied here. In Great Britain, the day hospital is considered a substitute for inpatient care with emphasis on treatment; the day care centers "provide social facilities—company, a cooked meal, possibly a bath and chiropody, *but none of the remedial services found in the day hospital.*" (Emphasis supplied.) (App. 3, p. 63.)

Certain of the adult day health centers in the United States resemble the English day hospital to the extent that their objectives are primarily related to rehabilitation health care and treatment. Thus, the sharp distinction made in England between "day centers" and "day hospitals" is less apparent here and would more accurately describe the differences between our "health care" oriented adult day centers and the so-called social model.

Very few facilities for adult day care in the United States call themselves "day hospitals." One such facility,[40] which has designated

[40] Burke Day Hospital, White Plains, N.Y.

its services as day hospital services, has established two levels of care: the day hospital and the day care center, and makes the distinction in terms of its relative emphasis on rehabilitation, restoration and individualized treatment on the one hand, and on less concentrated services which are geared toward maintainance of function with a greater emphasis on group activity on the other. The programs which approach the day hospital concept here use admission criteria which more closely resemble those for inpatient care, place the greatest emphasis on health care services, accept more severely disabled participants and tend to serve a younger group of participants. The potential effectiveness of day hospitals in the United States probably lies in the possibility that a concentration on treatment might be undertaken without the necessity for totally altering the living situation of individuals in need of such treatment, particularly when that need extends beyond periods of acute illness.

Various estimates have been made in the United States of the percentage of time in inpatient facilities devoted to treatment services in proportion to that which is devoted to hotel aspects of inpatient care; the need for 24-hour supervision by health professionals is cited as a major reason for inpatient stay when minimal treatment services are required; the convenience for the physician also carries a good deal of weight. The facts concerning the true needs of inpatients versus the use of day-centered treatment services remain to be explored and evaluated; the English system which uses day hospitals more extensively has tended to view their usefulness primarily in terms of rehabilitation and restoration for the older patient.

The English Day Hospital

Cosin describes the English day hospital and its purposes in the following way:

> The day hospital occupies a median position in continuing community care, because it can be used by either in- or outpatients, thus providing services according to patients' changing needs and helping to maintain many patients in their own homes. It is necessary to make quadruple assessment of pathological, psychological, social and physical factors . . .; these facilities are available in the day hospital. The purpose of the day hospital is to treat . . . to retrain or teach new skills, to assist when community and family resources are not available, and to provide a more humanitarian management. . . . Sharing responsibility for the patient facilitates his return home. . . .[41]

The day hospitals function:

> 1. To treat patients . . .
> 2. To measure the rate of improvement . . .
> 3. To facilitate and assist in an active program of community care by planning responsibility for that part of the week for which relatives need to be freed . . . or for periods when community resources (home help, homemaker, health visitor, voluntary visitor or friends) are not available.

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[41] Architectural and Functional Planning for a Geriatric Day Hospital, L. Cosin, International Journal of Social Psychiatry, London, 1971, vol. 17, No. 2, pp. 133–40.

> 4. To provide a more humanitarian management . . . than is otherwise provided by neglect in the community or the profound demoralization that can follow institutionalization.[42]

A strong case is made by both Brocklehurst [43] and Cosin for substantial financial savings through the use of the patient's "own bed" which eliminates financial outlays for new construction or for replacement due to obsolescence and for reduction of total institutional inpatient days. Added to this is a reduction of morbidity and mortality [44] assumed to increase in shifts from the accustomed lifestyle to institutional living.

The British concept is positive concerning its therapeutic-preventive objectives in the use of day hospitals in long-term care and practical as well, for removing the "hotel element" and reserving therapeutic services to the hospital staff presumably involves a saving in cost, which has been estimated in 1970 as preventing inpatient admission in 8 percent of the cases, in a controlled study of patients attending day hospitals, delaying admissions in 6.7 percent of the cases and enabling earlier discharge in 11.8 percent of the patients.[45] The day hospital is also credited with expanding overall hospital capacity. The utilization of day hospital care averages 1.71 days per week per patient: "Because we reduced the number of tendencies consistent with the patients' current needs, which may change . . . a 1-day hospital place keeps three people going in the community." [46]

The emphasis is upon providing services consistent with consumer needs as compared with 24-hour day-in-day-out utilization when services are not always consistent with need.

> In a nutshell the aim is to dissociate the "hotel" element of hospital care from the therapeutic content, leaving only the latter.[47]

Distinctions: United States and the British

One of the distinctions between the British day hospital and the "health related" adult day centers in the United States is that the former are frequently annexed to an ordinary hospital and provide for a full range of treatment and laboratory services. Robins in her site visit report comments:

> In many facilities in which day hospitals are housed it is customary for the staff and the equipment of the rehabilitation department to be shared by both day hospital patients and inpatients. Moreover it is a common practice for inpatients to actively participate in the day hospital program. Not only does the opportunity to get away from the wards boost the morale of the inpatients, but for those patients who

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[42] *The Role of the Geriatric Day Hospital*, Dr. L. Cosin, M.A. (Oxon), F.R.C.S., L.R.C.P., British Council for Rehabilitation of the Disabled, Tavistock House (South), Tavistock Square, London, W.C.1.

[43] *The Geriatric Day Hospital*, J. C. Brocklehurst, M.D., F.R.C.P. (Edin.), published by King Edward's Hospital Fund for London, 1970, p. 13.

[44] Statement by Dr. Lionel Z. Cosin, clinical director, United Oxford Hospitals Geriatric Unit; and clinical director, Rivermead Unit, United Kingdom, before the Subcommittee on Long-Term Care of the Special Committee on Aging, U.S. Senate, "Trends in Long-Term Care," 92d Congress, 1st session, part 14, June 15, 1971. U.S. Government Printing Office, 62-264, pp. 1375-1379.

[45] Reference cited in footnote 43, p. 13.

[46] Reference cited in footnote 44.

[47] Reference cited in footnote 43, p. 11.

are approaching discharge, participation in the day hospital program helps to ease the transition from inpatient to outpatient status. The patient knows that he will be treated in the same place by the same therapist when he goes home. In a significant proportion of the patients this practice tends to reduce the length of inpatient stay. (App. 3, p. 63.)

The distinction between the British day hospitals and centers in the United States, whether they are treatment oriented day care centers or more closely resemble the day hospital in objectives is a more flexible approach in the United States concerning the "mix" in both admission criteria and in the socialization services which are invariably a part of the services offered here.

The British system, focusing primarily upon the relief of geriatric inpatient beds as well as upon the therapeutic values of the home as a living situation, tends to emphasize a rehabilitation approach:

> Physical rehabilitation was regarded as the most important function of the day hospital by most geriatric consultants. . . . Admission of patients for primarily social care . . . or maintaining such patients after the need for rehabilitation is past is a controversial issue in Great Britain. . . . Some consultants reluctantly accept social care as a major role for their day hospitals. They argue that, while they do not regard this as a proper function for a day hospital, if they do not provide the care, no one else will, and the end result will be the admission of more inpatients. To a small extent many day hospitals have some of these patients who require only social care. (App. 3, p. 63.)

In general, however, the level of treatment in the British day hospital is more intensive and more closely resembles inpatient care than that usually provided in adult day care centers here.

Brocklehurst describes the services in the British day hospitals:

> They . . . provide facilities for physiotherapy and occupational therapy, for medical examination and nursing treatment, and usually for various other activities, including investigation, speech therapy, dentistry, chiropody, and hairdressing.[48]

Two of the centers studied in the U.S. Transcentury report which closely resemble the British day hospital devote more time to treatment and health care than other adult day centers: More than 3 hours and more than 2 hours, of these two centers respectively, of the participant day to the provision of health care services with proportionate emphasis in the use of health professionals—nurses and therapists[49]—and correspondingly greater emphasis on health need in admission criteria.[50] Participants in these two centers rank high in wheelchair use (50 percent and 73 percent), in incidence of partial or total paralysis (53 percent and 43 percent)[51] and in incidence of stroke (47 percent and 33 percent).[52]

> In a survey of 90 geriatric day hospitals conducted in 1970 in Great Britain . . . 30 percent of the patients suffered

[48] Ibid.
[49] Reference cited in footnote 4, p. 43.
[50] Reference cited in footnote 4, p. 20.
[51] Reference cited in footnote 4, p. 19.
[52] Reference cited in footnote 4, p. 23.

from stroke, 30 percent from arthritis, 22 percent from chronic brain syndrome, and 18 percent from other diseases. (App. 3, p. 63.)

Like all day care facilities in the United States, British day hospitals stress the absence of special needs transportation as a limiting factor in utilization and a major factor in cost. A major barrier to utilization of all day care services in the United States is absent in the British system. Great stress is placed there upon flexible use of "home helps" (homemaker-home health aides) which are funded by Government and are in relatively plentiful supply as are other services provided in the home: medical and nursing services and home delivered meals. (App. 6, p. 107.)

Per diem costs in the day hospitals reviewed by the Transcentury report in the United States are higher than those in adult day care centers and reliable experience is not yet available for the costing of this pattern of care here. As a replacement for inpatient care, the approach offers interesting possibilities both for the older population and for those in other age groups whose needs are similar. The British investment in day hospitals which is substantial (there were 119 geriatric day hospitals in Great Britain in 1970) (app. 3, p. 63) would support the conclusion that they are considered cost effective. Additionally, strong arguments in support of this pattern of care have been advanced by British clinicians:

> The great difference between the usual cold intellectual study of a patient in hospital and the existential realities of the patient's problems in a family setting lies in the insufficiently considered conclusions in management and care based on diagnosis obtained from inpatient analytical procedures which would not necessarily be correct in the community setting in which the patient, with his long suffering family, have to live.
>
> Because the day hospital can be used for inpatients before discharge or for outpatients, it can adopt a median position in planning community programmes of continuing care and help to produce the most warm, empathetic and accurately tailored milieu for a given environmental position.[53]

This pattern of care is educational for the institutional staff and must rely upon the development of physicians, nurses, therapists, and paraprofessionals who are knowledgeable and interested for its effectiveness.The tendency of health professionals to separate themselves from those who are in need of long-term care has been recognized with respect to long-term institutions in the United States.[54]

Observations of staff attitudes in both adult day care centers and the day hospital indicate that the hopefulness of the approach, the difference in milieu, and perhaps most important the experience of rewarding relationships between personnel and the consumers tends to replace avoidance with real interest and to enhance recognition, both of the possibilities for care and the validity of an attitude of respect for the individual throughout the entire life cycle.

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[53] Reference cited in footnote 42.

[54] *Nursing Home Care in the United States: Failure in Public Policy*, reports 1 through 9, prepared by the Subcommittee on Long-Term Care of the Special Committee on Aging, U.S. Senate, 1975.

Summary and Recommendations

The concept of a hospital facility which provides needed therapies on a regular basis during an 8-hour day for several days each week without the necessity for 24-hour care has been considered both cost effective and effective in human terms in Great Britain where it is being substantially developed primarily for older persons, and in the United States where it has been demonstrated in a very limited way as an effective resource for both older persons and for younger persons as well. It offers possibilities for innovative treatment approaches in rehabilitation and physical and social restoration, at the same time maintaining important ties to normal living patterns. Such possibilities are particularly attractive for those whose disabilities require either intensive short-term rehabilitation or long-term treatment when the interruption of a normal lifestyle, which long institutional stays represent, are considered counterproductive therapeutically. Appropriate adaptation of treatment to the precise needs of the individual might well prove cost effective and the potential for expanding existing bed utilization is a convincing argument for further exploration of this method of care.

Recommendations for demonstration of the day hospital in the United States are similar to those made with respect to the adult day center. In addition to the funding of demonstrations in order to determine how and for whom and to what degree such facilities would be effective, the use of existing hospital facilities in institutions which do not have full occupancy offers many advantages both in making good use of what is available and in strengthening institutional ties to the community and to its resources. The joint use of staff by day hospital participants as well as the use of such facilities for transitional purposes for inpatients for whom discharge is planned, appears sound and also cost effective. Emphasis on such use by those in younger age groups in need of such services in order to reduce or delay or avoid inpatient care is as reasonable as it is for the older group. As in the adult day care centers training opportunities and methods of effective administration and management will be necessary. Because day hospital care cannot be effective unless community resources such as transportation, home health and related inhome services are available, demonstrations and experiments must necessarily take place where these are established or simultaneously developed.

III. "AFTER-CARE" [55]

> . . . the problems of the homebound ill patient persist and grow and, indeed, may have become exacerbated. The homebound patient with multiple sclerosis or a stroke or a pulmonary or cardiac cripple, is probably less likely to get a doctor to visit him at home now than a couple of decades ago. . . . Moreover, it has been estimated that from 12 to 14 percent of all elderly persons are ill or disabled and thereby homebound . . . a homebound contingent of some 1.7 million

[55] This program has been called "after-care" because of its initial applicability to post-hospital care. The potential of the services extends beyond post-hospital care to a variety of other uses.

individuals is the largest single subgroup in the geriatric population . . . a vast group of parents and grandparents disabled and in need of personal care services. Their unmet needs are obviously extensive . . . there are many hundreds of thousands under 65 who face the same problems. . . . These are the facts of life that call for new approaches. . . .[56]

The pattern of organized "after-care" has been developed out of a hospital-based home care program. In New York City, the Montefiore home care program, more than 25 years ago, initiated the delivery of coordinated health care services to the homes of patients who might otherwise have remained inpatients for protracted periods, and subsequent home health services adapted the pattern in various ways: a significant number remain hospital based; free standing programs have also been developed and have been considered effective in many communities, although the extent of these programs in terms of range, duration, and population coverage have been limited in the United States.

The "after-care" concept at Montefiore grew out of a recognition that several factors have limited the full effective use of home care for the homebound individual, among them a limited availability of primary care physicians for home visits; a shortage of skilled therapists; decreased availability of visiting nurses; and, in the urban community at least, problems of security for personnel. After-care was therefore seen as an "alternative" to home care and "instead of treating patients in their homes . . . provides services to patients, who though homebound, are well enough to be picked up, delivered to the hospital for an afternoon of therapy and social activity, and later returned to their homes."[57] In the course of a single visit all of their essential treatment and health care needs are met. Usually groups of six are selected with composition of the group based upon common treatment needs.

During the course of a 3-hour stay they receive physical, occupational, and recreational therapies, access to doctor, nurse, and social worker as well as to such other institutional facilities as library, laboratory, X-ray. . . . An interesting and well received feature has been a group social hour conducted by the social worker, which has had great impact on these isolated and lonely patients.[58]

These visits are usually scheduled once a week although more frequent visits may be planned when necessary. The resources of the home care program from which patients are selected are available as needed. Coordination of care, responsibility for treatment plans, interim home care as needed and the professional "backup" remains the responsibility of the home care service at Montefiore.

Although this has obvious advantages, it is also apparent that an after-care program need not necessarily have a home care backup service.[59]

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[56] *The Montefiore After-Care Program,* Rossman, Isidore, M.D., the Nursing Outlook, vol. 22. No. 5, May 1974, pp. 325–326.
[57] Ibid.
[58] *Alternatives to Institutional Care,* Rossman, Isidore, M.D., bulletin of the New York Academy of Medicine, second series, vol. 49, No. 12, pp. 1084–1092, December 1973.
[59] *The After Care Project: A Viable Alternative to Home Care,* Rossman, Isidore, Ph. D., M.D., Medical Care, June 1974, vol. XII, No. 6.

In this context the "viability" of after-care need not necessarily be seen in its relationship to home care nor does it necessarily remain an "alternative." It becomes a supplement to other community-based resources for treatment and care; its potential value is inherent in the combination of planned, coordinated utilization of treatment resources with a minimum of stress for the consumer.

Basic to the protection of quality is the assumption that if the back-up does not necessarily reside in the home care program, the responsibility must still be placed and when services are needed in the home they must still be available. If simple administrative arrangements could be made in such services as home health care, health maintenance organizations, and even in private practice, the after-care approach could offer consumers of these services a more rational resource. Those who are limited in mobility could then have available comprehensively planned care services either as after-care or as coordinated treatment without the necessity for multiple visits which now occurs.

An example of the difficulties encountered by consumers with limited mobility is best illustrated in a review which was recently undertaken by one of the home health programs in an urban community. Records were kept of all prescribed medical supervisory, laboratory, and related appointments. Those who were unable to meet their appointments independently or with the help of family or friends, were assigned a homemaker-home health aide to accompany them, using taxis for transportation. The consumer (and the aide, who necessarily remained with the consumer) spent an average of more than 2 hours per visit. Almost one-third of the group were in the offices of providers (private physicians, clinics) for from 2 to more than 5 hours.[60] No facilities were available for food, rest, transfer from curbside to the site of care, or for return. The cost of paraprofessional time equaled one full-time attendant for 9 months. It might have been said that members of the study group were too ill to be living at home. This was not the case, however. The struggle with public transportation or taxi, with stairs and corridors, the hours without food, are a challenge for almost any convalescent or for any individual with physical limitations. The study emphasizes the need for more sensible provider arrangements; for treatment plans arranged around the needs of the consumer rather than in the context of provider convenience.

PROBLEM: SUSTAINED PHYSICIAN CARE

A major problem for all chronically ill and/or disabled individuals is related to continuity of physician care, except within the hospital or extended care facility:

> The British or Russian practitioner is accustomed to devoting up to half of his working day to house calls. In contrast here the house call seems to be phased out in favor of other approaches. The alternatives, some of which one may regard as medical ploymanship, are to invite the patient, even if febrile, weak, or incapacitated, to come to the emergency room or to the office on the grounds that diagnostic resources are better in those settings. The fact is that many medical

[60] San Francisco Home Health Service, study of field service worker visits; medical visits by type and time required, January–September 1969.

events . . . are not generally difficult to diagnose in the home setting. . . . Perhaps the basic issue is whether one is willing to accommodate himself to the patient or insists on the reverse.[61]

Long-term inpatient institutions report that continuity in medical supervision and treatment services are difficult to achieve. "With the exception of a small minority, doctors are infrequent visitors to nursing homes," [62] and many long-term institutions have neither the equipment nor the personnel to provide for continuity of medical supervision and treatment. The more responsible institutions for group living transport patients to diagnostic and therapeutic facilities but such arrangements encounter the same problems of physical strain, uncoordination and dissatisfaction as those experienced by the individual who relies on family or friends or on the resources of the home health personnel. Adaptations in programing care must, in order to be effective, be those which place the needs of the consumer in a health-related frame of reference.

Assessment of Advantages

Advantages which are stressed by the Montefiore after-care personnel are a greater economy in the use of staff, particularly professional staff, since group care in the therapies and in counseling is possible. The group "modules" may be multiplied and during the period of each scheduled half-day virtually all treatment needs, including podiatry, delivery of prescriptions, consultant visits, and an opportunity to discuss problems in a therapeutic setting are provided. Other factors which are economically advantageous are the saving in travel-time for home care personnel and, in the urban area where the after-care program has been developed, increased safety for visiting staff is a consideration. During periods of intercurrent illness the home care program provides the needed services in the home. For consumers who are too ill to leave their homes, home care is available.

The "costing out" of the after-care program by its director pinpoints group transportation as a major cost factor, as it is in all other community programs for those whose mobility is limited. The cost of chartering a specially equipped van for each six patients brought to after-care is high even when it is compared with six solo trips by taxi which would not, for these patients, be feasible. It is less than the ambulance services which are sometimes used in British day hospitals and by institutional facilities here.

Against this major cost is a saving of physicians' time, estimated at 1½ hours saved; six-sevenths of the therapist's time, the group delivery of other needed services and the elimination of time and costs for drug delivery. This program was considered feasible as an adjunct to a home care program and as a means of supplementing that program with needed services in a hospital setting. The growth in group practice programs makes this method an interesting possibility in other patterns as well and might well provide a pattern of care for the solo practitioners whose patients are usually referred to a single

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[61] Reference cited in footnote 58, p. 536.

[62] *Nursing Home Care in the United States: Failure in Public Policy*, Supporting paper No. 6, p. XVII. Prepared by the Subcommittee on Long-Term Care of the Special Committee on Aging, U.S. Senate, September 1975.

institution for diagnostic and treatment appointments, particularly when the private practitioner can be available for planned after-care groups.

The advantages stressed in the Montefiore after-care program might well be demonstrated in arrangements where the source of medical supervision is adapted to such coordination—particularly for consumers whose physical limitations make frequent individual visits extremely difficult to plan and exact a high cost in energy. Efforts to insure continuity of care are particularly important for this group and lapses in care cannot always be attributed to the indifference of the consumer. The tendency to lapse is more often related to considerations which outweigh the value of continuity.

Comment

Administrative adjustments adapted to groups such as these might greatly ease the problems of reaching health supervision and treatment. The advantages of planned, coordinated medical care and related treatment services made available on a "one visit" basis rather than in multiple uncoordinated visits is one which offers a solution to the problem of continuity for those in nursing homes, in congregate living facilities as well as for the individual in his own home who may be receiving home care as well as for the consumer who is limited in his capacity to arrange for medical supervision and related therapeutic services independently.

IV. SENIOR GROUP PROGRAMS (SENIOR CENTERS AND SENIOR CLUBS)

The senior center movement which began in the United States more than 30 years ago was one of the first of the community-based services to develop in response to the needs of older persons. Public and private social, educational and recreation agencies, church groups, and fraternal organizations became aware early of the increased isolation of older persons, particularly those who were economically disadvantaged, limited by chronic illness, suffering from changes in living requirements because of emerging new patterns in American family life. Initially developed to provide opportunities for social activities, the senior center movement has been singularly responsive to a wide range of needs in its membership; socialization, while still a central activity, has become only one of many services offered by a substantial number of senior group centers:

> The rapid growth of senior centers over the last three decades in this country has been impressive . . . it has been a self-help grassroots, bootstrap operation from the start . . .[63]

Passage of the Older Americans Act in 1965 has, however, provided a substantial stimulus to the development of such centers. A national directory published in 1966 listed a total of 400 centers in the United States. A similar directory published in 1974 lists nearly 5,000 senior centers and clubs. As in the adult day health center movement, there is

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[63] Statement of Pothier, William, member of the Board of Directors, the National Council on the Aging; president, National Institute of Senior Centers; and director, San Francisco Senior Center, before the Select Committee on Aging, U.S. House of Representatives, Hearings on "Problems Affecting the Elderly (Senior Centers)."

some overlapping in the objectives, activities, and general terminology used by the various organized community centers for older people. Although they may be classified as clubs, senior centers, multipurpose centers, nutrition, and socialization centers (the result of title VII funding), sharp distinctions are not established. Services and activities vary considerably:

> Senior centers have developed over the past three decades to meet, initially, the recognized needs of older individuals—socially enriching experiences that help to preserve human dignity and enhance feelings of self worth—and then, as the senior center movement expanded, to assist them in continuing personal growth and maintaining viable lifestyles. Senior centers perform a unique community function; they are the focal point (or physical place) to which older persons and their families may come for services and from which services reach out to the isolated and homebound elderly. Community residents seeking information about aging find it at senior centers, where they also can tap the talent and skills of their retired citizenry. Senior centers are the visible statement of how communities value their senior citizens.[64]

The support and maintenance of normal social and community activities for older persons is as essential as it is for all age groups. Such "normal" participation, however, is conditioned by a number of factors which affect the lives of individuals who are limited by changed circumstances of living: by reduced income, by physical limitations, by restricted opportunities in work life, by narrowed opportunities for intimacy, by fear or concern that the resources necessary to maintain personal integrity will not be available. Sensitivity to these factors has been reflected in the senior center movement as it has developed over the years.

Findings From Recent Studies

Although flexibility has been evident in the variety of approaches based on local need, recent studies of senior group programs have stressed aspects of their activity which imply that definitions of purpose and function are emerging.

Criteria for subjects in studies of the senior group movement are in themselves a form of definition:

—*That they were directed to older adults;* a requirement which assures the participant that the central focus of interest is in the specific needs of his group. This might be less essential in a more inclusive social structure. Given the categorized organization of our society this emphasis has probably been the most influential in the growth of the senior group movement;

—*That they were regularly scheduled to meet at least once a week throughout the year;* a requirement which defines continuity and the assurance of continuity as a key element in the programs; and

—*That they provide some kind of educational, recreational, or social activities;* a requirement broad enough to include those serv-

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[64] Directory of Senior Centers and Clubs. A National Resource; prepared by the National Institute of Senior Centers for the Administration on Aging of the U.S. DHEW under grant No. 93-P-575441/3-01, December 1974, Introduction, p. iii.

ices and/or activities best suited to the groups served—but stressing reliable content and related to the expressed needs of the group and the community.

In the directory of such centers [65] released in January 1974, 4,870 did meet the three requirements considered basic.

Detailed findings describe the center programs more vividly.

> The majority of all the senior programs were located in cities. Though rural areas often have high percentages of older persons they have many fewer programs to meet their needs.[66]

Overall, however, there has been an increase in the range of services offered by senior group programs. "Multipurpose" centers may offer, in addition to the required minimum of three services, such activities as friendly visiting and other useful volunteer services provided by participants as a community service; transportation, and special services to the handicapped. Even before the implementation of the title VII nutrition program, approximately 487 multipurpose centers were serving a hot noon meal daily; current data is not available but it is logical to assume that senior group centers participate significantly as locations for the 4,112 congregate meal sites funded by the nutrition program.

Another development of significance has been the provision of selected health services in senior group programs. The availability of health information, health counseling and referral to health care; transportation to health care and appropriate direct health services is among the major needs of older persons, particularly those with limited incomes. Early discovery and treatment of potential or actual high-risk problems is an important advantage to the individual and his family; its importance for the community at large as a measure of morbidity control is as great. Some form of health related service is provided by more than half the senior programs—with major emphasis placed on health related information and referral, health education, transportation to health resources, health screening, in that order.[67]

Characteristics of Participants

The characteristics of those attending centers resemble in some ways those who utilize other community based resources. Generally greater use of the centers is made by those over 65 in low-income groups rather than by the more affluent. Of all of the community services stressing older consumers, the center movement is impressive in its appeal to those below age 65. The 55–65 age group, while representing a relatively small percent of participants, does provide evidence that such services can appeal to younger adults whose use of the services may offer protection in later years.[68]

Those with lower incomes are also limited in their ability to take advantage of the services by transportation problems and the location convenience of the centers.[69] Location has been largely influenced by

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[65] Ibid.

[66] Pothier, William, interview, November 1975.

[67] *Challenge for Tomorrow*, a report on research findings of a study of senior group programs. Sara B. Wagner, Ed. D., senior research associate, the National Council on Aging, Inc., present at the Western Gerontological Society Conference, San Francisco, Calif., April 28, 1975, table 8.

