TRENDS IN LONG-TERM CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

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TRENDS IN LONG-TERM CARE

TUESDAY, JUNE 15, 1971

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to call, in room 457, Old Senate Office Building, Senator Jennings Randolph presiding.

Present: Senators Randolph and Percy.

Also present: Congressman Pryor.

Staff members present: William E. Oriol, staff director; Val Halamandaris, professional staff member; John Guy Miller, minority staff director; Margaret Fecik, assistant chief clerk; and Donna Colombo, clerk.

OPENING STATEMENT BY SENATOR JENNINGS RANDOLPH, PRESIDING

Senator RANDOLPH. A pleasant good morning to our guests who are here this morning. I wish to speak briefly before Bill Hutton and Lionel Cosin present their very important subject matter.

We are all intensely interested in the trends of what I call long-term care, and for that reason my remarks are in the form of welcome and will be very brief in my comments to be included in the record.