[68] Ibid, p. 15.

[69] Ibid, p. 14.

funding: Like so many of the adult day centers many of the senior group centers have been forced to use "found" housing, often inadequate to program needs.[70] Funding has also limited the availability of paid staff. The centers do have an impressive record in participant volunteer activity but the reliable leadership and energy in program development which full time paid staff provides is sharply limited by funding limitations. As in other community services for older persons the money problem is paramount. Reliance on multiple funding and the constant pressure to obtain funds for continuity, for population coverage, for service development to meet expressed need, for adequate housing of the center program siphons off valuable energy which should and could become an investment in the service program. Of those queried who "would like" to attend a senior group program a significantly high number were in the low-income group, 39 percent were black and problems of availability and transportation ranked among the barriers to participation.[71]

Summary and Recommendations

The senior group center movement which developed as the result of concern in public and private organizations for older persons who are isolated and frequently disadvantaged economically owes its astonishing growth as well as its flexible response to the needs of participants in large part to the energy and activity of its own membership and to the efforts of public and voluntary organizations developed nationally and at State and local levels. Its primary impetus is the recognition that it is an essential resource, a center for the support of older persons. It has provided a wide variety of services and activities but has been limited in its potential usefulness by the absence of funding for expanded geographic coverage, for adequate housing, for paid staff, and for transportation especially adapted to the needs of participants. As in all other community services, reliance upon multiple funding sources has limited the capacity of the movement to meet expressed need by potential participants who would willingly utilize such programs. The activities and services provided are more than a social luxury. They become a necessity for increasing numbers of persons who, deprived of normal participation in community life, are exposed to the risks which isolation produces—risks which involve the destructive and costly sequels to such isolation.

Recommendations for the extension and expansion of these centers have been made by program representatives:

First.—Funding[72] *of multipurpose senior centers at a minimum in each planning and service area (under title V of the Older Americans Act) from which area agencies on aging could coordinate the delivery of services. Use of community development funds primarily to meet felt need in local communities, particularly for facilities development where centers do not have adequate housing.*

Second.—Grants to assist in maintaining center activities and to subsidize expansion of activities—specifically directed toward increasing the number of multipurpose centers.

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[70] Leanse, Joyce, report to the board of directors, National Council on Aging, Sept. 28, 1975.
[71] Reference cited in footnote 67.
[72] Pothier, William, interview, November 1975.

Third.—Funding assistance to nonprofit centers as well as to those which are publicly supported with emphasis on support of centers in the community development program.

Fourth.—Support for the development of contractual arrangements between area agencies on aging and senior centers in order to insure more comprehensive community services.

Fifth.—Support for the development of standards which encourage and protect the quality of the centers and the services which they offer.[73]

V. HOME HEALTH SERVICES

The reiterated emphasis on home health services as a possible alternative to institutional care tends to exclude consideration of their potential value as a resource for the noninstitutionalized consumer who must rely on inhome services in order to use the centers and facilities described in this report. If maintenance in the community is an objective, the extension of treatment and supportive care into the home is a necessity for many of the disabled and chronically ill persons who are unable to be totally self-sustaining at home and who do not have family or others in the home capable of providing this support.

One of the multisite day centers, for example, reports that of 541 participants in day care, about one-half were also using home health services. Slightly more than half of these participants were living alone; approximately one-fourth with a spouse[74]*—and given the age range of the participants it is not likely that essential supportive care, health supervision and continuous treatment routines could be provided on days of nonattendance.*

For effective participation in noninstitutional programs it is evident that home health services are needed in order to provide the ongoing support necessary to make utilization of other community services a real possibility. When they are not available, or when they are too limited to serve as an enabling service, the "network" aspects of the community program cannot be realized and it is not possible to envisage the future development of day care, the day hospital, aftercare, nutrition and socialization centers, the senior group center, and related services without them.

"An Absence of Action"

Since the inception of medicare and medicaid, however, the spate of discussion, argument, reporting, and recommendation concerning home health services has been equaled only by the absence of action on all levels.

There has been no significant effort to test the value of the services as a reliable health resource by removing artificial barriers to their use, by stimulating population coverage and by supporting expansion of their service range in order to make them viable and thereby to demonstrate their real usefulness. Although there have been two re-

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[73] Pothier, William, interview, November 1975.

[74] Parks, Carol S., project director, Senior Health Improvement Centers, Tucson, Ariz., preliminary report, June 3, 1975.

ports by the General Accounting Office[75] recommending such stimulation, with concurrent reports from the Senate Special Committee on Aging,[76] and numerous recommendations by a wide variety of Federal, State, and local committees, commissions, and study groups, all of them recommending the development of such services as "alternatives" to institutional care; as "humane" in terms of the provision of the opportunity for choice; as "appropriate" in a wide variety of acute and long-term need situations; as a possible preventive resource which might control morbidity and thereby reduce utilization of acute and long-term care institutions—there has been no visible change with respect to increased availability of these services.

Expenditures for home health services peaked in medicaid in 1971 to 0.48 percent of total expenditures and had decreased by 1973 to 0.28 percent of total expenditures. In medicare, expenditures for home health services peaked in 1969 to 1.1 percent of total expenditures and had decreased by 1973 to 0.7 percent of total expenditures.[77] "GAO recommendations were, in short, to encourage expansion of the understanding and use of the benefits." [78] Encouragement of understanding has not, however, been an effective measure.

Factors which discourage use are more tangible. These have been described in previous Senate reports and in hearings and, more recently, in a department background paper.[79] Restricted use and development of the services are related to restrictions: The "homebound" but not "custodial" description; the nature of the services reimbursed the "posthospital" requirement; the need for "skilled", that is, treatment-nursing services; the interpretation of "part-time, intermittent" need, and limitations in the use of the homemaker-home health aide with respect to essential life supporting services; exclusion of services which are not "condition-related," and to reimbursement problems which confuse medicare parts A and B and differences and similarities and discrepancies between medicare and medicaid provisions, some real, some related to general misunderstanding:

> Providers contend that the enormous administrative overhead required to submit and collect on claims have had the effect of increasing administrative costs and the smaller agencies curtailing services. . . . Policies governing medicaid's home health program have further dampened the expansion of home health services. Medicaid's reimbursement policies permit States to set a flat rate that is unrelated to costs and charges.[80]

The situation with respect to expansion of home health services remains essentially the same, or perhaps somewhat less encouraging, than it was 5 years ago:

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[75] Study of Health Facilities Construction Costs, enclosure C, report to the Congress by the Comptroller General of the United States, 1973; "Home Health Care Benefits Under Medicare and Medicaid, July 1974."

[76] *Home Health Services in the United States*, a report to the Special Committee on Aging, U.S. Senate, April 1972: *Home Health Services in the United States, A Working Paper on Current Status*, July 1973.

[77] Callender, Marie, and LaVor, Judy, Home Health Care Developments, Problems and Potential, Office of Social Services and Human Development, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health, Education, and Welfare, app. 2, table III.

[78] Ibid, Introduction.

[79] Ibid, p. 47.

[80] Ibid, p. 27.

The problem of availability of home health services, and the benefit provisions under medicare and medicaid have a circular cause-effect relationship. There is a maldistribution of certified home health agenices (54 percent of the Nation's counties have no certified home health agency) to provide covered services under medicare and medicaid. Of the 46 percent of the counties covered, the coverage may not include the entire county. This lack of coverage is primarily because these certified agencies are one- or two-nurse agencies and cannot cover the entire area. Counties without certified agencies (the 54 percent) are primarily rural. Medicare and medicaid were expected in 1965 to produce the needed support, but it is agreed that their increasingly restrictive benefit interpretations slowed and then stopped the expansion of home health agencies. Most of the private insurance plans offering home health benefits adhere to the medicare provider standards. Thus, the benefit is not universally available and it is argued that the services and the number of providers has dropped since 1971 after the initial rise from 1966 to 1971. It is further argued that the administrative complexities of medicare and medicaid, and the small tradeoff in numbers of clients, have encouraged providers to stay out of the programs.

The number of home health agencies grew from 1,850 to 2,350—a growth rate of slightly over 20 percent—from 1966 to 1970.

In 1972 there were approximately 2,222 and by 1974 2,248 home health agencies—a substantial drop in growth rate.

Number of participating home health agencies, 1966–1974; all areas:

Year:	*Number*
1966	1,850
1967	2,111
1968	2,164
1969	2,209
1970	2,350
1971	2,284
1972	2,222
1973	2,211
1974	[81] 2,248

The value of noninstitutional community services has been recognized in other countries; along with day care, which relies on inhome supports, the Callender-La-Vor paper comments: [82]

> Forty-seven foreign countries provided constant attendance allowances for both work-related and nonwork-related disability. The allowances are payable under the disability provisions of old-age, survivors, and invalidity insurance programs. Seventy-six nations provide the allowances on their workers' compensation programs. The major developments

[81] Ibid., p. 28.
[82] Ibid., pp. 45–46.

have occurred since 1961, and are generally meant to provide in-home services when voluntary services are not available, or to offset rising costs of institutional care.[83] The criterion for the allowance is invalidity, regardless of cause, and the need for constant attendance. The allowance may provide for a friend or family member to stay home to care for the beneficiary, or may be used to purchase services outside.

In addition to the allowances provided through invalidity insurance and workers' compensation, most industrialized nations (except the United States) provide both home health and home help services. The home help services are designed to assist disabled and handicapped persons with various chores and food activities. The services are viewed as a means of keeping people independently at home and out of high-priced institutions. Voluntary as well as official governmental agencies provide home help services and are usually paid for out of public funds. These funds may be health programs, disability and social insurance, or social services.

The uncertainty concerning potential costs if viable home health services were to be developed is frequently cited as an obstacle to their development, along with difficulties encountered in comparing home health costs with institutional costs. A sensible approach might be the analysis of those programs which provide a broad range of services, or which, even to a limited extent, extend their services to the long-term consumer in order to determine costs over a period of time rather than in the framework of the present acute care-episodic-unit-cost estimates. Cost studies and utilization projections should not be insurmountable and, while frightening enough, the cost problem has not yet stemmed the tide in the institutional construction-utilization areas of the health care system.

The Major Obstacle

The major obstacle in home health services development appears to be more accurately described by the HIBAC report:

> Despite the demonstrated value of home health services, priority continues to be given by third-party payors and current legislation to the present institutionally oriented system of health care.[84]

This tendency or characteristic in the planning of care services will, if continued, affect not only expenditures—it will limit innovative and creative development in other noninstitutional approaches as well and will continue to offer to a growing segment of our population a sad choice—either the institution or possible isolation and neglect at home.

Recommendations made by HIBAC and by the Special Committee on Aging in previous reports have yet to be implemented. They include development of broad range home health services; expanded population coverage; manpower training, and access provisions which are rational in order to encourage expansion of understanding and appropriate use of the services.

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[83] Social Security Bulletin, "Constant Attendance Allowances for Nonwork-Related Disability," November 1974.

[84] Report from the Health Insurance Benefits Advisory Council, on Home Health Care. September, 1974.

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VI. "SPECIAL NEEDS" TRANSPORTATION

Limited mobility is a major obstacle in almost every aspect of daily life. The loss of the ability to walk, to get in and out of a bus, to move about freely, which most people take for granted is an imprisoning handicap. Access to treatment, to recreation, to the pursuit of personal interests is destroyed, and the simplest undertakings constitute an overwhelming problem requiring elaborate and frustrating planning and effort which discourage the attempt. In all of the centers and facilities, the availabilty of transportation—for the semiambulatory, for the frail and for those who are wheelchair-bound—is stressed as a key factor in the success of the program.

It is also a major cost factor. One of the centers reports that almost one-half of the daily cost is invested in contracted "special needs" transportation. A multisite center reports that it is unable to fund such transportation and must limit acceptance to those participants who have family or friends able to provide transportation. Centers which purchase their own buses emphasize the cost of purchase and maintenance and the cost of idle periods when the transportation personnel "have nothing to do."

Limited access is reported as a major obstacle by the senior group centers. Home health services report that both the cost and the time spent in planning for or providing assisted transportation to medical and other health care resources are a serious problem, since medical supervision in the home is a rare occurrence. Many of the day centers contract with "for-profit" commercial transportation companies with a high cost-plus-profit charge—particularly for chair-bound participants and this is a cost which siphons off a sizable proportion of limited funds.

> Transportation is the "biggest problem" . . . It is troublesome for all day care programs . . . It is probably essential . . . Where it wasn't provided, staff members often had to use their personal cars to provide it on an *ad hoc* basis. Some participants were probably left out of the program for lack of transportation.[85]

"Special needs" transportation is transportation specifically designed for handicapped individuals; usually minibuses equipped with wheelchair hoists and stabilizing locks; optimally with specially trained staff accustomed to transfer activities and sensitive to the needs and fears of the disabled or fragile individual.

The Tucson Experience

One community has faced this need and solved it sensibly. The city of Tucson, which offers a multisite day care program, an extensive senior group program, a multisite nutrition and socialization program, a mobile meals program, and home health services has integrated "special needs" transportation into its public transportation system. It considers all transportation a public utility:

> The handicapped have as much right to public transportation services as any other member of the population . . . if

[85] Reference cited in footnote 4, p. 56.

the city will handle this type of transportation for everybody who has special needs it will be a lot less costly to Government.[86]

(Government cost in this context is intended to mean the overall cost—not just a narrow cost concern in a single community.) It owns 24 specially equipped buses, employs well trained drivers described as "orderlies on wheels," who are capable of meeting emergencies. It operates the system 5 days each week from 7 o'clock in the morning to 10 o'clock at night, serves "low-income" handicapped persons, providing door-to-door or "care-to-care" transportation, emphasizing health-related need, although a part of its services meet recreational needs as well (center outings and picnics are served) and offers individual shopping service in the evenings and on Saturdays.

Approximately 1,179 to 1,765 rides are provided each month, most of them to clinics, physicians' offices, hospitals, and the community center programs. In May of 1975, about 1,000 handicapped individuals were provided special needs transportation—85 percent of them aged, 30 percent requiring transportation for medical reasons. Center participants are regularly served and the relationship between drivers and participants is striking—friendship, concern, understanding, and trust are evident. Both wheelchair and frail ambulatory or semi-ambulatory persons are served at a cost to the community of about $500,000 a year (1975).[87]

The service is in addition to the community's free transportation program for the elderly and low-income groups able to use the regular public transportation facilities. The average cost per ride is lower than taxi service or commercial special needs transportation, and while this has been a subject of concern in some quarters the rationale is sound. Consumers of this service are being provided tax supported health services usually nonprofit, and the addition of transportation to the cost of care on a nonprofit basis as well, is a sensible approach, leaving aside the question of the rights of individuals to public transportation facilities and the injustice of discrimination against the handicapped by denying them this access.

The addition of mobility—of the means of moving out of the home and into the community—restores more than the "right" to a public facility. It reduces or eliminates many of the destructive problems which ultimately affect the individual and the community: Limited access to care, services and social life creates new problems and new problems trouble the conscience of the community; they involve increased costs as well.

A public policy with associated funding which supports such transportation would not, as in other services, be supporting an "innovative" or "demonstration" approach. It would restore equity in public service to a group which has been deprived.

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[86] Interview with Carl W. Anderson, special needs transportation superintendent, department of transportation, city of Tucson, May 1975.
[87] Ibid.

PART 3

THE COMMUNITY NETWORK

The interdependence of community service components for effective, total quality must be self-evident. The absence of reliable transportation services cuts off access to the services for those who are most in need. The absence of health supervision and essential supports in activities of daily living in the home makes utilization of out-of-home center services impossible. Inadequate income and poor housing destroy the value of even the highest quality in center services. Unless there is geographic coverage and efficient organization and coordination of the services, they become unusable. Unless those who need any one or all of the services are aware that they exist and are enabled to make appropriate use of them, they become elite symbols of community intention rather than examples of action-oriented community efforts to control morbidity and humanize the existence of population groups which have been variously disadvantaged and ignored.

In discussing day care, Theodore Koff emphasized the key to effectiveness in all of the services:

> The primary essential is that [they] be a part of a *sequence* of services so that the individual can move in and out of the various service settings. . . . The extent to which there is a community support system which insures appropriate choice; awareness of health needs; central intake; coordination in planning and placement; transportation, and other such services, insures the success of each section of the sequence . . . the centers are a *part* of a system; they are not the *entire* system. Their use must be very flexible, depending on community perception of need. There is no single approach but the principles and standards must provide for quality—in professional services, in training—and for flexibility—for movement *out* as well as in.[88]

In its report on the planning and organization of geriatric services, a World Health Organization expert committee formulates the aims of health care for the elderly and aged in the following way:

> The spectrum of services:
>
> (1) To sustain them in independence, comfort, and contentment in their own homes, and when independence begins to wane, to support them by all necessary means for as long as possible;
>
> (2) To offer alternative residential accommodation to those

[88] Koff, Theodore H., Ed. D., associate professor, retirement housing administration, department of public administration, University of Arizona, interview, May 1975, Tucson, Ariz.

who by reason of infirmity, lack of a proper home, or other circumstances are in need of care and attention;

(3) To provide hospital accommodation for those who by reason of physical or mental ill health are in need of full medical assessment, therapy, rehabilitation, or long-term skilled medical and/or nursing care.[89]

The community network which encompasses the services described in this report (but does not exclude related community resources) is directed toward the first of these aims and stresses organized services which are the "necessary means" essential for life in the home and community for vulnerable high-risk groups.

COST

The projection of cost for the population which might benefit from the services and programs described in this report could not at present be made with any degree of precision. Some of the services must be considered "innovative" for the United States and have not had a long enough period of trial here; for others, the effort to analyze existing data has not been made, and would, in any case, be affected by the limitations which have been imposed upon their delivery, with the result that their full usefulness has not yet been demonstrated, particularly in relation to key factors which might affect cost savings through control of morbidity and arrest of deterioration which ultimately affects total cost in long-term care. (In this sense "preventive" care should be, but generally is not, considered "health related" in our present system which inappropriately emphasizes acute care services for a population group which has a major need for long-term services.)

The use of "dollar expense" in a context which uses a simple multiplication system, that is, unit cost or per diem cost in a given program or service multiplied by estimated utilization by a group of potential consumers, is an approach which frequently does not take into account the fluctuating need in long-term care: Many consumers do not need or use all of the services all of the time; many do not need or use any single service or combination of services continuously and there may be long periods when no services or only limited services are required. Dollar figures also ignore outcomes in another context:

> . . . The outcomes or values one does consider are largely noneconomic . . . life satisfaction, independence, physical functioning, and so forth.[90]

Data provided for a research plan of a cross national comparison between selected areas in the United States and England indicate that both the percentage of expenditures in the gross national product for health services, as well as the rate of increase, are higher in the United States, although health services, and specifically services considered "innovative" in the United States, are freely available in the United Kingdom.[91] (This data is not precise concerning differences in defini-

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[89] World Health Organization, technical report series, report of a WHO expert committee, "Planning and Organization of Geriatric Services," Geneva 1974.

[90] Doherty, Neville J. G., Ph. D., and Hicks, Barbara C., MSSW, The Use of Cost Effectiveness in Geriatric Day Care, paper presented at the 27th annual scientific meeting of the Gerontological Society, Portland, Oreg., October 28–November 1, 1974. (Supported by HEW Contract #OS–73–196.)

[91] Gurland, Barry, and Zubin, Joseph, A Feasibility Study of a Cross National Comparison of the Institutional Elderly Including the Cost Effectiveness of their Long Term Care. (HEW, Office of the Assistant Secretary for Planning and Evaluation.)

tion of health services or in the quality of the services delivered.) A general approach to the question of health needs in the aging population, moreover, is emerging in the international field which provides a less stereotyped approach to the "condition" of aging and for costs and values in the social structure:

> Persons with specific chronic diseases often regard themselves as being in good health because they can independently and satisfactorily engage in their usual daily living activities. This is particularly true in old age . . .[92]
>
> While it must be admitted that many of these conditions are chronic in type and hence not amenable to complete cure, many, if not all, are capable of amelioration, some to a very considerable degree . . .[93]
>
> Pathology of many chronic diseases remains irreversible. This does not mean, however, that the physical, emotional, social, and vocational sequence of these diseases must remain irreversible . . . Experience has shown that . . . much of the undesirable sequence of chronic diseases and disabilities can be minimized, alleviated, or even eliminated. Thus, rehabilitation constitutes the essential part of so-called "tertiary prevention," in terms of preventing the development of adverse persistent effects of diseases leading to permanent disability.[94]
>
> . . . it is also true that a strong case can be made economically for rehabilitating an increasing number of older disabled people . . . Their rehabilitation often pays a maximum return on public funds invested and it always achieves social and personal gains that are beyond measurement in economic values.[95]

The impact of insufficient, inadequate or poorly organized services upon those who are particularly vulnerable to neglect does, however, measurably affect dependency, and increased dependency where it is avoidable will measurably affect dollar outlays. The interdependence between adequate health services and cost control, while it is difficult to project precisely, must be considered in all planning and dollar investment in community programs and services, in order that short-range economies do not result in long-range costs.

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[92] United Nations Department of Economic and Social Affairs, The Aging: Trends and Policies, U.N., New York, 1975, p. 90.
[93] Ibid., p. 91.
[94] Ibid., p. 93.
[95] Ibid.

APPENDIXES

Appendix 1

ISSUES IN LONG-TERM CARE FOR PERSONS DISABLED EARLY IN LIFE; BY ELIZABETH M. BOGGS,* PH. D.

(Performed through a cost-sharing arrangement with the Division of Long-Term Care, National Center for Health Service Research, Health Resources Administration, DHEW, and the Office of Long-Term Care Standards Enforcement, DHEW Region IX)

IMPACT OF AGE ON LONG-TERM CARE NEEDS

Clearly the age of an individual needing any service is a relevant factor. In social terms, impairment of function must be seen in relation to role expectations for people in our society of comparable age. For the elderly, capacity for self-care and self-direction are normative values, more so than economic productivity; for those of work age (18–65) economic self-support is highly valued, and incapacity in that dimension constitutes deviance; for a child, schooling is the indicator task, but maturation, the development of physical, intellectual and social competence, is the underlying expectation. In the early years, self-direction is not assumed, and potential impairment is therefore often masked, at least in the legal sense that minority subsumes a need for protection.

DEMOGRAPHIC FACTORS IN LONG-TERM CARE

The National Center for Vital Statistics, through its household interview surveys of the noninstitutionalized civilian population finds that about one person in eight of the population at large has an activity limitation due to a chronic condition; of these about three-fourths (9.3 percent of the population or about 19 million people) are limited in their major activity. Major activity refers to ability to work, keep house, or engage in school or preschool activities. Of these persons with major activity limitations only 7½ million, or less than 40 percent are age 65 or over. Even when these figures are combined with the population of institutions housing long-term residents, age balance is not reversed. Moreover, there is reason to believe that the household interview technique under-enumerates younger people with mental handicaps who are outside of institutions. Program data (such as social security, disability allowances) consistently turn up mental retardation (in children and young adults) and mental illness

*Addenda to final report of task force (June 1975), Institutes on Health Care and Health Care Delivery, "Human Factors in Long-Term Care," National Conference on Social Welfare, San Francisco, Calif., May 1975.

in young and young middle-aged adults as a primary cause disability, even among the noninstitutionalized, although such is not reflected in National Center for Vital Statistics data.

The last decade has seen a spectacular increase in nursing home populations and a spectacular but not comparable decrease in mental hospital population. Partly as a result, it is difficult to assemble data, even on the institutional populations, which clearly describe comparable population bases. It appears, however, that in the population at large there are approximately 1.7 million persons in long-term institutional care because of mental or physical handicaps of whom about 700,000 are under age 65. The latter figure includes at least 150,000 children.

Long-Term Care Needs of the Newborn

Although estimates vary, 5 percent is a substantiable figure for "significant" abnormalities present at birth in liveborn infants. (Some authorities go as high as 10 percent.) Although mortality by age 5 is about 50 percent, it is offset, statistically, by the identification process which continues through the preschool and early school years. It is important to note that among those with predictably fatal disorders, the needs for sustained medical and social support for both patients and families is not dissimilar to those among the very old. Indeed the thanatologist, Dr. Elisabeth Kubler-Ross, has devoted much of her time to the study of dying children and their needs.

For infants with major birth defects who survive beyond age 5, the prognosis is most likely for long-term care reaching at least into early adulthood. Among the specific conditions with long-term care implications for which prevalence is increasing (due to increased survivorship) are: spina bifida (3 per 1,000), Down's syndrome (present in 1 out of 600 live births but frequently not immediately identified), hydrocephalus, and cardiac malformations (about 2 and 4 per 1,000 respectively). Mental retardation is a frequent concomitant of all these conditions.

Other important conditions calling for long-term care beginning in infancy are cerebral palsy, epilepsy, and autism. Prevalence of cerebral palsy in childhood is now estimated at about 0.5 percent. Manifestation of a tendency to recurring seizures can occur at any age but, usually begins in childhood; in 30 percent of all cases, epilepsy first appears in those under 5.

Long-Term Care Needs in Childhood and Youth

The National Center for Vital Statistics data on noninstitutionalized children identify over 1 million under 17, or about 1.6 percent, with major activity limitation. Of these one in eight (0.2 percent of child population) is "unable to carry on major activity," i.e., go to school. These figures must be regarded as conservative indicators of the long-term care needs of the child population inasmuch as there are over 3 million children actually enrolled in school programs for the education of the handicapped which are themselves "sustained" services. If one excludes those children classed as "speech impaired" (a relatively transitory disorder, as a rule) there remains over 1½ million children actually identified as chronically impaired in the "major

activity" of their age group. Of these over half are mentally retarded. Moreover, State vocational rehabilitation agencies annually accept over 100,000 youths (under 21) about three-fourths of whom are "rehabilitated" (i.e., prepared for gainful employment). Such youth are, by definition, "impaired" in their major activity, i.e., work. Again, mental retardation and mental illness are major contributors to the total, with orthopedic and sensory handicaps also significantly represented. Although only one-fourth of those accepted are not "successfully rehabilitated"—i.e., prepared for appropriate gainful activity, it is increasingly recognized that even those who are placed in employment are in many cases in need of continuing supportive service—i.e., long-term care, within the Brody* definition.

Adults of Working Age at Risk for Long-Term Care

The National Center for Vital Statistics' "limitation in major activity" classes include 2.7 million persons of working age who are unable to work in addition to over 8 million whose ability to work is limited in kind or amount as of 1972. Persons over 44 predominated in both groups, but more so in the totally disabled segment. These figures can be compared with program data from the Social Security Administration, which, in 1974, was paying current benefits to 2.6 million adults age 18 to 64 who were severely disabled to the extent that they were "unable to engage in substantial gainful employment." Of these, 1.8 million were disabled workers (mostly men) currently under 62 and 328,000 were adults who had been disabled in and since childhood. In addition some 80,000 disabled widows and widowers over 50 received benefits under a special clause. This grand total of nearly 2.7 million individually identified beneficiaries includes some who are in institutions but excludes disabled individuals not covered by social security such as certain government employees, railroad workers, housewives, and others without an extended earnings record in covered employment.

Annual data on the characteristics of these disabled persons at the time first found eligible for social security benefits are relevant. Among workers who became disabled prior to age 40, schizophrenia was the leading diagnosis; after that age, heart disease takes the lead in all age groups, with schizophrenia in second place, gradually giving way to emphysema and arthritis in those over 55.

By contrast, in the smaller group representing those whose disabilities originated before age 18, mental retardation is the major cause, followed by cerebral palsy, mental illness, and epilepsy.

Impact of Age at Onset of Disability

Although the age of a person at the time service is needed and received is an important determinant of the social as well as medical need, there are, because of the age-related social and economic roles and expectations of our society, equally important effects attributable to past and prospective duration and age at onset. For example, although the 11 percent or so of nursing home residents who are under 65 are on the

*Brody, Elaine M., "Long-Term Care: The Decisionmaking Process," in "Human Factors in Long-Term Care," Institutes on Health and Health Care Delivery, National Conference on Social Welfare, San Francisco, Calif., May 1975.

whole less impaired than older residents, their average length of stay is longer. There are, moreover, cumulative effects both direct and indirect, for those whose disability originates early. For the young adult, upward social and economic mobility is denied, often soon after he or she has assumed new family responsibilities and roles. Multiple sclerosis typically creates such problems. Tremendous emotional adjustments to revised aspirations at this age may be accompanied by intense indignation.

For the person disabled in early childhood, there is an even more fundamental deprivation, since normal growth and development may be significantly suppressed. With it the entire life experience becomes atypical. Not to have experienced normality (in vision, hearing, intellectual functioning, social relationships, or mobility) sets the affected individual apart from peers, and even from those with like disabilities or later origin, as is the case with the congenitally deaf or blind. Moreover, the seriously developmentally disabled person is, even with the best available programing, unlikely to achieve the economic entitlements and family status which are taken for granted by and for those who remain active until their declining years.

This is evidenced in a variety of ways. Persons severely disabled in childhood are less likely to be married during the period of adult disability than are persons who become disabled after marrying, and are thus more likely to be dependent for social, if not economic, support on older family members (parents), who themselves are becoming more vulnerable. Among identified noninstitutionalized adults (age 18 through 64) who were severely disabled before age 18, 48 percent were found to be "functionally dependent" as compared with 27 percent of those with later onset. Among members of the same age group in mental institutions for whom age at onset was known, 47 percent had been disabled since childhood. Even among those over 65 in the same institutions, 8 percent had been disabled prior to age 18.

Among adults receiving disability assistance in 1970, and for whom age-at-onset data was reported, more than 30 percent were disabled before maturity; few of these recipients were in institutions. This figure is likely to be increased when data become available on disabled recipients of supplemental security income under the federalized program which went into effect in January 1974.

These figures strongly suggest that disability originating early in childhood is a significant component of all adult disability. However, they are not entirely consistent with the results of the survey of noninstitutionalized disabled adults conducted in 1966 by the Social Security Administration. That survey found only one out of six severely disabled persons to have experienced onset in childhood. Again the survey method appears to have resulted in under-representation of the mentally handicapped. The contribution of childhood disability to adult disability probably lies between one-sixth and one-third.

Economic Factors

All data point to a greater prevalence of disability among low income people. The differences are more pronounced in the working years, since during this period disability is a cause as well as an effect of marginal economic status. Again age-at-onset of disability differentiates among members of the same age cohort. Those disabled in child-

hood do not have the same compensations as disabled workers with a history of participation in the work force; in addition, as just mentioned, they are less likely to be married and thus do not have the support of an able bodied spouse. At the same time half a million AFDC families have one incapacitated parent. There are 37,000 families with young children in which both parents are disabled.

Berkowitz has pointed out that public transfer programs are more likely to replace adequately income losses due to disability which is not severe than to replace the losses of those who experience severe disability during the years which are usually income producing. The entire family unit is affected by a reduction in the standard of living.

Berkowitz has also studied trends in the economics of long-term care as part of the total costs of disability. Counting the costs of income maintenance or replacement transfers and medical costs, he estimates the 1967 losses at $15 billion and the projected 1990 rate as $170 billion, of which somewhat more than half is attributed to medical costs. He does not estimate social service costs. The rate of growth of long-term costs thus estimated will exceed the rate of growth of the GNP and also the growth in costs of short-term disability. These projections do not include costs of long-term care of the elderly. They also exclude dollar data reflective of the "human factors" implicit in the impact on dependents and survivors of the premature disability and death of an adult of working age, although Berkowitz also made estimates of these effects as well.

Program Implications of Early "Onset of Disability"

Clearly "services integration" for disabled children reaches beyond the medical-social continuum to involve education as a major component. Moreover, the value system of our society, as well as practical considerations, leads to the emphasis on some form of work activity for the adult under 65 as a constructive objective, even when economic self-support is not feasible. The person who experiences disability before he has fully matured does have developmental potential even if expectations are altered, and his social and emotional growth must be fostered despite impediments. The service goal is to foster such growth, not merely to slow down decline.

At the present time, litigation and some legislation is leading to an extended concept of the public school responsibility to the severely handicapped. No longer is the classification of "unable to benefit from education" being permitted to justify exclusion from school programs. Courts have responded to expert opinions holding that every human being has potential for growth and change, especially during the so-called developmental period, and that it is the duty of schools to educe this potential even when major impairments are present.

The "developmental model" addresses the "whole child" in a way which requires concurrent attention to physical, social and intellectual growth.

Barriers to Effective Long-Term Care

Almost everything that Brahna Trager* says about deinstitutionalization, dehumanization, "community alternatives," "individual assess-

*Trager, Brahna, "The Community in Long-Term Care." in "Human Factors in Long-Term Care," National Conference on Social Welfare, San Francisco, Calif., May 1975.

ment" and other catch words of the seventies are applicable in spades to children and adults disabled early in life with long-term prospects for long-term care. Means tests present a special problem, since, if parents are self supporting the child is often ineligible for means-tested programs. SSI is beginning to breach this inequity but the income cutout level for children under 18 is still very low, especially in States where medicaid is available only to actual recipients.

Private medical insurance (and even federally aided crippled children's programs) still cover little long-term care for children, especially after "maximum therapeutic benefit" has been exhausted; NHI offers poor prospects for remedying the situation. "Catastrophic" is still measured in major episodes, rather than cumulative drawdown of resources. Exclusion from school places additional social and financial burdens on parents, as well as accentuating their sense of their own rejection by society.

When the economic and social pressures, and the needs of other family members, become too destructive, the residential institution may be seen as the only alternative option, drastic as it may be. For those who are well-to-do, there are good and bad private facilities; for those for whom an annual continuing cost of $6,000 to $18,000 a year seems stiff, there are waiting lists for both good and bad State operated or State subsidized facilities. Unfortunately in a significant number of both public and private facilities, "premature functional death" begins early and lasts a very long time.

The economic and social burdens experienced by families of disabled children and young adults are not only immediate and direct, but indirect and sometimes subtle. The prospects of long-term care without end for a young family member have a debilitating effect on even the most courageous parents. Richardson and his colleagues found in their longitudinal studies in Aberdeen that the presence of a mentally handicapped child was inversely correlated with upward social mobility of the parents, when social class factors were otherwise controlled. Career decisions by parents may be modified when choice of locale has to take into account special resources needed by a disabled child. If long-term care were more evenly accessible this social price could be avoided. Clearly the need for long-term care in the form of sustained social supports is even more urgent where ripple effects, for better or worse, are so important.

Sustained support requires a core of continuity, preferably through the instrumentality of an informed and client oriented advocate. Case closure is antithetical to long-term care, yet open-ended casework is seen by many professionals as unsatisfying. Fortunately there are some intimations that both professional values and accountability measures may increasingly favor the model of long-term prescriptive support services with continuity provided by an individual client program coordinator who works among, as well as within, systems.

Trends and Prospects

Of greatest significance are changing concepts of the structure of the service systems. For example, in 1970, Federal legislation (Public Law 91-517) was addressed to "developmental disabilities" (originating before 18, of indefinite duration, and "substantially" handicap-

ping). It dealt implicitly and explicitly with the need to replace the monolithic "institutional" model, with a coordinative but pluralistic approach both to planning and to clinical case management. It recognized the right of the severely disabled to participate prescriptively in the major generic delivery systems—health, social services, rehabilitation, education, recreation, as well as income maintenance where necessary, and the obligation of those systems to be responsive to special needs, each within its own sphere of competence.

Because the developmentally disabled person usually requires some special services, as well as a more-than-average amount of adapted generic services, and because he is himself impaired in his ability to "work the system," he, even more than others who are, or once were, competent, needs both an advocate and a skilled case manager. As this is written, the U.S. Senate has drafted an extension to the 1970 legislation which will require the setting-in-place of a truly comprehensive system for assessing and tracking the individual progress of developmentally disabled children and adults in accordance with "an individual written habilitation plan." The evaluation model assumes that the plan will draw on all relevant components of the human services systems as delineated above. It is a bold new approach, all right, and blows the mind. Its precursors are already being set up, however, on a demonstration basis, in response to concepts embodied in standards enunciated by the Accreditation Council on Facilities for the Mentally Retarded. ACF/MR is a unique interdisciplinary body, in which consumer and provider organizations have joined. The individual program plan, whether in the residential or community setting, and the client case coordinator, are key concepts.

The former Vocational Rehabilitation Act was extensively rewritten in the early 1970's to embody some of the same concepts, albeit in a more limited time frame. The intent of Congress was made clear that more severely disabled persons be served both, more intensively and for more extended periods, and more prescriptively, with more participation in decisionmaking by the client.

An even more promising event for the severely disabled was the passage, early in 1975, of the Social Services Amendments, creating the new title XX to the Social Security Act. Although it is likely that in many States the disabled, both children and adults, may be shortchanged once again in the short run, two trends may eventually reverse the tide. First there are States which have demonstrated effectively how social service funding can "put it all together" for pluralistic community programing for the disabled. Such demonstrations can be catching. Second, the concepts of the act itself call for better prescriptive packaging of health, rehabilitation, education, and income maintenance components, using social services as the matrix. For the first time institutional residents are perceived as part of the continuum of care, rather than a population apart. Moreover, the goal structure on which the legislation is predicated speaks directly to the spectrum of functional needs of the child and adult requiring long-term care. Their goals are:

(A) Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency,

(B) Achieving or maintaining self-sufficiency, including reduction or prevention of dependency,

(C) Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families,

(D) Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care, or

(E) Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

Although the social services reporting requirements being developed for use with title XX once again tend to stress "closures" based on achievement of goals through time-limited delivery of services, the use, in the act, of the terms "*maintaining*" in relation to self sufficiency and "*reducing*," as well as "*preventing*," dependency provide a statutory base on which advocates for those at risk in long-term care of all ages can construct delivery systems which include extended case management leading to sequenced services "on a sustained basis," as called for in the Brody definition.

REFERENCES

(1) Berkowitz, M., *Cost Burden of Disability and Effects of Federal Program Expenditures, Final Report*, Bureau of Economic Research, Rutgers University, New Brunswick, N.J. (HEW–OS–141) 1974.

(2) Boggs, E. M., "Some Issues Related to Long-Term Disability: A Position Paper," in Schreiber, M. (ed.) *Social Work and Mental Retardation*, John Day Co., New York, 1970, p. 244.

(3) Boggs, E. M., "The Need for Protective Services for the Mentally Retarded and Others With Serious Long-Term Disabilities," *ibid.*, p. 593.

(4) Dempsey, J. J., "Congenital Malformations and Long-Term Care: Epidemiology, Service Utilization and Costs, A Preliminary Appraisal of the Literature," working paper No. 1, DHEW, Office of Assistant Secretary for Planning and Evaluation, October 1974.

(5) Dempsey, J. J., "Cerebral Palsy: Epidemiology and Implications for Long-Term Care, A Preliminary Appraisal of the Literature," working paper No. 2, DHEW, Office of Assistant Secretary for Planning and Evaluation, November 1974.

(6) Office of Management and Budget, Executive Office of the President, *Social Indicators, 1973*, Washington, D.C., U.S. Government Printing Office, 1973.

(7) Franklin, P. A. "The Disabled Widow," *Social Security Bulletin*, 38: 20–27 (1975).

(8) Frohlich, P., *The 1967 National Survey of Institutionalized Adults—Residents of Long-Term Medical Care Institutions*. DHEW Publications (SSA) 75–11803, Washington, D.C., U.S. Government Printing Office, 1974.

(9) Kakilak, J. S. et al., *Services for Handicapped Youth: A Program Overview*, Rand Corporation, Santa Monica, Calif., (R–1220–HEW) May 1973.

(10) Kakilak, J. S. et al., *Improving Services to Handicapped Children*, Rand Corporation, Santa Monica, Calif., (R–1420–HEW) May 1974.

(11) Lazar, I. et al., *Cornell Studies of P.L. 92–603*, 6 volumes, Community Services Laboratory, Cornell University, Ithaca, N.Y., 1974.

(12) National Center for Health Statistics, *Health Resources Statistics—Health Manpower and Health Facilities, 1974*, U.S. Public Health Service, Rockville, Md.

(13) National Center for Health Statistics, Series 10, *No. 87, Impairments due to Injury, United States* 1971, DHEW Pub. No. (HRS) 74–1514, 1973, U.S. Public Health Service, Rockville, Md., 1973.

(14) National Center for Health Statistics, Series 10, *No. 96, Limitation of Activity and Mobility Due to Chronic Conditions—United States 1972*, DHEW Pub. No. 75–1523, U.S. Public Health Service, Rockville, Md., 1974.

(15) National Center for Health Statistics, Series 12, *No. 19, Characteristics of Residents in Nursing and Personal Care Homes—United States, June–August*

1969, DHEW Pub. No. (HSM) 73–1704, U.S. Public Health Service, Rockville, Md.

(16) National Center for Health Statistics, Series 12, *No. 22, Chronic Conditions and Impairments of Nursing Home Residents—United States 1969*, DHEW Pub. No. (HRS) 74–17017, U.S. Public Health Service, Rockville, Md.

(17) National Center for Social Statistics, *Findings of the 1970 APTD Study: Part I, Demographic and Program Characteristics*, DHEW Pub. No. (SRS) 73–03853, Social and Rehabilitation Service, Washington, D.C., September 1972.

(18) Haber, L. D.. "Epidemiological Factors in Disability: Major Disabling Conditions," No. 6 of *Reports from Social Security Survey of the Disabled: 1966*, Washington, D.C., Office of Research and Statistics, 1969.

(19) Brehm, H., "The Disabled on Public Assistance," No. 9 of *Reports from Social Security Survey of the Disabled: 1966*, Washington, D.C., Office of Research and Statistics, 1970.

(20) Haber, L. D., "The Measurement of Functional Capacity Limitations," No. 10 of *Reports from Social Security Survey of the Disabled: 1966*, Washington, D.C., Office of Research and Statistics, 1970.

(21) Treitel, R., "Onset of Disability," No. 18 of *Reports from Social Security Survey of the Disabled: 1966*, Washington, D.C., Office of Research and Statistics, 1972.

(22) Office of Research and Statistics, *Monthly Benefit Statistics, April 30, 1975*, DHEW Pub. No. (SSA) 75–11703, Social Security Administration, Washington, D.C.

(23) Rice, D. B. (ed.), *Critical Issues Involved in Rehabilitation of the Severely Handicapped, Report of a Study Group*, Arkansas Rehabilitation Research and Training Center, University of Arkansas, 1974.

(24) Rosen, B. M., Kramer, M., Redick, R. and Willner, S., *Utilization of Psychiatric Facilities by Children: Current Status, Trends, Implications*, Report Series on Mental Health Statistics, Series B, No. 1, National Institute of Mental Health, Rockville, Md. 1968.

(25) Stephenson, D., McWilliams, S. and Fisher, I. L., *Handicapping Conditions: A Resource Book*, Office for Handicapped Individuals, Office of the Secretary, DHEW, Washington, D.C. (in press).

TABLE 1.—TOTAL POPULATION AND NUMBER AND PERCENT DISTRIBUTION BY ACTIVITY LIMITATION STATUS DUE TO CHRONIC CONDITIONS, FAMILY INCOME, AND AGE: UNITED STATES, 1972

[Number of persons in thousands and percent distribution]

Family income and age	Total population	Percent	With limitation, but not in major activity[1]	Percent	With limitation in amount or kind of major activity[1]	Percent	Unable to carry on major activity[1]	Percent
ALL INCOMES[2]								
All ages	204,149	100	6,279	3.1	13,557	6.6	6,032	3.0
Under 17 years	64,865	100	884	1.4	906	1.4	131	.2
17 to 44 years	77,131	100	2,410	3.1	3,242	4.2	755	1.0
45 to 64 years	42,229	100	1,929	4.6	5,097	12.1	1,900	4.5
65 years and over	19,924	100	1,056	5.3	4,312	21.6	3,246	16.3
LESS THAN $3,000								
All ages	19,674	100	931	4.7	3,083	15.7	1,951	10.0
Under 17 years	4,304	100	52	1.2	83	1.9	---	---
17 to 44 years	5,611	100	272	4.8	359	6.4	209	3.7
45 to 64 years	3,615	100	222	6.1	969	26.8	606	16.8
65 years and over	6,144	100	385	6.3	1,672	27.2	1,136	18.5
$3,000 TO $4,999								
All ages	21,162	100	805	3.8	2,227	10.5	1,398	6.7
Under 17 years	6,167	100	90	1.5	125	2.0	---	---
17 to 44 years	6,457	100	224	3.5	424	6.6	158	2.4
45 to 64 years	3,913	100	210	5.4	677	17.3	433	11.1
65 years and over	4,625	100	281	6.1	1,001	21.6	807	17.4

TABLE 1.—TOTAL POPULATION AND NUMBER AND PERCENT DISTRIBUTION BY ACTIVITY LIMITATION STATUS DUE TO CHRONIC CONDITIONS, FAMILY INCOME, AND AGE: UNITED STATES, 1972—Continued

[Number of persons in thousands and percent distribution]

Family income and age	Total population	Percent	With limitation, but not in major activity [1]	Percent	With limitation in amount or kind of major activity [1]	Percent	Unable to carry on major activity [1]	Percent
$5,000 TO $6,999								
All ages	24,513	100	712	2.9	1,814	7.4	809	3.4
Under 17 years	7,864	100	109	1.4	123	1.6		
17 to 44 years	9,136	100	314	3.4	455	5.0	108	1.2
45 to 64	4,844	100	189	3.9	706	14.6	287	5.9
65 years and over	2,669	100	100	3.7	530	19.9	414	15.5
$7,000 TO $9,999								
All ages	34,620	100	884	2.6	1,944	5.6	646	1.9
Under 17 years	11,754	100	160	1.4	173	1.5		
17 to 44 years	14,061	100	369	2.6	572	4.1	113	.8
45 to 64 years	6,894	100	287	4.2	840	12.2	240	3.5
65 years and over	1,911	100	68	3.6	359	18.8	293	15.3
$10,000 TO $14,999								
All ages	51,073	100	1,403	2.7	2,160	4.2	464	1.0
Under 17 years	18,277	100	252	1.4	233	1.3		
17 to 44 years	21,253	100	637	3.0	743	3.5	76	.4
45 to 64 years	10,001	100	452	4.5	932	9.3	173	1.7
65 years and over	1,542	100	62	4.0	252	16.3	215	13.9
$15,000 OR MORE								
All ages	40,984	100	1,256	3.1	1,629	4.0	346	.8
Under 17 years	12,782	100	182	1.4	135	1.1		
17 to 44 years	16,715	100	515	3.1	540	3.2	47	.3
45 to 64 years	9,988	100	474	4.7	712	7.1	88	.9
65 years and over	1,499	100	85	5.7	242	16.1	191	12.7

[1] Major activity refers to ability to work, keep house, or engage in school or preschool activities.
[2] Includes unknown income.

Source of data: The information for table 1 was derived from data in the National Center for Health Statistics publication titled "Limitation of Activity and Mobility Due to Chronic Conditions," series 10, No. 96.

Data notes: The health interview survey of the civilian, noninstitutionalized population began in 1957. The information is obtained in household interviews in a continuing nationwide survey conducted by trained personnel of the U.S. Bureau of the Census. During 1972, the sample was composed of about 44,000 households, containing about 134,000 persons. A description of the survey design methods used in estimation, limitations of the data and definitions of terms are presented in the appendixes of the publications. During 1972, an estimated 12.7 percent of the population or 23,868,000 persons in the civilian noninstitutionalized population were reported to be limited to some extent in activity due to chronic disease or impairment. About 3 percent of the population or 6,031,000 persons were unable to carry on their major activity (working, keeping house, going to school). About 6.6 percent were limited in the amount or kind of major activity, and 3.1 percent or 6,279,000 persons were limited in other activities such as recreational, church or civic activities. Over the 15 years of the survey, the percentages of the population in each degree of activity limitation have been quite stable. As age increases and income decreases, the proportions of persons with limitations of activity and mobility rose regardless of sex or race. This information is important in estimating the present and future population in need of long-term care.

TABLE 2.—LONG-TERM CARE RESOURCES BY STATE AND REGION

	Senior centers	Homemaker programs	Home health agencies	Total nursing centers and personal care facilities	Certified intermediate care facilities [1]	Certified skilled nursing facilities [1]	JCAH accredited nursing homes	Certified ICMR	Institute for mentally retarded	Psychiatric hospital	General hospital
Total	[2] 4,769	[3] 1,611	[4] 2,286	[5] 22,004	[4] 8,789	[4] 7,384	[6] 1,592	[4] 1,258	[5] 1,236	[5] 497	[5] 6,491
Region I	331	117	339	2,054	1,101	547	131	17	59	52	334
Connecticut	70	41	87	380	58	205	37	0	21	12	47
Maine	48	11	20	288	137	17	9	1	11	3	57
Massachusetts	111	37	160	960	671	243	62	0	15	31	159
New Hampshire	19	7	41	140	52	19	9	0	3	1	35
Rhode Island	51	15	13	185	133	41	4	16	7	3	17
Vermont	32	6	18	101	50	22	10	0	2	2	19
Region II	867	178	188	1,644	262	816	197	0	62	59	448
New Jersey	92	42	45	548	103	222	36	0	20	14	111
New York	745	126	130	1,096	159	589	156	0	42	45	337
Puerto Rico	29	9	12	----------	0	5	5	0	----------	----------	----------
Virgin Islands	1	1	1	----------	0	----------	----------	0	----------	----------	----------
Region III	586	201	303	1,514	428	594	124	0	83	70	526
Delaware	24	4	7	34	12	14	2	0	7	1	9
District of Columbia	29	5	4	73	9	5	1	0	2	2	16
Maryland	98	31	23	195	12	102	28	0	7	14	57
Pennsylvania	289	78	115	753	203	408	61	0	58	35	254
Virginia	95	70	136	335	132	37	22	0	7	12	109
West Virginia	51	13	18	124	60	28	10	0	2	6	81
Region IV	444	242	423	2,521	1,034	1,157	171	20	64	59	1,143
Alabama	49	23	69	192	166	165	15	0	3	5	136
Florida	90	34	47	373	97	258	26	1	24	14	206
Georgia	46	10	15	283	327	248	25	7	5	11	183
Kentucky	41	29	41	344	80	84	27	3	4	6	117
Mississippi	6	29	88	134	16	96	13	1	2	2	122
North Carolina	128	68	53	843	83	164	21	4	12	7	144
South Carolina	36	27	18	118	59	79	18	4	2	5	89
Tennessee	48	22	92	234	206	43	26	0	12	9	146

TABLE 2.—LONG-TERM CARE RESOURCES BY STATE AND REGION—Continued

	Senior centers	Homemaker programs	Home health agencies	Total nursing centers and personal care facilities	Certified intermediate care facilities [1]	Certified skilled nursing facilities [1]	JCAH accredited nursing homes	Certified ICMR	Institute for mentally retarded	Psychiatric hospital	General hospital
Region V	1,116	405	391	4,404	2,343	1,652	480	150	178	129	1,153
Illinois	232	54	84	1,046	87	285	94	0	44	26	255
Indiana	87	58	28	522	391	120	38	0	10	11	119
Michigan	165	32	48	562	285	338	115	6	35	21	234
Minnesota	210	79	63	593	354	276	81	119	27	8	181
Ohio	278	87	101	1,191	661	346	61	3	51	26	213
Wisconsin	144	95	67	490	565	287	91	22	11	37	151
Region VI	274	82	257	1,838	1,616	366	77	41	66	32	976
Arkansas	34	6	78	218	200	76	10	5	5	1	99
Louisiana	34	23	73	212	203	11	8	9	13	5	149
New Mexico	22	8	6	60	34	8	7	2	7	3	59
Oklahoma	61	17	52	411	358	10	9	16	9	6	142
Texas	123	28	48	937	821	261	43	9	32	17	527
Region VII	265	115	134	1,974	1,205	240	96	1	51	28	574
Iowa	61	58	58	747	530	33	33	0	16	7	145
Kansas	62	25	32	480	343	65	22	1	8	7	157
Missouri	80	27	33	494	133	105	23	0	16	10	159
Nebraska	62	5	11	253	199	37	18	0	11	4	113
Region VIII	250	102	89	753	415	379	63	25	42	13	356
Colorado	48	21	29	212	165	149	18	17	23	7	88
Montana	50	24	10	103	43	74	7	6	5	----	72
North Dakota	47	33	9	109	25	52	16	0	2	1	61
South Dakota	59	20	22	153	64	56	10	2	2	2	66
Utah	32	4	9	142	106	37	4	0	8	1	39
Wyoming	14	----	10	34	12	11	8	0	2	2	30
Region IX	473	111	103	4,534	144	1,241	193	1	601	42	699

American Samoa											
Arizona	56	13	10	82		17	12		9	3	81
California	347	86	85	4,277	133	1,191	165	0	569	36	572
Guam			1			1					
Hawaii	57	6	4	132	11	15	11	1	22	1	22
Nevada	13	6	3	43		17	5		1	2	24
Trust territory											
Region X	163	58	59	768	241	402	60	4	30	13	282
Alaska	8	1	1	8	1	8	1	0	1	1	26
Idaho	38	6	9	64	6	50	8	0	1	2	49
Oregon	40	15	26	311	155	59	14	4	6	4	86
Washington	77	36	23	385	79	285	37	0	22	6	121

[1] The numbers of certified skilled and intermediate care facilities are not mutually exclusive because some facilities have dual certification. This applies to approximately 1/3 of the certified facilities and varies from State-to-State dramatically. The data for certified intermediate care facilities and intermediate care facilities for mental retardation only includes those facilities reported to Social Security by May 1975. Because a new set of regulations are being applied, many States will have many more or less facilities later this year pending outcome of the application of waivers. In some States, nursing homes are serving as intermediate care facilities for the mentally retarded and therefore, are certified as ICMR's but are not counted, by the National Center for Health Statistics as institutions for the mentally retarded.

The variation of resources available for long term, as well as, acute care from region to region and State-to-State is most important in providing appropriate service. Region V has more resources of all types per citizen than any other area of the country. Numbers alone do not tell the story but they do give an indication of the distribution and potential quantity of service available to meet peoples needs.

[2] Directory of Senior Centers and Clubs—A National Resource by the National Institute of Senior Centers under grant number 93-P-575441/3-01 from the Administration on Aging, 1974.

[3] Unpublished data from survey conducted by National Council for Homemaker-Home Health Aide Services, Inc., for the Public Health Service under Contract No. HSM 110-72-260, June 1974.

[4] Unpublished data from Management Information System, Social Security Administration, May 1975.

[5] "Health Resources Statistics," National Center for Health Statistics, 1974.

[6] "Long Term Care Fact Book," American Health Care Association, 1974.

Appendix 2

SELECTED TABLES—ADULT DAY CARE IN THE UNITED STATES—A COMPARATIVE STUDY

(Prepared by the TransCentury Corp. in accordance with provisions of contract awarded by the National Center for Health Services Research, Health Resources Administration, PHS, DHEW)

TABLE 1.—COMPARISON OF SELECTED PROGRAM CHARACTERISTICS OF ADULT DAY CARE PROGRAMS, RANK ORDERED BY AVERAGE DAILY ATTENDANCE

	Average daily attendance	Principal funding source	Length of operation (months)	Affiliation	Days per week in operation	Geographic location
Tucson senior health improvement programs	115	Model Cities	92	Nursing home, hospital	5	Tucson, Ariz.
San Diego senior adult day care program	52	Revenue sharing	20	Social service organization	5	San Diego, Calif.
On Lok senior health services center	47	Title IV, OAA	27	Free standing	7	San Francisco, Calif.
Burke Day Hospital	40	do	27	Rehabilitation center	5	White Plains, N.Y.
Lexington—Center for Creative Living	29	Title VI, SSA	25	County health department	5	Lexington, Ky.
Mosholu-Montefiore Geriatric Day Care program	28	Title IV, OAA	26	YMHA–YWHA, hospital	5	Bronx, N.Y.
Levindale adult day treatment program	25	Medicaid	60	Geriatric center	5	Baltimore, Md.
St. Camillus health care by the day program	18	do	34	Skilled nursing facility	5	Syracuse, N.Y.
Athens-Brightwood Day Care Center	11	Title VI, SSA	36	Social service organization	5	Athens, Ga.
St. Otto's day care programs	11	Medicaid	79	Nursing home	5	Little Falls, Minn.
Average	37.6		42.6			

Source: Average daily attendance reflects TransCentury findings from a count of actual attendance onsite visit days and program records of lunches consumed in sample months. Tucson program officials disagree with figures for their program. Their estimate is 143.

TABLE 2.—SELECTED DEMOGRAPHIC CHARACTERISTICS OF ADULT DAY CARE PARTICIPANTS; RANK ORDERED BY AVERAGE AGE

	Participants average age	Percent under 65	Percent over 85	Precent of participants who are female	Percent of participants living alone	Percentage of ethnic orientation
Montefiore	77	10	20	80	53	Jewish, 63.
Lexington	76	13	27	70	30	Black, 52.
On Lok	76	10	17	33	50	Oriental, 87.
San Diego	76	20	10	70	27	White, 73.
Athens	75	23	27	63	40	Black, 63.
Levindale	75	17	20	53	23	Jewish, 68.
Burke	71	33	14	73	20	White, 64.
Tucson	69	27	7	57	20	White, 53. Spanish surnames, 33.
St. Camillus	65	36	3	67	13	White, 83.
St. Otto's	54	70	3	67	33	White, 100.
Average	71	26	15	63	31	

Source: TransCentury sample of 30 participants' records selected randomly from active files.

TABLE 3.—COMPARISON OF INCIDENCE OF PARALYSIS AMONG PARTICIPANTS IN ADULT DAY CARE PROGRAMS, IN RANK ORDER

	Proportion with partial or total paralysis (percent)	Rank
Burke	53	1.0
St. Camillus	43	2.0
Tucson	33	3.0
On Lok	30	4.0
Lexington	20	5.5
San Diego	20	5.5
Athens	10	8.0
Levindale	10	8.0
Montefiore	10	8.0
St. Otto's	3	10.0
Average	23	

Source: TransCentury participant sample of 30 participants randomly selected at each program.

TABLE 4.—COMPARISON OF THE INCIDENCE OF WHEELCHAIR USE AMONG PARTICIPANTS IN ADULT DAY CARE PROGRAMS, IN RANK ORDER

	Proportion using wheelchairs (percent)	Rank
St. Camillus	73	1.0
Burke	50	2.0
Tucson [1]	27	3.0
Levindale	23	4.0
Lexington	13	5.5
On Lok	13	5.5
Athens [2]	10	7.5
San Diego [3]	10	7.5
St. Otto's	3	9.5
Montefiore	3	9.5
Average	23	

[1] The number of wheelchair participants at 3 of the 6 centers in the Tucson program is limited by the lack of specially-equipped bathroom facilities.

[2] The Athens program cannot accommodate more than 4 participants using wheelchairs per day because of restricted space.

[3] Because of fire regulations, the San Diego program will not accept participants who are wheelchair-bound.

TABLE 6.—COMPARISON OF THE INCIDENCE OF STROKE AMONG PARTICIPANTS IN ADULT DAY CARE PROGRAMS IN RANK ORDER

	Proportion who have suffered stroke (percent)	Rank
Burke	47	1.0
On Lok	40	2.0
St. Camillus	33	3.5
Tucson	33	3.5
Athens	20	6.0
Lexington	20	6.0
San Diego	20	6.0
Montefiore	13	8.0
Levindale	10	9.0
St. Otto's	3	10.0
Average	24	

Source: TransCentury participant sample.

TABLE 11.—COMPARISON OF AVERAGE NUMBER OF DIAGNOSED CHRONIC CONDITIONS AFFLICTING PARTICIPANTS IN ADULT DAY CARE PROGRAMS, IN RANK ORDER

	Average number of conditions per participant	Rank
Burke	4.8	1.0
Montefiore	3.9	2.0
On Lok	3.5	3.0
Lexington	3.3	4.0
St. Camillus	3.0	5.5
Tucson	3.0	5.5
Levindale	2.9	7.0
Athens	2.7	8.0
San Diego	2.1	9.0
St. Otto's	2.0	10.0
Average	3.1	

Source: TransCentury participant sample.

TABLE 12.—COMPARISON OF MEAN ADL SCORES[1] FOR PARTICIPANTS IN ADULT DAY CARE PROGRAMS, IN RANK ORDER

	Mean ADL score	Rank
St. Camillus	3.8	1
Burke	2.8	2
On Lok	1.8	3
Tucson	1.4	4
Levindale	1.1	5
San Diego	1.1	6
Lexington	.8	7
Athens	.5	8
Montefiore	.5	9
St. Otto's	.1	10

[1] An ADL score is an index computed to express dependency in activities of daily living. The score reflects both the number of activities in which a participant is dependent, and weighting for extent of dependency. Activities of daily living include: walking, wheeling, eating, and toileting. Weighting is assigned as follows: 1—requires assistance of equipment; 2—requires assistance of a person; 3—requires assistance of both equipment and a person.

Source: Computations using TransCentury participant sample.

TABLE 13.—COMPARISON OF RATIO OF PARTICIPANTS TO TOTAL STAFF IN ADULT DAY CARE PROGRAMS, IN RANK ORDER

	Number of participants per staff member	Average daily attendance	Total FTE[1] staff	Rank
Burke	1.3	40	31.41	1
Athens	1.5	11	7.13	2
St. Camillus	1.9	18.3	9.71	3
San Diego	2.0	52.1	26.53	4
On Lok	2.2	47	21.65	5
Montefiore	2.5	28	11.41	6
Lexington	2.5	29	11.51	7
Tucson	2.8	115	41.54	8
Levindale	3.2	25	7.72	9
St. Otto's	4.8	11	2.29	10
Average	2.5	37.6	17.09	

[1] The term full-time equivalent (FTE) may be confusing. It simply means total full-time and part-time hours worked per day, divided by the number of hours in the program's work day—usually 8, but for some programs, 7½.

Source: TransCentury estimates computed by dividing average daily attendance by number of full-time equivalent staff (FTE).

TABLE 15.—COMPARISON OF EMPHASIS ON HEALTH CARE SERVICES IN ADULT DAY CARE PROGRAMS, IN RANK ORDER

	Proportion of staff time in health care services (percent)	Minutes in health care services per participant-day[1]	Rank
Burke	56.6	108.6	1
St. Camillus	43.7	85.0	2
St. Otto's	42.1	32.8	3
San Diego	41.5	70.6	4
Montefiore	33.2	30.4	5
Levindale	29.3	15.7	6
Lexington	27.4	31.0	7
Tucson	25.8	35.6	8
On Lok	24.5	28.4	9
Athens	9.4	20.5	10
Average	33.4	45.9	

[1] Does not include time of therapies received on referral, if any, except Tucson.

Source: TransCentury computations.

TABLE 29.—COMPARISON OF PRINCIPAL CHARACTERISTICS OF 2 MODELS OF ADULT DAY CARE

	Model I	Model II
Participant characteristics:		
Average age	68.0	72.3
Living alone (percent)	16.7	34.6
Incidence of paralysis (percent)	48.3	17.1
Incidence of wheelchair use (percent)	61.7	12.9
Incidence of fractures (percent)	23.3	9.1
Incidence of stroke (percent)	40.0	20.0
Incidence of neurological disorders (percent)	25.0	28.8
Incidence of mental disorders (percent)	20.0	28.0
Incidence of hypertension (percent)	55.0	40.0
Incidence of blindness (percent)	6.7	2.5
Average number of diagnosed medical conditions	3.9	2.9
Mean ADL score	3.3	.9
Staffing patterns:		
Participants per staff member	1.6	2.7
Participants per health professional	5.9	21.8
Percent of staff time in health care services	50.1	29.2
Minutes of probable health care services per participant day	29.5	12.6
Minutes of physical therapy per participant day provided by a professional physical therapist	15.1	1.2
Minutes of occupational therapy per participant day provided by a professional occupational therapist	10.7	1.1
Minutes of speech therapy per participant day provided by a professional speech therapist	7.3	.3
Minutes of nursing services per participant day provided by a registered nurse	(1)	3.8
Minutes of nursing services per participant day provided by a licensed practical nurse	(1)	3.2
Program costs:		
Per diem, total	$43.09	$20.56
Health care services	17.60	5.38
Supporting health activities	19.60	11.82
Transportation services	5.89	3.36

1 Not significant.

Appendix 3

REPORT ON DAY HOSPITALS IN ISRAEL AND GREAT BRITAIN; BY EDITH G. ROBINS[1]

CARE OF THE ELDERLY IN ISRAEL

As a framework for the following observations, a brief overview of the health care system in Israel will be helpful.

Primary health care and arrangements for hospital care are provided to most employed workers and their families as well as to retirees through the Kupat Holim, the medical arm of the Israeli Federation of Labor (Histadruth). The Ministry of Health provides comprehensive health services to the medically indigent and to immigrants and their families who are not members of Kupat Holim. Private health care is available on a limited basis to those who wish to pay for services.

The Ministry of Health operates the majority of hospitals (including day hospitals), and Kupat Holim members may receive their care in these facilities, with the Kupat Holim paying for a portion of such care and the government making up the difference.

There are no government-operated nursing homes, but the government, through the Department of Social Welfare, does operate a few homes for the aged; other homes for the aged are operated by voluntary organizations. Only one home for the aged has a well equipped medical component.

A report entitled "The Organizational Structure of the Kupat Holim Services According to Regionalization and Integration" describes the move currently underway to merge the current 15 health districts into 8 health regions and 1 centralized medical center. Also included in the report is a description of the proposal for services to the aged and chronically ill to be conducted by the Kupat Holim that was approved in 1972. Efforts are currently being directed by the labor organization to implement these recommendations.

To obtain the information in the following report, conversations were held with the following:

Dr. Jacob Menczel, Director-General, Ministry of Health.

Dr. Joseph Silberstein, Director, Chronic Illness and Aging, Israel Ministry of Health.

Dr. Marian Rabinowitch, Chief, Department of Geriatric Rehabilitation, Tel Hashomer Hospital, Tel Aviv, Israel.

Dr. Daniel Kindler, Director of Day Hospital, Tel Hashomer Hospital, Tel Aviv, Israel.

Ms. Hassida Guaryahu, Director of the Unit for the Aged and Health, Municipality of Jerusalem.

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[1] Ms. Robins is Deputy Director, Division of Long-Term Care, National Center for Health Services Research, HRA, DHEW.

In reading the following discussion, these facts should be kept in mind:

(1) Until recently, there was little in the way of outreach services for the elderly; although a few programs recently have been undertaken, it is widely acknowledged by Israeli health and social welfare authorities that much more is needed.

(2) Very little is currently being undertaken in research on health services.

(3) There are no government-operated nursing homes, and for the most part the privately owned nursing homes are considered by Israel's health and social welfare authorities to be of very poor quality.

(4) While the proportion of elderly in Israel is currently relatively small, a marked shift in the makeup of the population is anticipated, resulting from the large numbers of elderly persons migrating to Israel. Estimates for 1980 forecast a doubling of the number of persons over 65 years of age.

(5) A high priority is being given to the development of home health services and day hospitals.

(6) High priority is also placed on increased development of preventive services and on creation of comprehensive health centers, combining Kupat Holim and government resources.

(7) Action is just getting underway to develop sheltered housing, based on models developed in Scotland and England.

Day Hospitals

Currently there are four day hospitals in Israel, and it is anticipated that there will be five more in operation by the end of the year. These day hospitals are based on the British model. Great interest was shown by Dr. Silberstein in the writer's paper presented at the Congress proposing four distinct modules of day care, including the module serving as a substitute for inpatient hospital care, the module providing time-limited restorative care, the module providing long-term maintenance care, and the module providing psychosocial care (see "Operational Research in Geriatric Day Care in the United States," p. 82.)

In Israel (as in England and the United States), there is an urgent need for day care for the socially isolated frail elderly, and this service calls for a different staffing from that in programs providing restorative and maintenance care. Dr. Silberstein noted that many of the Israeli day hospital participants remain in the program after the restorative goal is reached because of lack of other alternatives in the community. Where the patient is to go after discharge from the day hospital is the key problem, he emphasized.

The four existing day care programs are Shaarej Zedek, Tel Hashomer, Assaf Harofeh, and Pardess Katz. With the exception of the Tel Hashomer Day Hospital, each of these models is located directly in or on the grounds of the parent hospital that operates the program. The Tel Hashomer model is housed in what was formerly a private residence located in close proximity to the hospital.

No documentation on costs has as yet been obtained from these programs, but the need to obtain such data is recognized by Israeli health officials.

According to Dr. Silberstein, the day hospital has as its major objectives the shortening of hospital stay by providing treatment without the hotel services, and the prevention or postponement of inpatient care. In some instances, the day hospital also provides diagnostic work-ups.

Dr. Menczel was of the opinion that the day hospital should be used for more than the elderly, that it should be utilized for all age groups in need of protective long-term care. He also emphasized the need to have the day hospital located in a general hospital to provide easy access to all specified facilities required for therapy.

SHAAREJ ZEDEK DAY HOSPITAL, JERUSALEM; PROF. DAVID NEIR, DIRECTOR

Started 1 year ago, this day hospital is housed in two rooms in an old building on the grounds of the Shaarej Zedek Hospital, a general hospital that contains a 22-bed geriatric department and sponsors a home care program. The program started with three patients discharged from the geriatric ward; 6 weeks later there were 20 patients. Currently the program serves 15 persons daily, most of whom attend twice a week.

In addition to the more traditional reasons for acceptance into the program, the day hospital accepts patients for observation and for diagnostic tests.

Referral sources are as follows: Home care program, 12 percent; emergency room, 25 percent; out-patient department, 30 percent; hospital discharge, 33 percent.

The observation was made that women have a shorter length of stay because they want to return to their homemaker responsibilities; men have a longer length of stay because when they are ill, they become a burden to their wives, particularly among the more elderly. Average attendance is 15 days.

TEL HASHOMER DAY HOSPITAL, TEL AVIV; DR. MARIAN RABINOWITCH, CHIEF OF DEPARTMENT OF GERIATRIC REHABILITATION; DR. DANIEL KINDLER, DIRECTOR OF DAY HOSPITAL

This was the first day hospital in Israel, opened in February 1974. It is located in a rented house located a few minutes ride from the hospital, and contains two three-bed rooms for treatment of cancer patients. The program has a census of 55 participants and serves approximately 15 patients a day, with attendance three times a week, twice a week or once a week, as medically indicated. The average stay is approximately 3 or 4 months. Ambulance transportation is provided. The house in which the program was located contained several small rooms, and lacked a sizable general purpose room.

SUMMARY ON DAY HOSPITALS IN ISRAEL

Day hospitals are regarded in Israel as a vital aspect of care, but the two programs visited indicate that these are still in the formative stages.

Data gathering to document costs, utilization, diagnostic categories, etc., is rudimentary or nonexistent.

Transportation and programs to serve patients after discharge are the two most critical problems cited by all who are involved in these activities.

Dr. Joseph Silberstein, director of chronic illness and aging of the Ministry of Health, a dedicated physician who has a deep feeling about the health needs of the aged, is an ardent advocate of this form of care. As evidence, an excerpt from a letter to Robins from him after her visit reports: ". . . We go ahead with day hospitals. In fact there is a consensus that this is the field on which we must concentrate for the next few years. Staff shortages, rocketing hospital costs, and last, but by no means least, the needs of the patients dictate this course to us."

Rehabilitation

Information in this section—some of the ideas quite provocative—is based on an interview with Dr. Rabinowitch, chief, department of geriatric rehabilitation, Tel Hashomer Hospital in Tel Aviv. Dr. Rabinowitch trained for 9 years at Rancho Los Amigos is California, and is dedicated to the creation of an innovative and effective geriatric rehabilitation program.

(1) Rehabilitation should be highly selective, and is not for all patients. If the patient can't be rehabilitated, the physician should be strong enough to be honest and make appropriate referral. In rehabilitation, functional assessment is of greater importance than medical diagnosis.

(2) Any medical system without adequate emphasis on discharge planning is a failure.

(3) The same team (physician and allied professionals) providing treatment in hospital should provide care following discharge. (It takes about 3 years of working together to create maximum team effectiveness.) Most of the care in total course of treatment will be provided to an individual as an outpatient.

(4) Long admissions should be avoided. The goal of rehabilitation is to limit inpatient stays to no longer than 4 or 5 weeks, with discharge as soon as it is feasible to provide treatment out of the hospital. (After 6 to 7 weeks of hospitalization, the patient develops "hospital syndrome," and after experiencing freedom from care of patient for a protracted period, the family has a tendency to resist assuming responsibility for care in the home setting.)

(5) High turnover of patients can help to maintain morale of staff (professionals and paraprofessionals) by providing new challenges.

(6) Preadmission assessment should be made by a team (doctor, nurse, social worker) and include outcome planning. Periodic reassessments following hospital discharge should be made by same team.

(7) The goal of rehabilitation should be to enable the individual to live a productive life through maximum restoration of function. For some, the goal may be limited to improvement of the quality of life at home.

(8) Rehabilitation to improve the quality of life should apply to the terminally ill. "There can be no death with dignity in a hospital."

FAMILY SESSIONS

As a means of obtaining maximum family involvement and cooperation in treatment and discharge planning for inpatients in the Geriatric Rehabilitation Service, Dr. Rabinowitch biweekly sponsors a social encounter held during evening hours. A multidisciplinary team attends this session, at which a lecture is presented on a specific problem. A question-and-answer period follows the presentation, and time is allotted for informal conferences of the family with team members.

Some of these sessions are on subjects of interest to all of the families, and in other instances the sessions are devoted to a particular medical problem. For example, a recent meeting was directed to families of patients suffering cerebral vascular accidents. Other more general sessions, such as those dealing with psychological aspects of long-term care, bring together as many as 100 family members.

Dr. Rabinowitch reported that this program has been well received by the participating families and has given valuable insights to the professional staff members who care for the patients.

THE REHABILITATION CLUB—AN INNOVATIVE APPROACH

An innovative approach, the rehabilitation club, has been developed by Dr. Rabinowitch for patients discharged from the Tel Hashomer Day Hospital who need less intensive but continuing health supervision and psychosocial activities geared to their needs. An open door policy for admissions will be maintained for those discharged from the hospital directly to the community, or for those living in the community who could benefit from the services. The rehabilitation club is located in Ramat Gan, a town about 15 minutes ride from the hospital, and will become operative early in September 1975.

According to present plans, an assessment on each participant will be made by a Rehabilitation club team comprised of a physician, nurse, physical therapist, occupational therapist, recreational therapist, and medical social worker. A noonday meal will be provided, and emphasis will be on resocialization. Referrals will be made for homemaker service or health supportive services as required, but Dr. Rabinowitch emphasized that the greatest thrust of the program will be on provision of social rather than medical services.

It is anticipated that in addition to the paid staff, services will be provided by community volunteers, and that financial support will also be provided through the health insurance program and the municipality.

TERMINAL ILLNESS

Although the resources are not yet available for developing a program specifically designed for the terminally ill, Dr. Rabinowitch is making preliminary plans for such an activity in the future. He feels strongly that it is necessary to break the medical concept that the death of a patient should be viewed as a medical failure; instead, he asserts that care of the terminally ill should be made a positive part of the care plan.

Because Dr. Rabinowitch feels that it is not possible to have death with dignity in a hospital setting, he strongly recommends that when-

ever possible, the terminally ill patient should receive care in the home setting, and that hospital admission should be made only when supportive services in the home are no longer practical. For those who do not have the family resources for care in the home, he advocates service in a facility especially designed to serve the physical and psychosocial needs of such patients (based on the British model of the "hospice"). He points out that such a facility should not be utilized for patients in a "vegetative coma."

Home Health and Homemaker Services

HOME HEALTH SERVICES

Home health services are highly regarded in Israel as an alternative to institutional care. Seven distinct programs currently exist; three are hospital based, three are home based; and one program, still in the developmental stages, emanates from a Kupat Holim health center. Dr. Rabinowitch described the following criteria utilized by Tel Hashomer Hospital for eligibility for home health services:

(1) There must be a rehabilitation potential.

(2) The home setting must provide proper physical and emotional environment.

(3) Patient is not eligible for coverage from any other agency.

(4) Patient must be homebound or bedbound.

(5) Patient does not have "welfare mentality." (If it is judged that this attitude exists, referral is made to welfare agency.)

Generally, from three to four months of home care is provided with the aim of enabling the patient to be able to receive any additional care in an ambulatory care setting, with ambulance service provided if necessary to bring the patient from the home to the outpatient clinic.

HOMEMAKER SERVICES

Homemaker service was started in Israel by retired social workers in 1967. Workers receive 3 months of on-the-job training, work a maximum of 5 hours a day.

A program now underway involves the use of a homemaker to visit the isolated aged who have poor living conditions. A weekly visit is made to change linens, check on medications, and do essential errands. The homemaker also serves as liaison with the individual's social worker and physician. Twenty-two homemakers have been able to serve a caseload of 200 elderly in this program.

The Kupat Holim health program initially provided only home health care, but these services are currently being broadened to include homemaker services.

GERIATRIC DAY HOSPITALS IN GREAT BRITAIN

Because of the widespread demand for information on day care and day hospitals by health, welfare, and planning authorities in the United States, this report will present background information to assist the reader as well as highlights of observations and conversations with staff members of these programs and with the above-mentioned

authorities. The background information is based primarily on a book entitled *The Geriatric Day Hospital*, written by Professor Brocklehurst that focuses on a national survey of geriatric day hospitals (1969–70), an in-depth survey of five day hospitals, and a 6-year survey of Lennard Day Hospital in Bromley.

Throughout Great Britain, the geriatric day hospital has been accepted by health and social welfare authorities as well as by the public as a valuable modality of care for the elderly and for physically disabled younger persons who could benefit from such care.

The day hospital was originally conceived as a means of providing care and therapy for patients whose disability did not justify admission to a hospital bed, but necessitated continuous supervision throughout the day when the rest of household was out at work. The need for this form of care stemmed from the increasing shortage of psychiatric beds for the elderly mentally frail.

In 1945, the Malborough Day Hospital, associated with the psychiatric unit of the parent hospital, was created as the first operational program to serve psychiatric patients. In 1952, the principle was more broadly applied to geriatric patients who needed care primarily for physical rather than mental disabilities, and the Cowley Road Day Hospital in Oxford established by Dr. Lionel Z. Cosin served as a model.

The program proved so successful that by the end of 1970 there were 119 geriatric day hospitals in Great Britain. Increasingly, additional day hospitals are being established, usually in existing hospitals, but often in free standing facilities constructed and designed specifically for this purpose. The ultimate goal is to have a program in each of the 200 geriatric units in the nation.

A significant fact to be kept in mind by the reader is that there is no established set of criteria for day hospitals in Great Britain, and minimal data is available on costs. Many variations exist in terms of size, program staffing and patient characteristics. Communications between the various day hospitals take place on an informal basis, with a few individuals taking the initiative for the development of structured meetings and workshops. At the time of my visit, a day hospital conference was being planned for September 1975 by Professor R. E. Irvine, consultant physician to the Hastings geriatric unit and a recognized leader in the field.

I had the privilege of visiting five of the outstanding day hospitals in Great Britain (Withington Day Hospital in the University Hospital of South Manchester; Hastings Day Hospital; Bexhill Day Hospital; Lennard Day Hospital in Bromley, Kent; St. Pancras Day Hospital in London). More importantly, I had the invaluable opportunity of having in-depth discussions with the geriatric consultants of these programs who are acknowledged leaders of the day hospital movement in Great Britain—Professor J. C. Brocklehurst (South Manchester), R. E. Irvine (Hastings and Bexhill), and A. N. Exton-Smith (London). Enhancing this experience was the opportunity to visit King George VI Memorial Club, a social day center for the physically handicapped elderly. This organization provides a vitally needed level of care not commonly addressed in the United States—is much less health-service oriented than the day hospital. (Note: this may well be the type of care that is now reimbursable under the new title XX of the Social Security Act.)

Background Information

Professor Brocklehurst defines the geriatric day hospital as follows:

"A day hospital is a building to which patients may come, or be brought, in the morning, where they may spend several hours in therapeutic activity and whence they return subsequently on the same day to their own homes. The building is generally, although not always, within the curtilage of an ordinary hospital. It may be not more than a single room specially adapted, or a whole purpose-built structure of many varied rooms. Geriatric day hospitals provide facilities for physiotherapy and occupational therapy, for medical examination and nursing treatment, and usually for various other activities including investigation, speech therapy, dentistry, chiropody, and hairdressing. The building and its facilities may be used entirely for day patients coming from their homes, or it may be used by inpatients as well, who come over from the wards in the morning and return in the afternoon.

"Geriatric day patients are almost always brought by special transport and thus make moderate demands on the ambulance service, the cost of which may well be the most expensive element in day hospital treatment. Usually between 4 and 8 hours are spent every day in the day hospital. This long period of time differentiates day patients from those attending for short periods of treatment in physical medicine departments. The prolonged period is necessary for elderly people. Though the pace must be slow, the activity must be as continuous as possible. Everything the patient does—walking along corridors, having lunch, taking part in remedial exercises or in group projects—involves a therapeutic activity designed to improve his health and overcome his disabilities. Geriatric day hospitals may also be used to prevent breakdown in health, both in patients and in their families. In a nutshell, the aim is to dissociate the "hotel" element of hospital care from the therapeutic, leaving only the latter."

In many hospitals in which day hospitals are housed, it is customary for the staff and the equipment of the rehabilitation department to be shared by both the day hospital patients and the inpatients. This is considered to be economic use of staff and facilities. Moreover, it is a common practice for inpatients to actively participate in the day hospital program. Not only does the opportunity to get away from the wards boost the morale of the inpatients, but for those patients who are approaching discharge, participation in the day hospital program helps to ease the change from inpatient to outpatient status. The patient knows he will continue to be treated in the same place by the same therapist when he goes home. In a significant proportion of the patients, this practice tends to reduce the length of inpatient stay.

Transportation appears to be a crucial problem that has yet to be fully resolved. Most of the patients come by ambulance, and for the most part, 8- or 10-seater vehicles with hydraulic lifts are used; in some areas, taxis and hospital sitting cars bring patients. In general, most of the patients travel 5 miles or less to reach the day hospital, with the first patients arriving between 9 and 10 o'clock in the morning and the last patients leaving between 3 and 5 o'clock in the afternoon.

Brocklehurst stresses that there are many advantages to having special ambulance crews assigned to this task, crews that are aware of the need for special assistance required by elderly passengers, and who can be depended upon to report crises or mishaps that arise at home. According to Brocklehurst, whether or not a patient gives up day hospital treatment in the first week or two may depend largely on the quality and understanding of the ambulance crew.

Some day hospitals serve a very limited number of patients (fewer than 10 a day), while others are much larger serving 50 or more daily. Of the programs surveyed by Brocklehurst, one-third were small, having fewer than 20 places a day, and only 24 percent had more than 40 places daily. The survey findings indicated that day hospitals with 20 or fewer places were overfilled, with patients attending in excess of the real capacity of the program. According to Brocklehurst, the most popular size of day hospitals—20 to 40 places a day—would serve a target population of 60,000 to 180,000 of average age structure. He warns that an excessively large day hospital capacity could discourage discharge and interfere with proper function of the program.

Great variations in staffing patterns exist among day hospitals in Great Britain. However, the average 30-place day hospital has the service equivalent of 10 full-time workers, with 5.7 full-time equivalents of occupational therapists, physical therapists, speech therapists and aides, and 4.2 full-time equivalents in all grades of nurses. The proportion of different types of staff utilized varies with the patient needs. In general, there are four ancillary workers for every three nurses (including aides).

The consultant geriatrician and his junior medical staff spend between 7 and 14½ hours a week in the day hospital. The consultant geriatrician saw patients at the day hospital at least 1 day a week in 80 percent of the facilities surveyed, and the day-to-day care was provided by the other medical staff. In 15 of the 90 programs surveyed, consultants other than geriatricians visited the day hospital patients (psychiatrist in eight, physical medicine specialist in four, general physician in two, and orthopedic surgeon in one).

More than half of the patients were over 74 years old; less than one-fifth were under 65. About one-fourth of the patients could walk alone, and 13 percent were wheelchair patients. Although 20 percent of the men and 8 percent of the women had some urinary incontinence, in only 2 percent of the patients was this the major reason for attendance.

A survey of the 90 existing geriatric day hospitals conducted in 1970 indicated that the majority of these programs provided services on a 5-day-a-week basis, and had places for between 20 and 40 persons each day. The survey further revealed that 57 percent of the patients attended once a week, 28 percent twice weekly, 10 percent three times a week, and 5 percent attended either four or five times a week. Almost 40 percent of the patients attended for longer than 1 year, and those attending for social reasons or for stroke rehabilitation attended for the most prolonged periods of time.

In the day hospital surveyed, 30 percent of the patients suffered from stroke, 30 percent from arthritis, 22 percent from chronic brain syndrome and 18 percent from other diseases. The principal reasons for attendance were physical maintenance (42 percent), rehabilitation (27 percent), and social reasons (26 percent). Five percent came for other reasons, primarily medical and nursing procedures.

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Physical rehabilitation was regarded as the most important function of the day hospital by most geriatric consultants; physical maintenance therapy came second. Medical and nursing procedures provided in the day hospital were considered by the consultants to be of lesser importance. According to Professor Brocklehurst, this may be an indication of the fact that relatively few patients can benefit from such services in the day hospital, rather than a reflection of a feeling that the service itself is not important.

The day hospital has an important staff education function. Eighty-three of the programs had an arrangement for regularly scheduled case conferences attended by doctors, nurses, ancillary, and social workers or for a review clinic run by doctors and nurses only. In some case conferences, patients are discussed but not seen, and in others, patients are first discussed and then each brought in to meet the group, discuss progress, and demonstrate what has been achieved. Brocklehurst stresses that the case conference not only provides an opportunity for the geriatric rehabilitation team to exchange ideas, but serves as an excellent medium for teaching students of all disciplines.

Admission of patients for primarily social care in day hospitals or maintaining such patients after the need for rehabilitation is past is a controversial issue in Great Britain. Brocklehurst reports:

"Some consultants reluctantly accept social care as a major role for their day hospitals. They argue that, while they do not regard this as a proper function of a day hospital, if they do not provide such care, no one else will, and the end result will be the admission of more in-patients. To a small extent many day hospitals have some of these patients who require only social care."

In general, those coming for social care in Great Britain are not coming to allow relatives to go out to work, but more often attend the day hospital to give relatives a breather once a week. Another important reason for social care is to combat the patient's social isolation.

Some authorities recommend as beneficial a mix of the mentally disoriented with other patients in the therapeutic environment. On the other hand, the geriatric consultants in day hosiptals surveyed by Brocklehurst considered social care of the mentally confused to be of little value as a day hospital service.

Brocklehurst calls for a more positive approach to this problem than has been given to date, and points to the need for experiments to determine whether mentally confused patients could best be cared for in geriatric or psychiatric day hospitals or in social day centers.

In Brocklehurst's view, the provision of social care may be seen as an extension of the geriatric hospital service into community and preventive medicine. He strongly recommends the use of social day centers for many patients discharged from day hospitals (see section on social day centers).

Withington Day Hospital, University Hospital of South Manchester, Prof. J. C. Brocklehurst, Geriatric Consultant

The program is housed in a single story building forming a configuration of the letter "E". One wing is primarily for administrative offices; one for occupational therapy, including a demonstration kitchen, bath areas and an X-ray room; one wing is for physiotherapy, and also contains consulting rooms, nursing treatment rooms, and a

soundproof room for speech therapy. Specially designed toilet areas have been provided for men and women. An open area outside of the building is utilized as a raised garden tended by the patients during the summer. A large general activity area and a well-equipped gymnasium are also provided, along with a section for administrative offices. The facility is well equipped, spacious, and attractive.

The prime emphasis in this comprehensive day hospital is rehabilitation. Maintenance, medical, and social problems are also dealt with, but to a lesser degree. For all patients, the program contains activities designed to promote resocialization and reorientation to living in the community and to maximize ability for independent living.

The day hospital currently serves approximately 70 patients daily, including 45 participants from the community and 25 inpatients. It is planned to gradually increase the number served to achieve a daily census of 120, comprised of 60 community participants and 60 inpatients.

Transportation is primarily by ambulance, with taxi service used to a limited extent for participants living outside of Manchester. Four ambulances bring participants from the community, while porter service and internal ambulance service is used for participating inpatients. Transportation was identified as the biggest problem; lack of additional transportation was given as the main factor preventing program expansion.

The program day is from 8 a.m. to 5 p.m., with patients attending from one to five times a week, depending on need. The majority of patients come two to three times a week; early strokes come daily. The average length of attendance is from 13 to 16 days over a 2- to 3-month period.

The team consists of doctors, nurses, occupational therapists, physiotherapists, speech therapists, dietitian, medical social workers, podiatrist, aides, and administrative personnel. Unit meetings of all day hospital staff are held periodically to encourage interaction between the disciplines.

The patients' physical conditions cover a wide range, with strokes predominating. Age range is from 50 to over 90 years.

An impressive array of equipment for physical and occupational therapy is provided. Included is an experimental rowing machine designed by Professor Blocklehurst for muscle strengthening.

An innovative board that is centrally located identifies the daily activities for each patient. Magnetic symbols of various colors and shapes are used to indicate the specific activities and services. This insures each patient participating in each service prescribed, and prevents the need for waiting for services.

The care plan is developed by a multidisciplinary team from the day hospital. The physician is not part of the team, but his recommendations are incorporated into the plan. Case review clinics are held at which each patient is reviewed at least once a month, and more often if medically indicated.

I had the opportunity of attending a case review session, chaired by Professor Brocklehurst and attended by the day hospital professional staff as well as a group of medical students. The procedure consisted of a discussion of an individual case by Professor Brockle-

hurst, with professional staff contributing pertinent information. Discussion concerned not only the medical but the social aspects of the case. (This provided the medical students with knowledge about such community resources as meals on wheels, home help aides, home nursing, etc.) Following the discussion, the patient was brought to the room, and progress and problems were discussed by the patient and Professor Brocklehurst. Significantly, the patient was made part of the process by Professor Brocklehurst, and his attitude permitted the patient to feel completely at ease.

Varied problems were presented for discussion. In one case, the patient fell frequently in his home, and a decision was reached to supply a wheelchair to be used in the home as a preventive measure. In another instance, during the discussion period prior to the patient's appearance, the problem of decreasing mental capacity was discussed, and retesting for mental acuity was recommended. The students had the opportunity to observe the patient when he was brought into the room. In still another case, Professor Brocklehurst called attention to an ill-fitting brace, and ordered the appliance to be adjusted.

In each case presented, the schedule for day hospital participation was discussed with the patient. For some, changed schedules (either increase or decrease in participation) were discussed and mutual agreement was reached on proposed changes.

During the course of the case reviews, Professor Brocklehurst very adroitly questioned the students for their opinions, and the resulting dialogue was teaching in action. It would appear that with skillful leadership such as that provided by Professor Brocklehurst, this approach could be adapted in U.S. day care programs to provide effective teaching programs in the medical and social aspects of care for the elderly not only for medical students but for students of social work, nursing, and the various therapies.

Social care in day hospitals is provided for patients with physical or mental disability, including many who use wheelchairs and some who are incontinent. Many of the patients suffer from chronic brain syndrome, and to a lesser extent, day hospitals serve younger patients with chronic neurological disorders. In most instances, such patients could not be managed at social day centers.

In his excellent report, Professor Brocklehurst suggests that patient needs should be taken into consideration in planning the physical facility. He points to the fact that since 13 percent of the patients are in wheelchairs, and an additional 59 percent use walking aids, proper allowance must be made in constructing day hospital buildings. This would call for wide corridors, with access to lavatories around baffle walls and not through doors which have to be opened.

Hastings Day Hospital, St. Helen's Hospital, Hastings, Prof. R. E. Irvine, Geriatric Consultant

Hastings is a popular area for retirement, with approximately 25 percent of the population aged 65 and older, and a sizable segment of this group in the 75 and older age category.

While the day hospital places emphasis on short-term rehabilitation to permit the patient to return to independent living, the majority of

the patients attend for maintenance or for purely social reasons. Professor Irvine underscores the fact that this indicates "the need, at present not catered for, for a day center run by the local authority. Were day care not available many of these people would need inpatient or residential care, probably for long periods."

Irvine holds firmly to the concept that the occupational therapist is the most effective director of the day hospital. In a report on day hospital, he said:

"Day units may be oriented to nursing or to rehabilitation. In my view, the proper orientation is to rehabilitation, and the proper person to be in charge is the occupational therapist. She understands best how creative work brings reablement of mind and body, sustains morale, and restores to the patient, however infirm, a sense of his unique value as a human being."

Hastings Day Hospital provides diagnostic workups, functional assessment, short-term rehabilitation, long-term rehabilitation, services to prevent deterioration, and support for relations caring for participants.

Providing 30 places a day, the facility is located in a purpose-built building that also serves as the occupational therapy department for the hospital. Most of the long-term patients attend once or twice a week, although a lesser number, including those receiving short-term rehabilitation, attend more often.

A study carried out in the first 2 years after the day hospital started in 1965 revealed that approximately two-thirds of the 328 patients served were over 70; 15 were under 50, with the youngest a spastic girl, 23. The average age was 75.

Approximately half of the patients have cerebrovascular disease, and many of these suffered mental as well as physical impairment. In 75 patients, the principal diagnosis was arthritis. Other forms of neurological disease, principally multiple sclerosis, cervical spondylosis with myelopathy, Parkinsonism and motor neurone disease, accounted for a further 37. Fourteen patients had recent fractures, mainly of the femur, and there were nine recent amputees. Among the remaining 30 were a wide variety of diagnoses, including diabetes, bronchitis, and heart disease. In most of the patients, psychological and social factors were as important as the medical factors in determining the need for day care. Forty-nine, or one in seven, lived alone.

Referrals are made by family physicians and by the hospital departments of physical medicine, orthopedics and psychiatry. Slightly less than one-third of the participants were former hospital patients who needed continuing care and rehabilitation after discharge from the hospital.

Only two of the day hospital patients in the 2-year study required care in long-term beds, and according to Irvine, this is probably the most significant fact to come out of the study.

Irvine is concerned with the problem of the growing number of those who need long-term protected care, and how this will affect the day hospital. He proposes two courses of action that may be taken: (1) to expand existing day hospital programs, and (2) to have the local authorities establish sufficient social day centers to serve those in need of preventive services.

BEXHILL GERIATRIC UNIT AND DAY HOSPITAL, PROF. R. E. IRVINE, GERIATRIC CONSULTANT

The Bexhill Day Hospital is housed in a bright modern facility, and serves the surrounding community that, like Hastings, is composed of a high proportion of retirees.

At this facility, I had the privilege of attending a case review session that is a weekly occurence, following a working luncheon. Chaired by Professor Irvine, participants in the program include the multidisciplinary staff of the geriatric unit and day hospital; the local physicians whose patients are to be reviewed are also invited to participate. Five physicians attended the review session, and this was considered an excellent turnout. Apparently, it is not easy for the physicians to find the time for regular attendance.

Of the 52 cases reviewed, 19 were day hospital participants and the remainder were inpatients of the geriatric unit.

Some of the cases were dispensed with in short order; other required more detailed discussion by social workers, nurses, therapists and/or the physicians in attendance. This appeared to be a valuable educational experience for all concerned, and decisions were made by consensus of the total group. Irvine very skillfully conducted the review process.

LENNARD DAY HOSPITAL, BROMLEY, PROF. R. NAYLOR, GERIATRIC CONSULTANT

Established in 1962, Lennard Day Hospital was the first nonpsychiatric geriatic day hospital in Great Britain. Professor Brocklehurst was the first director of the program, and continued in that role until his transfer to Manchester several years ago.

Most of the facility in which it is housed was built specifically for use of the day hospital. The new portion is comprised of three sides of a square, with the fourth side of the square the existing hospital. In the center of the day hospital is a beautiful garden-courtyard, and the glass walls lining the three corridors of the new part of the structure provide an unencumbered view of the garden-courtyard, giving a cheerful touch to the environment.

The physiotherapy department is located in a bright and well-equipped gymnasium. Occupational therapy is administered in three smaller patient activity rooms. A dining room that seats 36 is located in the facility and two seatings are made at lunch.

Inpatients also participate in the day hospital program; approximately 36 day hospital patients and an equal number of inpatients are served daily.

Day patients are transferred in four 10-seater ambulances of the Greater London Council ambulance service, each of which has a hydraulic lift.

An outreach team goes to the general hospital for referrals, and most of the admissions are for rehabilitation therapy from the surgical ward of the general hospital.

Because the program has been ongoing for 13 years, the local physicians know about it and also refer patients. However, Professor Nay-

lor pointed out that a large proportion of physician referrals are inappropriate for day hospital care. He also reported that in many instances, it is difficult to get good cooperation from the family physician after the patient is enrolled in the day hospital. Naylor speculated that the reason for this attitude may be that, in general, physicians know about the rehabilitation of young patients but are not very knowledgeable about rehabilitation of the elderly.

Naylor said that the program at one time was much larger, accommodating 110 participants. In his view, this program was not successful because with the larger numbers, services became depersonalized, the area needed to accommodate the program was so large that the therapists got fatigued. The program was then cut back to its present size.

On the first day of enrollment, the patient is seen by the geriatric registrar for assessment and examination, and a care plan is developed. The geriatric registrar attends the program daily, and provides continuing medical supervision to those patients needing it, and cares for any participants who might be unwell. He maintains contacts with the family physician. Regular case conferences are held at which treatments are reviewed and social problems discussed. A review is carried out for each patient at least once a month.

The primary aims of the program are physical rehabilitation and maintenance, and the ultimate goal is to discharge the patient whenever feasible. Naylor is of the firm opinion that day hospitals should be directed by a nurse rather than an occupational therapist, as some others in Great Britain recommend.

FIVE-DAY WARD

An innovative program, the first of its kind, has recently been established by Naylor in conjunction with the day hospital. The 5-day ward has 16 beds and is used for patients suffering from strokes, fractures, and Parkinson's disease. Patients arrive on Monday morning and are returned to their homes on Friday afternoon. The rationale behind this is the difficulty in getting staff to work on weekends. Research is planned to determine the reaction of family physicians to this new form of care. At the time of my visit, the ward with its 16 beds had no visible patients; they were all involved in therapy or activities.

Supportive services as needed during the weekend are provided by the community. Dr. Naylor indicated that another unique feature of this program is the sharing of responsibility by the community and the hospital for the patient who needs hospital care.

St. Pancras Day Hospital, St. Pancras Hospital, London, Prof. A. N. Exton-Smith, Geriatric Consultant

Located in an innercity area, St. Pancras Day Hospital has a target population of 130,000 and serves 35 participants daily. Staff consists of one nurse, two nurse-trainees, two nurse aides, one part-time physical therapist, one part-time occupational therapist, and one speech

therapist twice a week. (The feeling was expressed that the ideal arrangement would be to have the services of a speech therapist available on a 5-day a week basis.) The facility is spacious and well equipped, and a stroke rehabilitation unit is being established. Of particular interest is the day hospital bathroom area, with toilets and washbasins specially designed to easily accommodate wheelchair patients. (The writer has photographs of this equipment.)

Professor Exton-Smith is actively involved in furthering the day hospital program in Great Britain, and has collaborated with Professor Irvine in planning a day hospital conference in September 1975. Dr. John P. Keet, clinical lecturer and senior registrar of the day hospital, is a bright young physician who is carrying out collaborative research with Baylor University (Texas) for the development of psychometric instruments for objective measurements of the effect of behavior modifying drugs.

Approximately 25 percent of the total participants are stroke patients; 5 percent have Parkinsonism. The largest group suffer from inmobility of some sort, including a significant proportion suffering from arthritis. Very few senile patients are admitted, and continence in such patients is a requirement.

Half of the participants attend one or two days a week; the remainder attend more often. Post-hospital stroke patients attend two to three times a week until it is feasible to reduce attendance to once a week, followed by once a month. When indicated, following discharge, the participant is discharged to a social day center.

Oral medications are not customarily administered by staff. Periodic checks are made on intake of medications through surprise visits to the home by day hospital staff at which time remaining pills are counted to make sure the medications have been taken as prescribed.

Transportation is by ambulance manned by a driver and an aide, with the target population residing in a 5-square-mile area. Two ambulances and two crews are provided for this program.

The following problems were identified by staff:

(1) Transportation—having the ambulances arrive promptly, and having sufficient ambulances to do the job.

(2) Discharge—preventing a bottleneck between the day hospital and the social day center. Approximately 20 percent of the participants participate in the day hospital on an indefinite basis; many could be discharged to the social day center if they could be accommodated in this program.

(3) Communication between general practitioners and day hospital physicians could be improved.

(4) Nonattendance at day hospital by participants.

(5) Need for a psychogeriatric program; this is the only service needed by approximately one-eighth of day hospital participants.

Staff members agreed that in general, the overriding problem is the lack of policy decision on whether the day hospital should be purely a medical operation, or whether the program should also serve those whose primary need is social. They are aware of the fact that, in many instances, if such social needs are not addressed, these problems degenerate into medical problems that require long-term inpatient care.

Social Day Centers

For the physically and/or mentally handicapped elderly, social day centers provide personal care in a protected social setting—company, a cooked meal, and in some cases bathing and podiatry services, but do not provide the therapeutic services found in the day hospital. These centers are usually run by local authorities or voluntary bodies, and frequently both groups are involved with their work coordinated through the old people's welfare committee. In accordance with the 1968 Health Services and Public Health Act, transportation must be provided in these programs. Referral is usually made by the family physicians or the social worker.

In *The Geriatric Day Hospital*, Brocklehurst repeatedly called for the creation of more social day centers that would serve as appendages to geriatric day hospitals.

Discussing the problem in the introductory chapter, Brocklehurst wrote:

"Almost all papers written about day hospitals stress the importance of developing complementary social day centers in the community for those whose needs are social rather than medical. Woodford-Williams and Alvarez went further and suggested the need for four complementary day establishments within the geriatric service—a day club, a workshop for the elderly, a day ward, and a day hospital."

Of the 119 day hospitals in operation or expected to be in operation in 1970, 76 reported that social day centers with supporting transportation services were already available.

Brocklehurst regards social day centers as essential to the proper functioning of day hospitals, and emphasizes that when such centers do not exist, discharge from the day hospitals is adversely affected.

The following excerpts relating to social day centers were contained in the report of the survey of 5-day hospitals:

LENNARD DAY HOSPITAL, BROMLEY

The neighborhood has three social day centers with their own transport, and more are planned. Their use is limited largely by insufficient transport, and at present not everyone who would be suitable can be transferred to a social day center.

DAY HOSPITAL AT JOYCE GREEN HOSPITAL, DARTFORD

A somewhat ruthless policy of discharging patients as soon as useful therapy is completed has been the rule since the day hospital opened. We are fortunate in having several social day centres run by the old people's welfare committees in our area to which we can refer some of our patients on discharge. A return to isolation and inactivity is thus avoided, but despite this we find some patients no longer require active therapy who, if not attending the day hospital once a week, put themselves to bed at once on return home. Sometimes they have to be admitted as inpatients, later to be mobilized. We have, therefore, to keep this group of perhaps 20 patients attending at least once a week. They tend to get in the way of patients undergoing active therapy, and additional space where they can be accommodated and kept occupied is badly needed.

WESTBROOK DAY HOSPITAL, MARGATE

The statutory and voluntary agencies must develop day centres and clubs in the area to cope with the demands of healthy, but socially isolated, elderly people.

LINTON DAY HOSPITAL, MAIDSTONE

. . . Some of these social cases could be discharged if there were suitable day centres in the town.

HASTINGS DAY HOSPITAL

. . . Many more (than for short term rehabilitation) come for maintenance and for purely social reasons. The last reason is an indication of the need, at present not catered to, for a day centre run by the local authority.

Often the main difficulty is transportation. Without this essential service, social day centers simply became luncheon clubs for the able-bodied, excluding those whose needs are greatest.

The concluding chapter of Brocklehurst's report indicates that provision of social day centers seems to follow a year or two after the opening of a day hospital. He warns that if social day centers are not developed, a sizable number of patients coming for social reason only tend to accumulate in the day hospital.

KING GEORGE VI MEMORIAL CLUB (SOCIAL DAY CENTER) CAMBERWELL, MRS. ANN DARSELY, DEPUTY WARDEN

This social day center is unique in that it is not run by the local authority, but rather is a voluntary effort, supported by contributions with limited input from the government. The program is designed specifically for the disabled and handicapped, and does not admit those whose only problem is social isolation.

The program is carried out in a free standing facility, and includes a cheerful, spacious general purpose room, a small administrative office, a kitchen and bathing and toilet facilities.

Ambulance service is provided, with three pickups a day, the first pickup starting at 9 in the morning and arriving at the center at 9:45 a.m. The earliest arrivals are the first to leave in the afternoon, and those who don't arrive until 11:30 a.m. leave at 5 in the evening.

A total of 250 are enrolled. The program could accommodate 300, but limited ambulance capacity to transport wheelchair participants is the restricting factor. Between 45 and 50 attend daily, the majority coming once a week. Where the need is indicated, a limited number is permitted to attend twice a week. Participants suffer from arthritis, multiple sclerosis, stroke, cardiovascular disease (a number of whom have pacemakers). The age range is from 70 to 90, with one participant age 96. At the time of my visit, I observed that a large proportion were in wheelchairs or used walking aids. Primary sources of referrals are day hospitals and health visitors.

Staffing is as follows: three administrative personnel (warden, deputy warden, secretary); full-time occupational therapist (paid by the government); hairdresser (3 days one week, 2 days the next);

chiropodist (1 week a month); hall orderly (male—assists in bathing male participants); bathing attendant (bathing is done using a special shower seat); and two escorts for ambulance services. With the exception of the occupational therapist, the remainder of the staff is paid from funds raised through voluntary efforts in the community. Many volunteers participate in the program, both in the center itself and through helping participants shop for groceries.

Participants pay a minimal amount (8 pence) for lunch, tuppence for tea and thruppence for coffee and a sweet, and the borough helps to make up the deficit for food cost. Except for diabetics, no special diets are provided.

The warden and deputy warden are nondegree social workers, and except for the occupational therapist, there are no professionals working in the center.

As I observed the program, I could sense a happy and relaxed feeling on the part of the staff as well as the participants. Undoubtedly, much of this can be attributed to the leadership. Although the warden was not present on the day of my visit, the deputy warden, Mrs. Darsley, is an outgoing person who relates easily to the participants and who brings a spirit of gaiety to the program. From my observations in the United States as well as in England, it is this intangible quality by the leadership of combining an attitude of caring with a spirit of lightheartedness that positively affects the response of participants to the program.

In essence, the program provides occupational therapy, personal grooming (including bathing), podiatry, lunch and snacks, and socialization. Through the borough, the social service program provides funds (1½ pounds per participant) to supplement the recreational activities. Mrs. Darsley told me that although in the past, a yearly holiday involving a week at a resort area was planned, this practice has been discontinued. Considered a huge success by those who attended, wheelchair patients had to be excluded from the activity, and this did not seem fair. Therefore, starting with this year, the week-long holiday has been replaced by more frequent day-long outings at which all can participate. (Participants contribute 50 pence each for every outing.)

Mrs. Darsley pointed out that although the social day center program of the King George VI Memorial Club is not unique (except for the fact that it is supported primarily through voluntary rather than governmental effort), there are in fact a very limited number of programs in Great Britain that are designed exclusively for the disabled and handicapped.

REFLECTIONS ON VISITS TO DAY HOSPITALS IN GREAT BRITAIN AND ISRAEL

In Israel, where day hospitals are a fairly recent innovation, the concept appears to be enthusiastically accepted in the ongoing programs, while other physicians in the nation have mixed feelings—some anxious to initiate the program in their facilities, others concerned about starting a program because of lack of available space, staff, etc. However, the health authorities I talked with, Dr. Jacob Menczel, director-general of the Ministry of Health, and Dr. Joseph

Silberstein, director of chronic illness and aging, feel strongly that sufficient programs should be developed so that all who could benefit from such services should have access to day hospitals.

In Great Britain, day hospitals are an accepted module of care in the health delivery system, with resources provided by the government. (The writer was particularly impressed in London at the sight of a large building being constructed next to a hospital, with a large sign in front indicating that this was to be a day hospital.)

No regulations pertaining to day hospitals are in effect in Great Britain and thus many models have evolved. To my knowledge, however, no research has been undertaken to determine the relative effectiveness of the various models with respect to costs, quality of care, size, program content, location, staffing, and physical facilities.

Despite the fact that ambulance transportation is provided through the health system, transportation was mentioned as one of the most serious problems in each of the programs visited. In some cases, program expansion is limited by the number of ambulances available. In other instances, the problem of having day hospital ambulances diverted for emergency use was identified.

The urgent need to have a lower level of care (social day center) to which day hospital participants could be discharged was repeatedly emphasized.

In the United States, many health and social welfare authorities feel that efforts should be concentrated upon the practitioners of the future—doctors, social workers, therapists, nurses, nutritionists—those who are *now* receiving their training. The experience in Great Britain demonstrates that properly conducted case review conferences in the day care programs can be a valuable educational experience for sensitizing the future health practitioners to the multifaceted and closely interwoven health and health-related problems of the elderly.

The experience of visiting the program in Great Britain and Israel was exceedingly valuable to me, and I am deeply grateful for the opportunity to have made the trip, and to the various health authorities and program staff personnel who gave so generously of their time in sharing ideas.

OPERATIONAL RESEARCH IN GERIATRIC DAY CARE IN THE UNITED STATES [1]

In recent years, sharply accelerated interest has been focused on the potentials of geriatric day care and day hospital care as modalities of care for shortening, delaying or preventing the need for institutionalization, especially for the long-term patient. In a concerted effort to determine whether such modalities could be effectively integrated into the health care system, operational research in geriatric day care is currently being supported by the U.S. Department of Health, Education, and Welfare. This paper will describe experiments designed to provide guidelines for future policy decisions.

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[1] Presented at the 10th International Congress on Gerontology in Jerusalem, Israel (June 22–27, 1975), by Edith G. Robins, Deputy Director, Division of Long-Term Care, National Center for Health Services Research, Health Resources Administration, U.S. Department of Health, Education, and Welfare.

Because of differences in nomenclature used to identify similar forms of ambulatory care in other countries, I would like to describe four modules of such care in the United States. Let me hasten to point out that these modules do not represent categories established by Federal regulation. They have been developed by me to help clarify the subject under discussion.

Each of these four modules has certain commonalities, such as: psychosocial activities to improve and maintain mental health; health supervision and supportive services; nutrition services, including the noonday meal and snacks; and transportation. Modules I and II describe programs that provide a time-limited therapeutic regimen to acutely ill patients with the ultimate goal of restoring them to independent living or to permit them to be transferred to a less intensive form of care. In contrast, Modules III and IV provide long-term maintenance services designed to permit the individual to remain in the home setting as long as possible. The experiments discussed in this paper are based on services described in Modules II and III.

Module I

Module I provides intensive restorative medical and health supportive services to individuals who otherwise would have remained as inpatients had this form of care not been available.

Such patients are brought to the facility and receive the full range of medical services along with the health supportive services during the day, and are returned to their homes evenings and weekends. When indicated, transportation is in the form of ambulance service. A vital aspect of this program is training of family members to assume limited responsibility for home care; and any needed supplemental home health services are provided by public health nurses, home health aides, or physical or speech therapists.

This model of care does not now exist in the United States, but Federal support has been provided for an experimental model to be established for research purposes in a highly sophisticated rehabilitation center in New York. It is anticipated that the findings of this experiment will indicate whether or not this is a feasible, cost-effective form of care that is acceptable by the patient and his family in lieu of inpatient rehabilitation services.

Module II

Module II provides time-limited, intensive restorative services to the post-hospital or post-nursing home patient.

A major difference between Modules I and II is that in Module II, physician services are not provided directly by the program as in Module I. Rather, continuing medical care is the responsibility of the patient's personal physician and is provided in a setting other than Module II. The personal physician makes recommendations for care that are incorporated into the care plan developed by the module's multidisciplinary team.

The physician on the Module II staff serves as the leader of the multidisciplinary team, and also plays a major role in policy development, staff training, and provision of staff consultation to insure the delivery of high quality care.

Module III

Module III provides long-term health maintenance services to a high risk population who either are eligible for institutional care or could reasonably be expected to be eligible for such care in the near future if continuous health monitoring and supportive services were not provided. This form of care often provides the essential physical relief to family members in their efforts to maintain the individual in the home setting, or provides the essential supervision during the hours when family members are at work and there is no one in the home to give the needed care. The majority of Module III participants live with family members or others who can provide health supervision and needed services in the home setting; in some instances, additional supportive services in the home are required.

Depending on individual circumstances, the possibility exists for an individual to receive intensive care from Modules I or II for a portion of a week, and receive the less intensive form of care from Module III for the remainder of the week.

Module IV

Module IV provides preventive care for the frail elderly who primarily require psychosocial activities in a protected environment. In this module, there is far less need for health services and therapies. Primary emphasis is placed on socialization and the maintenance of proper nutrition in order to prevent or to decelerate the mental and physical deterioration that is a frequent by-product of the aging process and is accentuated by social isolation.

Interchange Between Modalities

The health status of the long-term patient, particularly the elderly patient who has multiple diseases, is subject to frequent change. The necessity for periodic transfer from one module of care to another can thus be anticipated.

Related Modalities of Care

Psychiatric day hospitals have long played an important role in treatment plans for psychiatric patients. Increasing attention is currently being directed at the potential for highly specialized day care programs for cancer patients, the mentally retarded, etc. Such categorical approaches to day care are not included in the experiments to be described in this paper.

Experiments in Geriatric Day Care

As early as 1963, the Federal Government provided support for day care experiments. More recently, legislation was passed specifically requiring additional research. Public Law 92–603 (Social Security Amendments of 1972) mandated that experimental programs be developed to provide day care services for individuals eligible under the medicare and medicaid provisions of the Social Security Act. Under this authority, seven experimental research studies are being developed.

Two of the programs are being conducted in inpatient rehabilitation centers, two in medical centers with fully developed rehabilitation services, one in a skilled nursing facility, and two in free standing facilities.

The research plan and methodology for these experiments were developed by a DHEW Interagency Task Force. Random allocation of eligible patients to either experimental or control groups is an underlying requisite in each demonstration study. Moreover, for purposes of comparability of data, the following working definitions of the therapeutic model of day care were developed:

> *Day care* is a program of services provided under health leadership in an ambulatory care setting for adults who do not require 24-hour institutional care and yet, due to physical and/or mental impairment, are not capable of full-time independent living. Participants in the day care program are referred to the program by their attending physician or by some other appropriate source such as an institutional discharge planning program, a welfare agency, etc. The essential elements of a day-care program are directed toward meeting the health maintenance and restoration needs of participants. However, there are socialization elements in the program which, by overcoming the isolation so often associated with illness in the aged and disabled, are considered vital for the purposes of fostering and maintaining the maximum possible state of health and well-being.
>
> *Impaired adult* is a chronically ill or disabled individual whose illness or disability may not require 24-hour inpatient care but which, in the absence of day care services, may precipitate admission to or prolong stay in a hospital, nursing home, or other long-term care facility.

Purpose of Experimental Programs

The purpose of the experimental programs is to provide ambulatory care services to impaired adults who are capable of only marginal self-care. Such care, provided on a short-term basis, serves as a transition from an acute care hospital, long-term care institution, or home health care program to personal independence. When provided on a long-term basis, such care serves as an alternative to institutionalization in a nursing home or other long-term care facility. As mentioned earlier, programs to be tested are comparable to those described in Modules and II and III.

Standardized Instruments Used in Each Study

Referral sources include individuals, institutions, and agencies who have agreed to refer patient to the demonstration.

Through the use of a presumptive screening form, the referral source alerts the program to patients meeting basic eligibility criteria. This presumptive screening form includes patient identification data, diagnostic information, and a statement of reasons why the patient was referred. An informed consent form is used to obtain the patient's agreement to become a participant in the demonstration project.

A patient status instrument, developed especially for these experiments, is the major source of data on the patient's health and functional status, including psychological, social, economic, and demographic characteristics. At the first assessment, this instrument is used to determine whether or not a patient is a suitable candidate for the demonstration, and to provide information for the development of patient care plans.

The demonstrations will accept patients judged to be suitable for the experimental services and will randomly assign patients into two groups. Patients in the "expanded benefits" group will be covered for the cost of authorized day care; patients in the control group will not have this additional coverage.

The assessment team care plan is a form on which the assessment team records its "ideal" plan of treatment for the patient and its prognosis for patient outcomes. This plan, when completed, is not shown to the patient's attending physician or to other health services providers, but is used to compare prescription patterns actually followed with those the assessment team regards as "ideal," and to compare predicted patient outcomes with actual outcomes.

Evaluation of Each Study

Evaluation will be addressed to the major policy issue of whether day care services ought to be routinely provided as benefits under the medicare and medicaid programs. The evaluation will provide estimates of the effectiveness and costs of these "experimental" services as compared with traditional service modes, and on some of the potential consequences in terms of patient outcomes. Information will be analyzed on patient and family satisfaction with this form of care. Appropriateness of placement decisions and care planning will be evaluated. Attention will also be directed to the role of the experimental services in the total health services system in terms of linkages between referral sources and providers.

Special Challenges of Day Care Experiments

The research I have described is being carried out to test the effectiveness of a new concept of care that realistically is still in an evolutionary stage, and this presents a very special challenge. For maximum effectiveness of these experiments, answers are needed to very basic questions such as: What mix of patients is most effective? What is the optimal staffing pattern? How does the setting (hospital, nursing home, rehabilitation center, free standing facility) affect the services that could or should be offered? What pattern of fee schedules should be developed (fee for service, inclusive fee, fee for modality of care provided)? And for meaningful communication, a very urgent need exists for the development of a standardized nomenclature for the various modalities of geriatric day care.

Day Care Programing in the United States

The day care experiments are just now becoming operational, and findings will therefore not be available for at least a year and a half.

At the State and local levels, however, authorities are not waiting for the final word.

A flurry of activity has taken place in communities throughout the Nation directed toward the development of geriatric day care programs. A few States have seized the initiative and issued their own guidelines, and in a very limited number of cases are already providing reimbursement for such care through medicaid.

To assist the States in their efforts, and to provide an effective forum for exchange of ideas, it is anticipated that a federally sponsored National Conference on Day Care will be held in Washington, D.C., in the fall. We hope that those of you who are involved with this new modality of care will be able to join us at that time.

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Appendix 4

MATERIALS SELECTED FROM HOME HEALTH CARE DEVELOPMENT, PROBLEMS, AND POTENTIAL; BY MARIE CALLENDAR AND JUDY LAVOR [1]

REPORT FROM THE HEALTH INSURANCE BENEFITS ADVISORY COUNCIL ON HOME HEALTH CARE, SEPTEMBER 10, 1974

BACKGROUND

The recommendations in this report are made in the belief that home health care is a basic component of any comprehensive health program. Properly utilized, in-home health services can provide a preferred means of restoring and maintaining the health of individuals and families, as well as reduce or prevent hospitalization or long-term institutional care. Furthermore, studies indicate that the majority of older persons prefer to remain in their own homes. The familiar intimacy of the home setting meets a unique and vital health need: convalescence is faster, more complete.

The home health care benefits currently available under the medicare and medicaid programs as well as from other third party payers are far from meeting the full range of patients' health care needs. Home health care currently accounts for less than 1 percent of medicare expenditures and an estimated 0.4 percent of Federal/State expenditures under medicaid. Increased utilization may follow the recent elimination of beneficiary coinsurance payment for home health care under the medical insurance portion of medicare; however, further changes are needed before home health care can reach its full potential as an important contributor to the Nation's health care delivery system.

The present low utilization of home health care benefits can be attributed to a variety of factors. These include the medicare statutory requirement for "skilled nursing care"; the absence of coverage under the medicare law for homemaker services; the lack of recognition on the part of physicians, other providers and patients of the available benefits or of the services of local agencies; the reluctance of some physicians to prescribe home care; and the absence of home health care services in rural or remote areas. From the consumer standpoint, home health services of quality are not a valid resource in terms of availability and accessibility. About half of all the counties in the Nation had no home health agencies as of July 1973.

The report of the Special Senate Committee on Aging, "Home Health Services in the United States" (April 1972), identifies convincingly the problems which home health agencies are encountering in their endeavor to provide vitally needed services to home bound

[1] Office of Social Services and Human Development, Office of the Assistant Secretary for Planning and Evaluation, HEW.

patients under medicare or medicaid programs. The Special Committee on Aging feels that the legislative instrument materially limits the delivery of home health care. In addition, participants in the hearings before the Special Senate Committee on Aging identified restrictive administrative policies, complex reimbursement procedures, narrow interpretation of the law, and limited coverage as serious roadblocks to the development of additional home health services.

This is reinforced by the GAO report of July 9, 1974, "Home Health Care Benefits Under Medicare and Medicaid," which emphasizes the same problems and makes specific recommendations to improve utilization and assure more effective and uniform interpretation of existing benefits.

While home care can normally be provided at a fraction of the cost of inpatient care, there are no definitive national cost figures. The GAO report cites the fact that several studies have pointed out that home health care can be considerably less expensive than care in a hospital or skilled nursing facility. The committee believes that it will prove to be more cost effective to utilize home health care services instead of institutions for the long-term care patient. It urges the Secretary to continue the special studies authorized by section 222 of Public Law 92–603 in order to broaden the existing base of knowledge about home health care.

There is ample documentary evidence that home health services represent a logical, humane, and economical means of maintaining a quality of life and of forestalling or shortening institutional care. The restrictive laws now in effect do not recognize the value of preventive, supportive, and counseling services in health maintenance. The chronic diseases to which the aging are prone demand sustained attention to prevent health care crises requiring institutionalization.

Home health care is also preferred for those who require only part-time or intermittent health services. A home health aide can frequently make it possible for an ailing person who lives alone, or with a spouse too frail to provide care, to remain at home.

Despite the demonstrated value of home health services, priority continues to be given by third-party payers and current legislation to the present institutionally oriented system of health care. Reversing this priority would make it possible for home health care to emerge as a major national health resource and to take its rightful place in any comprehensive health insurance program that may be enacted.

There is a broad concensus and increasing activity regarding the need to expand the breadth, scope, and reimbursement of home health services, subject to appropriate utilization safeguards. Such expansion could be accomplished by revising or eliminating restrictve administrative and statutory requirements; embarking on a program to develop an affirmative attitude toward home health services by third-party payers, physicians and others in the health care community, and consumers; and providing strong Federal support for the development of comprehensive home health services throughout the Nation.

Recommendations Relating to Medicare

Although the committee believes that a number of administrative and legislative changes would be desirable in the medicare home health

benefit, it has agreed that the recommendations below should be given highest priority. The administrative recommendations are considered by the committee as having potential for immediate implementation. The legislative recommendations have longer range implications and should be considered essential to any development of new health legislation or modification of existing benefits defined by statute.

ADMINISTRATIVE ACTIONS

(1) The term "home health aide" should identify an individual who could render a broad range of services addressed to health and health related needs. Current instructions are interpreted unevenly and, as a result, limit home health aide services to those which are only incidental and which are needed to protect the health and safety of the patient. Without a broad range of supportive services, aged persons who live alone may be forced from their own homes into an institution earlier than necessary. Since these supportive services are so often essential to the care and continued independence of the ailing elderly, it is recommended that efforts are made to uniformly interpret these services so that they become an integral part of the overall services.

(2) The adequate utilization of home health services requires knowledge and understanding by both the consumer and the health professional. It is recommended that the Department embark on a strong public information program to fully acquaint families, patients, physicians, hospitals, home health agencies and other health organizations with home health services currently available in the community.

LEGISLATIVE ACTIONS

(1) The words "skilled nursing care" in the physician certification requirements of the statute, and the words "skilled nursing services" in the conditions of participation for home health agencies, should be replaced by the words "nursing care," or "nursing services," omitting the word "skilled." The "skilled" nursing requirement has been one of the main barriers to the provision of needed home care to the elderly since it has limited benefits to those who are acutely ill and need rehabilitation, while denying needed benefits to patients whose condition has stabilized or who require a somewhat lower level of care than that defined as "skilled."

(2) At present, in order for a beneficiary to be eligible for any home health benefits, a physician must certify that the beneficiary needs either skilled nursing care or physical or speech therapy. Once this qualification is met, other covered services such as occupational therapy, medical social services, home health aide services, etc., are then covered. The physician certification requirement should be changed to provide that the need for any one of the covered services would qualify the person for home health benefits, provided the services are based on medical need and rendered as part of a written care plan approved by a physician.

Recommendations Relating to Medicaid

With regard to the medicaid program, the Home Health Committee endorses the GAO recommendations to improve the administration of the medicaid home health care benefits program by:

(1) Impressing upon the States that home health care is generally a less expensive alternative to institutional care and is, therefore, intended to be used when home health care would meet the patient's needs and reduce costs.

(2) Clarifying for the States the specific home health services which are eligible for Federal financial participation and define these services.

(3) Encouraging the States to establish payment rates for home health care at a level that will stimulate greater utilization of home health care.

(4) Encouraging and assisting home health agencies in their efforts to increase the awareness and support of the health field regarding medicaid home health care benefits as an alternative to institutional care.

Conclusion

The council urges that the Secretary approve the recommendations herein because of their contribution to sound patient care in the home and their potential for reducing unnecessary institutionalization

TABLE I

Part A-OASDHI hospital insurance: Number of claims approved for payment and amounts reimbursed by type of benefit, January 1969-June 1974 1/

Period claim approved 2/	Total 3/		Inpatient hospital		Home health Part A		SNF	
	Number	Amount reimbursed (000) 4/	Number	Amount reimbursed (000) 4/	Number	Amount reimbursed (000) 4/	Number	Amount reimbursed (000) 4/
1-69 to 12-69......	7,683,608	$4,485,495	6,129,417	$4,101,504	629,506	$48,870	922,016	$335,092
1-70 to 12-70......	7,458,521	4,818,723	6,275,717	4,546,519	566,561	46,455	616,154	225,748
1-71 to 12-71......	7,342,988	5,333,234	6,401,848	5,116,979	491,596	41,772	449,546	174,483
1-72 to 12-72......	7,575,459	5,852,811	6,666,846	5,653,233	520,902	47,924	387,710	151,654
1-73 to 12-73......	7,980,697	6,480,324	6,989,175	6,254,878	567,068	54,346	424,454	171,101
1-74 to 12-74......	4,382,519	3,779,636	3,861,779	3,656,890	305,963	31,319	214,777	91,428

1/ Includes only those bills recorded in the Social Security Administration central records before September 27, 1974. A bill does not necessarily represent a total stay in a covered facility or a complete series of visits covered under an established home health plan. Usually, more than one bill is submitted for each stay in a long-term hospital or in a skilled nursing facility and for visits under a home health plan. Through June 1973, includes data for services rendered to beneficiaries aged 65 and over. Beginning July 1973, includes data for services rendered to beneficiaries aged 65 and over and the new groups of beneficiaries who became entitled to hospital insurance benefits on or after July 1, 1973 (effective date for this provision of the 1972 Amendments). The new group includes persons entitled to Medicare because they meet the disability provisions of the Social Security Act and those entitled solely because of chronic renal disease.

2/ Period in which the intermediaries approved bills for payment.

3/ Included in total, but not shown separately, are bills for outpatient diagnostic services approved for payment under the hospital insurance program.

4/ Actual benefit payments as represented in trust fund transactions differ from amounts reimbursed as shown above, which represent payments for covered services based on an interim rate (either per diem or a percent of total charges) and adjusted at the end of each provider's operating year on the basis of audited reasonable costs of operation. Payments exclude deductibles and coinsurance amounts and noncovered services as specified by law.

TABLE II

Medicare: Number of home health agency (HHA) paid claims and the amount reimbursed, fiscal years 1967-73 1/

Period claim approved 2/ (Fiscal Year)	Total		Part A		Part B	
	Number of claims	Amount reimbursed 3/	Number of claims	Amount reimbursed 3/	Number of claims	Amount reimbursed 3/
1967............	554,886	$28,947,917	232,766	$15,277,589	322,120	$13,670,328
1968............	871,613	49,990,860	442,715	31,160,712	428,898	18,830,141
1969............	1,098,052	69,730,509	582,950	44,750,650	515,102	24,979,859
1970............	1,108,521	73,282,783	630,674	49,619,298	477,847	23,663,485
1971............	807,962	58,282,169	507,070	42,661,794	300,892	15,620,375
1972............	761,792	58,632,879	502,051	44,657,622	259,741	13,975,257
1973............	778,092	63,829,310	517,538	48,420,774	260,554	15,408,536

1/ Includes only those bills recorded in the Social Security Administration central records before March 30, 1974. A bill does not necessarily represent a complete series of visits covered under an established home health plan. Usually, more than one bill is submitted for visits under a home health plan.

2/ Period in which the intermediary approved bills for payment.

3/ Actual benefit payments as represented in trust fund transactions differ from amounts reimbursed as shown above, which represented payments for covered services based on an interim rate (either per diem or a percent of total charges) and adjusted at the end of each provider's operating year on the basis of audited reasonable costs of operation. Payments exclude deductibles and coinsurance amounts and noncovered services as specified by law.

TABLE III

Total Medicaid Expenditures and Total Expenditures for Home Care FY 1968-1973

Year	Total Expenditures (in Billions)	Total Home Care Expenditures (in Millions)	% of Total Expenditures by Home Care
1968	$3,200	5.5	.17
1969	$4.167	10.5	.25
1970	$4.767	15.4	.32
1971	$5.939	28.3	.48
1972	$7.346	24.9	.34
1973	$8.714	24.3	.28

	Total Medicare (Millions)	Total Home Health (Millions)	% HH to total Medicare
1967	$3,394.6	$28.9	0.9
1968	$5,347.1	$50.0	0.9
1969	$6,597.7	$69.7	1.1
1970	$7,149.2	$73.3	1.0
1971	$7,875.0	$58.3	0.7
1972	$8,819.2	$58.6	0.7
1973	$9,478.0	$63.8	0.7

TABLE IV

Number of facilities participating in the health insurance program terminated in fiscal years 1970 and 1971, and net change, by type of provider, type of termination, and division

Division and type of termination	Hospitals						Extended care facilities						Home health agencies			Independent laboratories		
	Number			Beds			Number			Beds			Number			Number		
	Fiscal 1970	Fiscal 1971	Net change	Fiscal 1970	Fiscal 1971	Net change	Fiscal 1970	Fiscal 1971	Net change	Fiscal 1970	Fiscal 1971	Net change	Fiscal 1970	Fiscal 1971	Net change	Fiscal 1970	Fiscal 1971	Net change
All areas...	63	141	+78	3,397	13,914	+10,517	695	708	+13	35,511	39,016	+3,50	49	170	+121	60	124	+64
Voluntary.......	37	132	+95	2,629	13,695	+11,066	664	689	+25	33,716	37,648	+3,932	49	168	+119	50	121	+71
Involuntary.....	26	9	-17	768	219	-549	31	19	-12	1,795	1,368	-427		2	+2	10	3	-7
New England.......	4	12	+8	675	1,114	+439	61	59	-2	3,074	3,491	+417	4	6	+2	1	8	+7
Voluntary.......	4	12	+8	675	1,114	+439	61	59	-2	3,074	3,491	+417	4	6	+2	---	7	+7
Involuntary.....	---	---	---	---	---	---	---	---	---	---	---	---	---	--	---	1	1	0
Middle Atlantic...	---	13	+13	---	2,712	+2,712	21	47	+26	1,283	2,836	+1,553	5	12	+7	10	17	+7
Voluntary.......	---	13	+13	---	2,712	+2,712	20	46	+26	1,203	2,800	+1,597	5	12	+7	4	16	+12
Involuntary.....	---	---	---	---	---	---	1	1	0	80	36	-44	---	---	---	6	1	-5
East North Central	13	22	+9	1,131	2,857	+1,726	98	111	+13	5,309	6,237	+928	5	13	+8	5	17	+12
Voluntary.......	10	22	+12	1,032	2,857	+1,825	92	107	+15	4,942	5,902	+960	5	13	+8	4	16	+12
Involuntary.....	3	---	-3	99	---	-99	6	4	-2	367	335	-32	---	---	---	1	1	0
West North Central	5	12	+7	187	405	+218	101	81	-20	4,162	3,047	-1,115	8	13	+5	3	3	0
Voluntary.......	2	11	+9	112	380	+268	100	81	-19	4,132	3,047	-1,085	8	13	+5	3	3	0
Involuntary.....	3	1	-2	75	25	-50	1	---	-1	30	---	-30	---	---	---	---	---	---
South Atlantic....	5	15	+10	130	3,261	+3,131	47	78	+31	2,507	5,069	+2,562	16	23	+7	16	12	-4
Voluntary.......	3	13	+10	105	3,188	+3,083	44	76	+32	2,425	4,961	+2,536	16	21	+5	14	12	-2
Involuntary.....	2	2	0	25	73	+48	3	2	-1	82	108	+26	---	2	+2	2	---	-2
East South Central	3	14	+11	91	1,419	+1,328	28	25	-3	1,240	1,241	+1	2	10	+8	1	6	+5
Voluntary.......	1	14	+13	48	1,419	+1,371	26	25	-1	1,114	1,241	+127	2	10	+8	1	6	+5
Involuntary.....	2	---	-2	43	---	-43	2	---	-2	126	---	-126	---	---	---	---	---	---
West South Central	24	28	+4	607	881	+274	174	117	-57	10,277	6,080	-4,197	3	53	+50	11	13	+2
Voluntary.......	12	23	+11	262	773	+511	162	111	-51	9,510	5,753	-3,757	3	53	+50	11	13	+2
Involuntary.....	12	5	-7	345	108	-237	12	6	-6	767	327	-440	---	---	---	---	---	---
Mountain..........	4	7	+3	135	186	+51	49	49	0	2,155	2,782	+627	2	6	+4	3	9	+6
Voluntary.......	2	7	+5	72	186	+114	49	48	-1	2,155	2,698	+543	2	6	+4	3	9	+6
Involuntary.....	2	---	-2	63	---	-63	---	1	+1	[illegible]	84	+84	---	---	---	---	---	---
Pacific...........	2	14	+12	48	656	+608	116	141	+25	5,504	8,233	+2,729	4	34	+30	10	37	+27
Voluntary.......	2	14	+12	48	656	+608	110	136	+26	5,161	7,755	+2,594	4	34	+30	10	37	+27
Involuntary.....	---	---	---	---	---	---	6	5	-1	343	478	+135	---	---	---	---	---	---
Outlying areas....	3	4	+1	393	423	+30	---	---	---	---	---	---	---	---	---	---	2	+2
Voluntary.......	1	3	+2	275	410	+135	---	---	---	---	---	---	---	---	---	---	2	+2
Involuntary.....	2	1	-1	118	13	-105	---	---	---	---	---	---	---	---	---	---	---	---

TABLE V

Number of facilities participating in the health insurance program terminated in fiscal years 1973 and 1974 and net changes, by type of provider, type of termination, division

Division and type of termination	Hospitals						Skilled nursing facilities						Home health agencies			Independent laboratories		
	Number			Beds			Number			Beds			Number			Number		
	Fiscal year 1973	Fiscal year 1974	Net change	Fiscal year 1973	Fiscal year 1974	Net change	Fiscal year 1973	Fiscal year 1974	Net change	Fiscal year 1973	Fiscal year 1974	Net change	Fiscal year 1973	Fiscal year 1974	Net change	Fiscal year 1973	Fiscal year 1974	Net change
All areas...	170	89	-81	13,261	10,448	-2,813	301	198	-103	15,697	11,545	-4,152	110	53	-57	200	122	-78
Voluntary.......	164	85	-79	13,122	9,802	-3,320	295	182	-113	15,333	10,076	-5,257	109	52	-57	195	120	-75
Involuntary.....	6	4	-2	139	646	+507	6	16	+10	364	1,469	+1,105	1	1	0	5	2	-3
New England.......	8	5	-3	470	257	-213	15	13	-2	926	731	-195	11	5	-6	12	7	-5
Voluntary.......	8	5	-3	470	257	-213	14	10	-4	851	545	-306	11	5	-6	12	7	-5
Involuntary.....	0	0	0	0	0	0	1	3	+2	75	186	+111	0	0	0	0	0	0
Middle Atlantic...	15	12	-3	2,020	2,377	+357	32	29	-3	1,457	2,497	+1,040	17	8	-9	39	30	-9
Voluntary.......	15	11	-4	2,020	1,795	-225	31	24	-7	1,361	1,906	+545	17	7	-10	39	30	-9
Involuntary.....	0	1	+1	0	582	+582	1	5	+4	96	591	+495	0	1	+1	0	0	0
East North Central	21	13	-8	1,695	1,329	-366	61	35	-26	3,520	1,745	-1,775	10	9	-1	20	14	-6
Voluntary.......	20	13	-7	1,675	1,329	-346	60	34	-26	3,508	1,695	-1,813	10	9	-1	17	14	-3
Involuntary.....	1	0	-1	20	0	-20	1	1	0	12	50	+38	0	0	0	3	0	-3
West North Central	12	8	-4	851	279	-572	29	19	-10	1,145	660	-485	5	5	0	6	4	-2
Voluntary.......	12	8	-4	851	279	-572	28	18	-10	1,057	572	-485	5	5	0	6	4	-2
Involuntary.....	0	0	0	0	0	0	1	1	0	88	88	0	0	0	0	0	0	0
South Atlantic....	17	10	-7	1,387	1,025	-362	55	30	-25	2,848	1,636	-1,212	33	17	-16	29	16	-13
Voluntary.......	17	10	-7	1,387	1,025	-362	55	28	-27	2,848	1,499	-1,349	33	17	-16	29	15	-14
Involuntary.....	0	0	0	0	0	0	0	2	+2	0	137	+137	0	0	0	0	1	+1
East South Central	11	10	-1	470	491	+21	22	17	-5	843	620	-223	4	0	-4	7	2	-5
Voluntary.......	8	10	+2	392	491	+99	20	17	-3	750	620	-130	4	0	-4	6	2	-4
Involuntary.....	3	0	-3	78	0	-78	2	0	-2	93	0	-93	0	0	0	1	0	-1
West South Central	22	13	-9	1,073	368	-705	20	12	-8	1,039	632	-407	22	4	-18	13	4	-9
Voluntary.......	21	10	-11	1,059	304	-755	20	12	-8	1,039	632	-407	21	4	-17	13	4	-9
Involuntary.....	1	3	+2	14	64	+50	0	0	0	0	0	0	1	0	-1	0	0	0
Mountain..........	11	6	-5	553	321	-232	10	8	-2	734	420	-314	4	1	-3	7	4	-3
Voluntary.......	10	6	-4	526	321	-205	10	8	-2	734	420	-314	4	1	-3	7	3	-4
Involuntary.....	1	0	-1	27	0	-27	0	0	0	0	0	0	0	0	0	0	1	+1
Pacific...........	19	12	-7	2,320	4,001	+1,681	53	32	-21	2,801	2,267	-534	4	4	0	64	37	-27
Voluntary.......	19	12	-7	2,320	4,001	+1,681	53	28	-25	2,801	1,850	-951	4	4	0	64	37	-27
Involuntary.....	0	0	0	0	0	0	0	4	+4	0	417	+417	0	0	0	0	0	0
Outlying areas....	34	0	-34	2,422	0	-2,422	4	3	-1	384	337	-47	0	0	0	3	4	+1
Voluntary.......	34	0	-34	2,422	0	-2,422	4	3	-1	384	337	-47	0	0	0	2	4	+2
Involuntary.....	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	-1

TABLE VI

1972 - Home Health	Patients	Expenditures	Services							Limitations
TOTALS	113,322	$21,250,390	NS	[illegible]	[illegible]	PT	OT	SP	MS	
1. Alabama			✓	✓	✓					
2. Alaska			✓	✓	✓					
3. Arizona										
4. Arkansas	179	$26,155	✓	✓	✓					
5. California	14,500	$1,329,551	✓	✓	✓					
6. Colorado	862	100,615	✓	✓						Buy-ins and all ser… [illegible]
7. Connecticut	38	10,245	✓	✓		✓	✓	✓	✓	Prior auth
8. Delaware	150	25,215	✓							
9. District of Columbia	3,692	181,233								
10. Florida	873	50,665	✓		✓					none.
11. Georgia	1,582	66,724	✓		✓					[illegible]
12. Hawaii	373	272,687	✓	✓						none
13. Idaho	38	13,150	✓	✓	✓					
14. Illinois	4,257	83,000								
15. Indiana	1,784	457,154	✓	✓	✓	✓	✓	✓	✓	none
16. Iowa	223	32,351	✓	✓						
17. Kansas	346	62,133	✓	✓	✓	✓	✓	✓	✓	
18. Kentucky	1,819	455,505								
19. Louisiana	1,327	265,859	✓	✓	✓					
20. Maine	1,239	193,556	✓	✓	✓	✓	✓			
21. Maryland	1,781	175,925	✓	✓	✓					
22. Massachusetts	? —	?	✓	✓	✓					
23. Michigan	1,793	350,017	✓	✓	✓	✓				
24. Minnesota	2,292	353,457	✓	✓	✓	✓	✓	✓	✓	
25. Mississippi	754	87,522	✓		✓					
26. Missouri	36	1,637	✓							[illegible]
27. Montana	228	46,840								
28. Nebraska	158	67,159	✓	✓	✓	✓	✓	✓	✓	
29. Nevada	132	56,437	✓	✓	✓	✓	✓	✓	✓	
30. New Hampshire	863	133,129								
31. New Jersey	1,480	464,362								
32. New Mexico	125	15,945	✓	✓		✓	✓	✓	✓	
33. New York	32,800	15,504,747	✓		✓					
34. North Carolina	792	92,219	✓	✓	✓					
35. North Dakota	72	9,045	✓	✓	✓	✓	✓	✓	✓	
36. Ohio	3,390	320,123	✓	✓	✓	✓	✓	✓		
37. Oklahoma	—	—								
38. Oregon	10	2,160	✓	✓	✓	✓				
39. Pennsylvania	23,900	975,700								
40. Rhode Island	5,457	189,041	✓							15 visits; [illegible]
41. South Carolina	689	183,912	✓	✓	✓					
42. South Dakota	89	13,380	✓	✓	✓	✓	✓	✓	✓	
43. Tennessee	1134	106,042	✓	✓	✓					60 services [illegible]
44. Texas	1345	89,660	✓		✓					[illegible]
45. Utah	318	41,769	✓	✓	✓	✓		✓	✓	
46. Vermont	457	73,357	✓	✓	✓	✓				
47. Virginia			✓	✓	✓					Prior auth [illegible]
48. Washington	1520	156,692	✓	✓		✓				
49. West Virginia	176	14,752	✓	✓		✓				Prior auth [illegible]
50. Wisconsin	1915	342,612	✓	✓						[illegible]
51. Wyoming	12	3,392	✓		✓	✓				
52. American Samoa										
53. Guam										Services [illegible]
54. Puerto Rico			✓			✓				
55. Trust Territory										
56. Virgin Islands	69	$5,870	✓	✓						

TABLE VII

Number of participating extended care facilities, nursing beds, beds per 1,000 hospital insurance enrollees, participating home health agencies, and independent laboratories, by division and State, July 1971

Division and State	Extended care facilities			Home health agencies	Independent laboratories
	Facilities	Beds 1/	Beds per 1,000 enrollees 2/		
All areas	4,287	307,548	15.2	2,284	2,751
United States	4,277	306,998	15.3	2,279	2,686
New England	288	20,340	16.0	365	162
Maine	22	853	7.1	23	---
New Hampshire	13	688	8.4	41	1
Vermont	13	744	15.0	16	5
Massachusetts	104	7,298	11.6	173	93
Rhode Island	24	1,301	12.4	16	16
Connecticut	112	9,456	32.9	96	47
Middle Atlantic	622	59,437	15.1	299	494
New York	292	34,461	17.6	127	233
New Jersey	104	7,658	11.1	49	128
Pennsylvania 3/	226	17,318	13.6	123	133
East North Central	726	49,977	13.1	326	409
Ohio	193	15,531	15.6	96	99
Indiana	94	4,100	8.3	31	34
Illinois	154	8,622	7.9	86	162
Michigan	151	13,891	18.2	49	94
Wisconsin	134	7,833	16.4	64	20
West North Central	307	13,362	6.9	204	125
Minnesota	102	4,515	10.9	57	12
Iowa	67	2,528	7.1	43	14
Missouri	59	3,639	6.5	29	54
North Dakota	5	307	4.5	9	9
South Dakota 3/	11	511	6.3	24	4
Nebraska	23	1,064	5.8	5	9
Kansas	40	798	3.0	37	23
South Atlantic	524	36,389	12.7	325	267
Delaware 3/	12	591	13.1	7	8
Maryland	69	5,651	19.4	26	61
District of Columbia	5	884	13.4	3	5
Virginia 3/	57	3,572	9.8	136	24
West Virginia	18	1,047	5.3	20	8
North Carolina	52	4,263	10.3	29	14
South Carolina 3/	60	4,174	21.6	43	9
Georgia	78	5,527	15.1	19	21
Florida	173	10,680	11.5	42	117

See footnotes at end of table.

TABLE VII--Continued

Number of participating extended care facilities, nursing beds, beds per 1,000 hospital insurance enrollees, participating home health agencies, and independent laboratories, by division and State, July 1971--Continued

Division and State	Extended care facilities			Home health agencies	Independent laboratories
	Facilities	Beds 1/	Beds per 1,000 enrollees 2/		
East South Central	269	16,076	12.6	263	78
Kentucky	83	5,444	16.0	32	30
Tennessee	60	2,917	7.6	83	23
Alabama 3/	96	6,297	19.3	63	12
Mississippi 3/	30	1,418	6.3	85	13
West South Central	194	10,838	6.0	275	229
Arkansas 3/	20	1,044	4.4	75	10
Louisiana 3/	23	1,936	6.4	80	28
Oklahoma 3/	21	884	3.0	56	41
Texas	130	6,974	7.1	64	150
Mountain	199	11,593	16.6	77	142
Montana	20	578	8.3	11	8
Idaho	34	1,784	25.8	9	2
Wyoming	1	23	0.7	9	3
Colorado	72	4,911	26.0	19	38
New Mexico	16	955	13.1	5	22
Arizona	19	1,435	9.1	9	43
Utah	21	950	12.3	12	12
Nevada	16	957	30.4	3	14
Pacific	1,148	88,986	37.2	145	780
Washington	106	3,872	12.0	23	62
Oregon	67	3,564	15.7	25	33
California	954	79,917	44.7	91	667
Alaska	6	186	28.1	1	2
Hawaii	15	1,447	32.3	5	16
Outlying areas	10	550	3.1	5	65
Guam	1	33	25.1	1	---
Puerto Rico	9	517	3.0	3	65
Virgin Islands	---	---	---	1	---
American Samoa	---	---	---	---	---

1/ Includes skilled nursing beds only.
2/ Provisional as of July 1, 1970, based on number of enrollees in hospital insurance program as of March 31, 1971.
3/ Subunits of State Health Department home health agencies certified on a statewide basis counted separately.

TABLE VIII

Number of participating skilled nursing facility beds per 1,000 hospital insurance enrollees, participating home health agencies, independent laboratories, outpatient physical therapy, and portable X-ray, by division and State, July 1974

Division and State	Skilled nursing facilities			Home health agencies	Independent laboratories	Outpatient physical therapy	Portable X-ray
	Facilities	Beds 1/	Beds per 1,000 enrollees 2/				
All areas	3,952	294,000	13.9	2,248	3,029	116	113
United States	3,946	293,437	14.0	2,234	2,973	115	113
New England	287	22,203	16.9	338	192	12	12
Maine	17	660	5.3	20	--	--	--
New Hampshire	18	896	10.3	41	2	2	2
Vermont	21	1,140	22.1	17	4	--	--
Massachusetts	86	6,592	10.2	160	111	3	5
Rhode Island	20	1,099	10.2	13	20	---	--
Connecticut	125	11,316	35.2	57	55	7	7
Middle Atlantic	656	68,056	16.9	279	495	13	17
New York	328	42,741	21.5	129	235	3	11
New Jersey	123	9,594	13.3	44	127	2	3
Pennsylvania	205	15,721	12.0	106	133	8	3
East North Central	668	43,133	10.9	327	463	26	13
Ohio	177	14,037	13.7	101	106	6	2
Indiana	99	4,345	8.5	28	39	4	--
Illinois	156	7,295	6.5	83	199	11	8
Michigan	144	12,277	15.5	48	100	3	--
Wisconsin	92	5,179	10.5	67	19	2	3
West North Central	240	11,571	5.9	225	144	5	3
Minnesota	78	4,294	10.1	62	15	4	3
Iowa	37	1,446	4.0	57	14	--	--
Missouri	55	3,137	5.4	33	65	1	--
North Dakota	5	136	1.9	9	9	--	--
South Dakota	10	308	3.7	21	5	--	--
Nebraska	18	977	5.2	11	9	--	--
Kansas	37	1,373	5.0	32	27	--	--
South Atlantic	499	33,153	10.6	309	310	18	6
Delaware	11	628	13.2	6	11	2	--
Maryland	64	5,405	17.4	23	68	1	--
District of Columbia	5	602	9.2	4	4	--	--
Virginia	38	1,618	4.2	135	28	1	--
West Virginia	26	1,572	7.7	18	13	2	--
North Carolina	74	5,513	12.3	52	12	1	--
South Carolina	69	4,603	22.1	17	14	--	--
Georgia	60	3,536	9.1	15	28	1	1
Florida	152	9,676	9.1	39	132	10	5
East South Central	240	13,370	9.9	286	92	7	--
Kentucky	85	5,389	15.3	41	36	--	--
Tennessee	45	1,676	4.1	90	25	2	--
Alabama	89	5,424	15.6	68	17	2	--
Mississippi	21	881	3.7	87	14	3	--
West South Central	88	5,753	3.0	248	250	16	1
Arkansas	12	639	2.5	78	11	--	--
Louisiana	11	1,290	4.0	72	34	2	--
Oklahoma	8	462	1.5	50	48	3	--
Texas	57	3,362	3.2	48	157	11	1
Mountain	171	8,420	11.0	84	160	15	3
Montana	23	689	9.5	10	7	--	--
Idaho	31	1,636	22.0	9	3	--	--
Wyoming	3	69	2.1	10	3	1	--
Colorado	61	3,700	18.6	27	41	8	--
New Mexico	9	402	5.0	6	23	2	1
Arizona	16	1,073	5.8	10	49	2	2
Utah	14	434	5.2	9	16	1	--
Nevada	14	417	11.2	3	18	1	--
Pacific	1,097	87,728	34.7	138	867	3	58
Washington	92	3,614	10.6	23	63	--	3
Oregon	58	2,642	10.9	26	40	--	1
California	923	79,917	42.4	84	745	2	53
Alaska	5	95	12.9	1	2	1	--
Hawaii	14	1,460	29.2	4	17	--	1
Outlying areas	6	513	2.6	14	56	1	--
Guam	1	33	21.9	1	--	--	--
Puerto Rico	5	480	2.5	12	56	1	--
Virgin Islands	--	---	---	1	--	--	--
American Samoa	--	---	---	--	--	--	--

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1/ Includes skilled nursing facility beds only.
2/ Based on number of enrollees in hospital insurance program as of January 1, 1973, reflected in SSA records as of October 1, 1973.

TABLE IX.—NUMBER AND PERCENT OF PARTICIPATING HOME HEALTH AGENCIES PROVIDING SELECTED SERVICES AS OF DECEMBER 1971 AND SEPTEMBER 1974

Selected services[1]	December 1971		September 1974	
	Number	Percent of all agencies	Number	Percent of all agencies
All agencies	2,256	100.0	2,237	100.0
Physical therapy	1,664	78.8	1,171	52.3
Occupational therapy	447	19.8	340	15.2
Speech therapy	636	28.2	495	22.1
Medical social service	494	21.9	421	18.8
Home health aide	1,351	60.2	1,365	61.0

[1] All participating agencies must offer nursing services to qualify under the program.

Source: Social Security Administration, Office of Research and Statistics.

TABLE X.—NUMBER AND PERCENT OF CERTIFIED HOME HEALTH AGENCIES PROVIDING SELECTED SERVICES, BY TYPE OF AGENCY, JANUARY 1969

Type of agency	Number of agencies	Physical therapy		Occupational therapy		Speech therapy		Medical social service		Home health aide		Nutrition guidance	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All agencies	[1] 2,161	1,571	72.7	352	16.3	477	22.1	432	20.0	1,042	48.2	393	18.2
Visiting Nurse Association	541	461	85.2	112	20.7	140	25.9	78	14.4	245	45.3	45	8.3
Combined government and voluntary	107	85	79.4	25	23.4	36	33.6	18	16.8	54	50.5	22	20.6
Official health	1,294	830	64.1	129	10.0	193	14.9	214	16.5	589	45.5	203	15.7
Hospital based	172	154	89.5	62	36.0	82	47.7	98	57.0	126	73.2	104	60.5
Rehabilitation facility based	12	12	100.0	11	91.7	10	83.3	7	58.3	5	41.7	3	25.0
Extended care facility based	15	12	80.0	5	33.3	7	46.7	5	33.3	11	73.3	9	60.9
Proprietary	20	17	85.0	8	40.0	9	45.0	12	60.0	12	60.0	7	35.0

[1] Based on 2,161 of the 2,184 certified agencies for which data were available.

Source of basic data: Social Security Administration (type of agency and services provided from application form SSA-1515).

Source: Ryder, Claire; F.M.D.; Stitt, Pauline; O.M.D.; Elkin, William; F.M.S., "Home, Health Services—Past, Present, Future," American Journal of Public Health, vol. 20, September 1960.

TABLE XI.—NUMBER OF PROFESSIONAL AND TECHNICAL EMPLOYEES (FULL-TIME EQUIVALENTS) IN 2,209 HOME HEALTH AGENCIES PARTICIPATING IN MEDICARE AS OF JULY 31, 1969

Professional and technical employees	Number of employees	Visiting nurse associations	Combination Government and voluntary agencies	Official health agencies	Hospital based agencies	Other
Registered professional nurses	15,152	4,818	1,667	8,091	364	212
Licensed practical nurses	1,409	657	127	283	241	101
Physical therapists	999	232	53	482	145	87
Occupational therapists	146	36	7	32	35	36
Speech therapists	170	32	6	65	36	31
Medical social workers	301	46	9	123	98	25
Home health aides	4,061	1,641	524	1,417	187	292

Source: HEW, SSA, Office of Research and Statistics, "Health Insurance Statistics," H 122, Jan. 7, 1971 issue.

TABLE XII.—*Estimated number of homemaker-home health agencies by category*

Family and Children's agencies:	
(*a*) Governmental	900
(*b*) Voluntary	400
Health oriented agencies, including mental health:	
(*a*) Governmental	700
(*b*) Voluntary	500
Single service homemaker-home health agencies	175
Proprietary registries	175
Total	2,850

SOURCE: "Home Health Services in the United States," a report to the Special Committee on Aging, U.S. Senate, April 1972, p. 32.

TABLE XIII.—HOME HEALTH AGENCIES WITH HOME HEALTH AIDE SERVICE, AS OF JUNE 28, 1970[1] AND SEPTEMBER 1974

Type of facility	June 1970		September 1974	
	Facilities	Aides	Facilities	Aides
Visiting Nurse Association	300	1,679	343	1,894
Combination government and voluntary agency	58	489	34	171
Official health agency	649	1,570	718	1,679
Rehabilitation facility based program	7	54	5	36
Hospital based program	151	233	171	257
Extended care facility based program	16	52	3	4
Proprietary	21	28	30	186
All others	49	104	61	341
Total home health agencies with home health aide service	1,254	4,276	1,365	4,568

[1] Information obtained from Social Security Administration.

Appendix 5

SELECTED TABLES FROM A REPORT ON RESEARCH FINDINGS OF A STUDY OF SENIOR GROUP CENTERS; BY SARA B. WAGNER, Ed. D.[1]

TABLE 1.—NUMBER OF SENIOR GROUPS BY FACILITY AND LOCATION

Facility	Location		
	Urban	Suburban	Rural
Church	510	242	111
Housing project	353	67	47
Recreation facility	780	383	274
Separate facility	593	143	266
Total	2,236	835	698

TABLE 2.—METHOD OF SUPPORT FOR GROUPS IN DIFFERENT FACILITIES

Facility	Public—Government	Nonprofit
Churches	213	631
Housing projects	304	171
Recreation, community centers	840	583
Separate facilities	538	450
Total	1,895	1,835

TABLE 3.—NUMBER OF SENIOR GROUPS REPORTING SIZE OF MEMBERSHIP BY TYPE OF FACILITY AND ORGANIZATION

Membership	Organization type															
	Multipurpose center				Senior center				Club				Club within larger organization			
	SF[1]	HP[2]	CC[3]	Ch[4]	SF	HP	CC	Ch	SF	HP	CC	Ch	SF	HP	CC	Ch
Under 50	132	28	81	42	56	31	43	35	32	32	147	117	15	5	76	24
50 to 99	40	16	39	25	57	21	45	40	23	19	141	123	9	5	61	11
100 to 149	29	22	24	16	31	18	28	24	15	11	65	78	14	2	35	3
150 to 199	24	21	18	8	22	10	16	6	7	2	38	44	2	6	16	2
200 to 299	50	25	33	13	26	23	23	9	16	3	57	31	3	0	17	4
300 to 399	35	11	21	8	18	8	12	7	6	3	18	11	2	1	4	1
Over 400	104	32	61	24	41	17	21	13	9	1	30	13	7	0	17	3
Average membership	219.7				175.1				123.7				130.9			
Average daily attendance	68.6				56.5				62.3				53.1			

[1] Separate facility.
[2] Housing project.
[3] Community or recreation center.
[4] Church.

[1] Senior research associate, National Council on the Aging, Inc. Presented April 28, 1975, at the Western Gerontological Society conference, San Francisco, Calif.

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TABLE 4.—SESSIONS OPEN BY ORGANIZATION TYPE

Sessions open	Multipurpose center	Senior center	Independent club	Club in larger organization
1	89	111	691	104
2 to 3	113	176	567	130
4 to 5	95	108	105	55
6 to 9	127	113	76	50
10 to 12	753	377	83	96
More than 12	198	79	28	53
Average number	9.2	7.2	2.7	5.9

TABLE 5.—AVERAGE NUMBER OF DIFFERENT TYPES OF STAFF MEMBERS REPORTED BY ORGANIZATION TYPE

Staff	Multipurpose center	Senior center	Independent club	Club in larger organization
Full time (paid)	3.1	2.3	1.9	3.3
Part time (paid)	3.8	2.9	3.1	4.7
Volunteers	23.5	15.3	11.1	13.1
Students	6.9	6.5	9.8	7.7

TABLE 6.—*Number of services reported*

Services:	*Average number of services per category*
Transportation	2.45
Recreation	5.80
Education	3.85
Information and referral	5.28
Participant counseling	4.91
Outreach counseling	4.42
Employment	1.54
Health	2.40
Special services to handicapped	1.55

Service category:	*Most frequently offered specific service*
Transportation	To center.
Recreation	Arts and crafts.
Education	Lectures.
Information and referral	Health.
Participant counseling	Health.
Outreach counseling	Health.
Employment	Counseling.
Health	Screening.
Special services to handicapped	Transportation.
Community services	Visitors.
Center services	Committees or boards.

TABLE 7.—LEVELS OF SERVICES BY ORGANIZATION TYPE

Level	Multipurpose center	Senior center	Independent club	Club in larger organization
1	1,182	611	644	302
2	1,102	558	556	258
3	952	479	498	212
4	569	231	127	76

Level 1 requires education, recreation and information and referral or counseling.
Level 2 requires all level 1 services plus service to the center or to the community.
Level 3 requires all level 1 services plus service to the community.
Level 4 requires all level 1 services plus health services.

TABLE 8.—NUMBER OF SENIOR GROUPS PROVIDING HEALTH SERVICES AND HEALTH RELATED SERVICES

Services	Multipurpose centers	Senior centers	Independent clubs	Clubs within larger organization
Clinic	272	104	75	60
Dental	83	23	21	20
Full-time nurse	102	24	19	12
Part-time nurse	263	105	55	42
Immunization	315	96	65	59
Pharmacy	57	16	42	17
Physical exams	171	64	62	39
Screening	424	165	100	50
Therapy	65	21	17	13
X-ray	54	16	22	20
Physician, part time	94	41	17	15
Physician, full time	1		1	
Education (health)	683	316	303	155
Transportation (medical treatment)	643	302	157	129
Special services, hearing aids	45	25	18	8
Training for deaf, blind	92	27	37	3
Therapy	89	44	21	29
Accommodate wheelchairs	937	642	768	302
Nonmember counseling health	388	167	143	87
Member counseling health	646	241	207	99
Information and referral health	1,053	516	456	236

TABLE 9.—NOON MEAL SERVICE

Noon meal on site	Organization type			
	Multipurpose center	Senior center	Independent club	Club as part of larger organization
1 to 2	176	133	180	76
3 to 4	57	31	12	7
More than 4	487	182	40	55

TABLE 10.—*Convenient to Senior Center or Golden Age Club*

	Total percent
Total public 55 and over:	
55 to 64	49
65 to 69	52
70 to 79	52
80 and older	45
Under $7,000	44
$7,000 to $14,999	55
$15,000 and over	57
White	53
Black	27

TABLE 11.—*Attendance at a Senior Center or Golden Age Club in past year*

	Total percent
Total public 55 and over	13
55 to 64	8
65 and over	18
65 to 69	19
70 to 79	19
80 and over	16
Men	11
Women	15

Under $7,000	18
$7,000 to $14,999	10
$15,000 and over	8
Some high school or less	14
High school graduate, some college	13
College graduate	14
White	13
Black	17

TABLE 12.—TIME OF LAST ATTENDANCE AT SENIOR CENTER OR CLUB

	Race		Income			Education		
Time	White	Black	Under $7,000	$7,000–$14,999	Over $15,000	High school or less	High school	College
Within last day or 2	10	8	12	12	4	15	6	1
Within last week or 2	32	53	37	29	19	39	26	22
A month ago	23	14	24	18	20	19	23	42
2 to 3 months ago	15	9	10	19	29	10	20	7
Longer ago than that	20	14	17	22	25	16	23	27

Appendix 6

COMMUNITY SERVICES FOR THE AGED: THE VIEW FROM EIGHT COUNTRIES; BY SHEILA B. KAMERMAN*

Caring for the aged is a concern of all industrialized countries, be they socialist, capitalist, or mixed economies. Using different words, with variations in emphasis, the eight countries covered in a recently completed cross-national study of social services reported an almost unanimous rationale for their growing concern for the aged and for the expanding social provision.[1] First are the demographic changes which are occurring everywhere. More people are living longer. Declining birth rates and increased longevity have led to the present situation of high percentages of aged in all these countries. Second, social and economic trends have contributed to creating a social problem out of a normal process. Older workers may be defined as nonproductive or too expensive to retrain, or redundant, as technological changes lead to reductions in certain categories of workers. Society pressures for earlier retirement. At the same time, with increased physical mobility children are less likely to live near elderly parents; and as more women work, there are fewer daughters at home to care for those parents living nearby. Constrained by inadequate resources, the aged must cope with more extensive periods of enforced retirement, greater likelihood of isolation, and increased needs as time passes.

In addition to the emergence of the aged as a numerically important group and a group with expanding needs and problems, the aged are becoming increasingly politicized. In many countries they vote, they are articulate, and they are beginning to organize as an independent political constituency. Thus, countries are responding to the needs of the aged because they have influence and power.

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[1] The countries are: Canada, Federal Republic of Germany, France, Israel, Poland, United Kingdom, United States, and Yugoslavia.

The Cross-National Studies of Social Service Systems is a research project based at Columbia University School of Social Work. The project director is Alfred J. Kahn, and the author of the article is associate director. Basic support for the study was provided through the Social and Rehabilitation Service, HEW. The studies in Israel, Poland, and Yugoslavia were funded under Public Law 480. Research in Canada was financed entirely by the Canadian Council on Social Development. Supplementary funds or in-kind aid were provided by various institutions and agencies in the United Kingdom, France, Federal Republic of Germany, and Israel. A grant from the Office of Child Development, HEW, supported the preparation of materials for the U.S. report relating to the children's field and a contract with NIMI covered preparation of analyses and reports related to its interests. The topics covered in the study, in addition to community services for the aged, are: child care programs, services for abused and neglected children, residential arrangements for delinquent and neglected children, family planning services, and social service delivery at the local level.

The individual country reports are available through Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, Mich. 48106. The U.S. report on Community Services for the Aged is a chapter in Sheila B. Kamerman and Alfred J. Kahn, *Social Services in the United States* (Philadelphia, Pa.: Temple University Press, 1976). The full cross-national analysis is scheduled for publication early in 1977 as Alfred J. Kahn and Sheila B. Kamerman, *International Perspectives on Social Services.*

Using the United Nations' criterion for describing countries as "young" if their aged population is equal to 4 percent or less of the total population, "adult" when the aged represent 4 to 7 percent, and "old" when the aged equal 7 percent or more, all the countries covered here are "old." However, like the aged themselves, this is a heterogeneous group of countries ranging from the "young-old" (Israel 7.3 percent, Yugoslavia, 7.8 percent, Canada 8.0 percent, Poland 8.5 percent) ; to the "old-old" (United Kingdom 13 percent, France 13.4 percent, Federal Republic of Germany 13.5 percent), with the United States at approximately the mid-point (10 percent). The percentage of aged is still increasing in all these countries. Those countries with the largest percentage anticipate reaching a plateau of about 13 to 15 percent in the mid- or late-1980's. The others will follow.

Some countries recognized the needs of their aged earlier but all those described here evinced a rapidly growing concern beginning after World War II and culminating by the late 1960's or 1970's as the "younger" countries also undertook deliberate efforts to address the problem.

In what follows we look first at how community services are viewed in other countries and second at the cross-national similarities in the perception of the needs of the aged and the development of national policy goals and major programs. Third is a description and analysis of the differences among countries, identifying some of the major issues debated. Fourth and last is a discussion of one particular aspect of community services, the delivery system, and the need for a new model.

How Community Services for the Aged Are Viewed in Other Countries

Our cross-national study focused on those social policies and programs directed at the aged in each country. It covered laws, benefits, services, expenditures, eligibility, coverage, utilization patterns, and fees. To assure international comparability, we adopted the arbitrary, chronological definition of "old age" employed by the U.S. Census Bureau: all those aged 65 and over. From a social policy perspective, this was an error. Indeed, although the parameters of the cohort vary among countries, the only functionally comparable criterion is "pensionable age"—usually, but not always, 65 for men and 60 for women. Clearly, the critical age for the whole demographic category in countries where social insurance is institutionalized—as it is in all industrialized countries—is the age at which individuals are eligible for old-age and retirement pensions. Thus, both size and composition of the aged cohort may vary over time as retirement age is lowered and/or changes are made for men or women in pensionable age.

In contrast, if there is a chronological age that provides a social policy beacon in the field of social gerontology, it is probably age 75. All of the countries covered point out that at the very least there are two generations of aging, with 75 being the dividing line.[2] Current concern in these countries is turning increasingly to the rapid growth of this latter group, especially those 80 and over. It is among these

[2] Some suggested three: 65 to 75; 75 to 85; and 85-plus.

elderly that frailty, chronic illness, and physical incapacity are particularly characteristic. It is this group that constitutes the major service users in all countries and it is in response to their needs that current policy projections are being made and demands for service assessed.

Our approach in this cross-national study of community services to the aged was essentially descriptive and operational. We did not ask what kinds of social services are provided for old people in each country because we did not know what the term "social services" would evoke. Rather, we said: "What do you do in your country for old people who are physically or socially isolated and need some kind of help?" Inevitably, the responses covered every domain—income maintenance, health, housing, employment, and personal social services.[3]

We strove for comparability; yet, despite our efforts, there are areas of noncomparability. We note certain caveats: (1) Terms are used differently. Thus a facility labeled "medical" in one country may be described similarly but labeled "nonmedical" in another; a "retirement" home may be referred to as an "institution" in one country and "sheltered" or "congregate" housing in another; (2) quantitative adequacy of individual social programs cannot be compared cross-nationally unless placed in the context of the country's overall system of provision. For example, the meaning of higher or lower labor force participation rates for the aged can be assessed only if we know what alternatives are available: Are there pensions for all and are benefit levels adequate to live on? What are the preferences of the aged? The extensiveness of family care of the aged can be appraised only in the context of the availability of options and/or the legal responsibility of family members. Similarly, the quantitative adequacy of long-term care facilities can be evaluated only in a larger context. Coverage for 1 percent of the aged may be overwhelmingly inadequate when the only alternative is self-care—or adequate where special housing covers 10 percent of the aged and there are extensive and accessible home health services for all others wanting and needing help. Alternatively, patterns of coverage may be adequate when three-fourths of the aged cohort are under 75, and inadequate when the cohort pattern is reversed. Clearly, cross-national comparisons must be made carefully.

Cross-National Similarities: Needs, Goals, and Programs

In general, the needs of old people may be seen fairly uniformly among countries having a similar percentage of aged in the population. Appropriateness and adequacy of personal social services, however, can only be assessed in the context of what else is available to meet basic human needs. If we are concerned with providing community services for old people, it is essential to know how and to what extent their needs for income, medical care, and housing are being met. Experience in all countries indicates that inadequacies in

[3] Personal social services is a term first used in Britain and employed increasingly in this country to describe that category of social services contributing to socialization, development, help, social care, and access to other services and benefits. The personal social services include such programs as: family and child welfare, information and referral, community and senior centers, and so forth.

any of the major established social services can only overload the others and can in no way be compensated for through personal social services alone.

All countries indicate three primary categories of need for the aged: income on retirement, medical and related health care as illness and disability increase over time, and shelter and care for incapacitated aged with no families. Considered to be of lesser importance (but not underestimated) are the needs for services and activities related to living in retirement and care for the aged with families and/or with lesser incapacities. Societies are distinguished by their responses with reference to: the adequacy of income; the extensiveness of free or low-cost medical care; and the availability of different types of shelter and care at low cost for differing degrees of incapacity, as well as services related to adaptation to retirement and increased leisure.

Whereas the needs of the aged are perceived with some consistency, proclamations of national policy toward the aged are almost completely uniform across country lines. Chronologically, the British were the first to specify what has subsequently become the theme of national aging policy in all other countries. Moreover, British official statements regarding policy for the aged reflect the most comprehensive perspective, including implications and ramifications for program development. More specifically, according to a Ministry of Health circular issued in February 1962: "Services for the elderly should be designed to help them to remain in their homes for as long as possible." In general, the rationale for this policy, which is articulated in one or another form in *every* country, is that: Older people prefer remaining in their own homes; the aged live longer and more happily in their own homes; home-based care is cheaper than institutional care for many aged.

The strategies identified for implementing policy objectives are remarkably similar also. However, what emerges as the key problem in responding to the agreed-upon needs of the aged is neither the appropriateness of national policy objectives nor the efficacy of selected strategies but, rather, the failure to implement policies or to integrate—or harmonize—implementation strategies employed in different systems.

All countries stress an income strategy first and have some form of social insurance (social security) and social assistance laws and programs. All except the United States and Israel supplement this with extensive comprehensive health insurance and/or services. All countries identify housing and community services as important and have some relevant legislation, but provision is far less adequate almost everywhere for these services.

Community services for the aged are now following the same pattern that characterized the development of income maintenance and health programs as they became institutionalized in other countries. Historically, the family was considered to be the primary support of elderly parents and adult children were legally responsible for their maintenance. Filial responsibility continues to be the law in Yugoslavia but is no longer in effect in most industrialized countries. As more people live longer and retirement is accepted as part of the normal life cycle. societal support for the universal need of old people for retirement income has become increasingly institutionalized. Similarly, with increased longevity and concomitant incapacities

characteristic of larger numbers, responsibility for providing health care is becoming an accepted societal responsibility, standard in almost all industrialized countries today.

At present, housing and the personal social services are in transition, although the same pattern has already emerged in at least two countries (United Kingdom and Sweden), and traces can be discerned in others. Emerging first as residual provision on a means-tested basis, the issue is no longer whether these services are needed only by the poor aged. The use of long-term care facilities, congregate housing, information and counseling services—by the aged of all classes—clearly attests to the universality of these needs, even though income-related fees may be charged.

The major models of living and care arrangements for the aged are remarkably similar across country lines. It has been suggested elsewhere that international similarities in income maintenance policies and programs (e.g., social security, social assistance) are the result of "societal learning" among countries.[4] Programmatic developments in services for the aged are clear illustrations of this process. It would seem that recognition of the needs of the aged and concern with development of appropriate social policy and programs emerged in several countries at a time when opportunities for international interchange were expanding. Visits, conferences, discussion, exchange of papers, all offered opportunities for learning and clearly countries have learned from one another through both formal and informal means.

So it should come as no surprise that no one model is unique to any country; and no country is completely lacking any one of the models in some form or other. If one were to ask for a listing of all services available to the aged in each country, the resulting "shopping list" would look very much the same every place. The list would include:

—Long-term care facilities for the ill, disabled, or senile aged requiring extensive medical and nursing care (with or without special subdivisions related to the extent and level of care).

—Long-term care facilities for those isolated, frail aged needing personal care primarily.

—Congregate or sheltered housing for those who do not require the total care framework of a personal care facility but for one reason or another cannot manage in their own homes (because the home is too large, too isolated, on a high floor with no elevators, too far from shopping, without available community support services, not equipped to meet special needs related to limited physical impairment).

—Community support services, either in-home (homemaker; home help; home health; meals-on-wheels; chore and shopping; visiting and reassurance services) or out-of-home (congregate meals, senior centers, legal services, information and referral services, transportation, daytime care, vacation programs).

The major trends in the development of new and innovative service models include:

(a) Multifacility (or multifunction) living and care complexes containing a range of separate but related facilities with different

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[4] Hugh Heclo, *Modern Social Politics in Britain and Sweden* (New Haven: Yale University Press, 1974, 306 ff.).

degrees or levels of care—one question raised in relation to these facilities is whether the aged should be required to move to a different facility when they need more extensive care and, if so, how, by whom, and on what basis should this change be made.

(b) Comprehensive, community-based service centers which may be established either as autonomous, free-standing structures under social welfare auspices or ancillary structures integral to medical facilities. Regardless of the base, these centers provide the fulcrum for a range of services.

Cross-National Differences in Community Services

Despite the extensive similarities cross-nationally, there are substantial differences among the countries. However, these differences do not relate to the existence of innovative programs or new social inventions. Instead they have to do with such factors as the following:

—Differences in emphasis on one or another program,
—Differences in administrative auspice,
—Differences in quantitative adequacy of services,
—Differences in criteria for eligibility and fees for service,
—Differences in coordination and integration of planning and service delivery.

The extensiveness of community services ranges from the comprehensive British program, based on a series of mandated health and social services, to the beginning of demonstration and pilot program development in several other countries. Four domiciliary or home-related health services are mandated by law in Britain to complement hospital and institutional provision: the general practitioner physician; the home nurse; the health visitor; the chiropodist. Many long-term or institutional care facilities provide geriatric day hospitals, day centers, and short-stay beds to take very infirm aged for a few weeks to relieve a family situation or to permit a family to take a vacation. Three key social services are also mandated and provided by all local authority social services departments: home helps; meals-on-wheels (and congregate meals); counseling, information, and advice services. Several other services such as supervisors or "wardens" of sheltered houses and subsidized transport, visiting, and reassurance services are widespread even though not mandated. There are also a large number of recreational, self-help, and advocacy services and centers, although these are considered of lesser importance (relatively) since they are directed toward the younger, more independent, less "needy" aged.

DIFFERENCES IN EMPHASIS ON ONE OR ANOTHER PROGRAM

In some countries (Canada, France, Poland, Yugoslavia), expansion of long-term care facilities are stressed because coverage is still considered inadequate. In others, housing is considered most important (Sweden).[5] In still others, community services are emphasized but the dominant program may be senior centers with socialization and recreational activities (United States) or home health services (United Kingdom).

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[5] Where included, data on Sweden come from an earlier study. See, Alfred J. Kahn and Sheila B. Kamerman, *Not for the Poor Alone* (Philadelphia, Pa.: Temple University Press, 1975).

Sweden, too, has a comprehensive program, from another perspective: very high pension levels; extensive housing; and extensive provision of home helps. In Sweden national policy explicitly supports family care by providing allowances for family members to function as home helps for an aged relative.

DIFFERENCES IN ADMINISTRATIVE AUSPICES FOR PROGRAMS OR SERVICES

Community services for the aged, like *all* services for the aged in Poland, are operated under health auspices. This has the advantage of assuring service integration through a single administrative auspice, but it does lead to service programs heavily oriented to medical care.

In contrast, in Britain, only the clearly medical services are under health auspices while all others are part of an integrated personal social services system. In the United States, programs may be operated under any number of separate auspices (e.g., health, two separate social services auspices, sometimes even under community action agency auspices).

Another aspect of this question of program auspice has to do with whether programs are operated under public, private (not for profit), or proprietary sponsorship. For example, 90 percent of the long-term care facilities in the United Kingdom are public, as contrasted with 54 percent (serving 80 percent of the institutionalized aged) in Israel under voluntary auspices and 77 percent of the facilities covering 67 percent of the beds, under proprietary auspices in the United States. Certainly such differences have implications for the nature of the delivery system and have consequences for accountability also.

QUANTITATIVE ADEQUACY, AVAILABILITY OF SERVICES, AND COVERAGE

These coverage figures are provided for illustrative purposes only; "adequacy" can only be assessed in a larger context, as discussed earlier.

Long-term care facilities cover 0.04 percent of the aged in the republic in Yugoslavia with most extensive coverage. There are beds for 3 percent of the aged in the United Kingdom, 5 percent in the United States and the Federal Republic of Germany, still more in Canada.

Homemaker/home helps are available at a rate of 1 full-time home help to less than 700 total population in the United Kingdom (1 to around 260 in Sweden) in contrast to 1 to 6,000 in Germany, 1 to about 7,000 in France and the United States and still higher ratios in the other countries.

Meals programs serve about 1 percent of the aged in the United States and the Federal Republic of Germany and 6 percent in the United Kingdom.

ELIGIBILITY AND FEES

Community services for the aged in Britain (as in Denmark and Sweden also) are increasingly provided to all needy aged in contrast to France and the Federal Republic of Germany where there is a mixture of selective (means tested) and universal services and the United States, Canada, and Israel, where the major personal social services for the aged are all means tested (or have very limited coverage as in Poland and Yugoslavia). It is interesting to note that one current

recommendation is to eliminate the income-related fees charged in Britain for home-help services. Seventy-three percent of the aged receiving these services obtain them free and it is now thought that the administration costs for determining eligibility and keeping records outweigh the financial return from fees.

THE EXTENT OF COORDINATION AND INTEGRATION IN RELATION TO PLANNING AND SERVICE DELIVERY

(a) *General Considerations*

Once one goes beyond the preoccupation in some countries with expanding quantitative service provision generally and increasing the development of—or emphasis on—community services, a different cluster of issues emerges. At present, these tend to be the concern of the most heavily industrialized countries and those with the largest percentage of aged in their population. Yet one can safely assume that similar concerns will emerge in the other countries also, in time.

Paramount here are such issues as: What should be the criteria for determining the need for care or services, and for priorities for planning and resource allocation? For example, what should be the balance between long-term care facilities, brief and intermittent care facilities, and home-related care and service? The United Kingdom is using coverage for 2½ percent of the aged as the criterion for quantitative adequacy of long-term care facilities. This figure is predicated on sheltered housing serving 4 percent of the aged and continued expansion of home-care (health and social) services. However, the composition of the British population of aged is changing and the population over 75 is increasing far more rapidly than those aged 65 to 75. What effect this demographic shift will have on such needs assessments remains to be seen. Clearly, we still do not possess firm criteria for such assessments.

As quantitative provision of long-term care becomes more adequate—and as new types of facilities and services emerge—there is growing concern with the quality of care and the problems of standard setting and regulation. Related to both this and the earlier question is what should be the role of individual preference in determining need for and type of care: To what extent ought planning decisions take account of the preferences of the aged and how can feedback from elderly service consumers be employed in assuring accountability and maintenance of service standards? Clearly, program evaluations must begin to tap these key assessments.

The role of special cash allowances, in contrast to in-kind benefits and other services for the aged, is still not clear. Several countries provide cash allowances, sometimes on a discretionary basis, to supplement service provision when emergencies arise. Others offer cash as an alternative to services, in effect "cashing-out the service." Rent allowances are a particularly common form, although home-help and related services allowances are also provided. It is worth noting that despite its extensive use of "cashing-out," the Federal Republic of Germany is now expanding provision of in-kind benefits, implicitly acknowledging that the market does not necessarily respond to demand for certain services and aged people have needs that cannot be met by cash alone.

Finally, there are those issues related to the organization and structure of a community service delivery system for the aged.[6] In brief, these include:

—The need for a firm infrastructure of basic social services if the personal social services are to function adequately—a need explicitly acknowledged by all countries covered.

—The dilemma of a categorical service program (for the aged only) versus a general, integrated, family-based, personal social service system. Either option has costs and benefits and the debate continues in Europe as in the United States.

—The fragmentation of services among health, housing, and social services and the search for a more integrated delivery system.

(*b*) *Service Delivery: The Importance of Social Care*

In planning services for the aged, it makes no sense to dichotomize institutional and community care, as was urged for some years in this country, or to place the whole burden of care on a community service system, as some urge now. Inevitably some old people need permanent long-term care with extensive medical and nursing care; but some need such care only occasionally. To decree that institutionalization is "bad" is to ignore the reality of human needs. Moreover, since long-term care is needed, such an approach can only lead to similar types of provision emerging in facilities now described by different names (congregate housing, for example) to serve different purposes. What is needed, therefore, is a full spectrum of facilities, regularly monitored with regard to standards and quality of care, and available on the basis of need and preference.

What emerges from analysis of community services for the aged in other countries, is that:

(1) The major users of services other than the socialization/recreational services are those aged 75 and over—the fastest growing group among the aged.

(2) The most heavily used services, where available, involve a mix of health and social services.

(3) In those countries where they are available, a cluster of home-based services have been identified as critical for helping the aged remain in their own homes—or in congregate housing.

(4) Regardless of whether these services are provided in ordinary or specially designed housing, the important common theme is the element of practical care and help.

To describe these services we borrowed a term from the British—*the social care services*—to encompass the cluster of practical, helping measures such as: homemaker-home health, personal care and hygiene; delivered meals; shopping, chore, escort, reassurance, and visiting services.

The importance of this category of services is obvious in every country.[7] What has not yet emerged is a delivery structure organized

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[6] More extensive discussion of the issues will be provided in Alfred J. Kahn and Sheila B. Kamerman, *Social Services in International Perspective*, publication pending.

[7] For another discussion of these services in the United States, see Robert Morris and Delwin Anderson, "Personal Care Services: An Identity for Social Work," *Social Service Review*, vol. 49, No. 2 (June 1975), pp. 157–174. For discussion from the perspective of health and medical services, see Victor R. Fuchs, *Who Shall Live? Health, Economics, and Social Choice* (New York: Basic Books, 1974), pp. 63–67.

around providing these services. For the most part, even where available, the cluster of services described tends to be fragmented and provided as discrete services. Some are provided under medical auspices; others under social welfare auspices; but rarely are they available in one place under an integrated delivery structure. Except in the United Kingdom, there is no realization that these services should be the fulcrum of any community services system for the aged and that stressing this social care function could improve service delivery generally, making it far more responsive to the needs of the aged.

Such services could be made available to the aged living in ordinary housing as well as those living in special or congregate housing. They would encompass the "caring" component of medical care and would include both long- and short-term care. At affordable prices (either on a subsidized basis with graduated fees or as a reimbursable social insurance benefit), social care services could be provided from either a medical or nonmedical base—from a hospital or clinic facility or a community center. In fact, it might be particularly valuable to experiment with alternative bases to see what the consequences might be of employing different auspices. Within the framework of social care services, medical care could still be separate as would housing, but any aid provided an old person would be required to give social care equal weighting in assessing the adequacy of the individual's living arrangements.

Social care services are identifiable, concrete aids and represent the key to achieving what most agree is the major objective: supporting the aged in comfort and dignity, be it in their own home, another's home, or a special facility. Viewing community services for the aged in these eight countries has revealed—and underscored—their importance as the cornerstone of a delivery system.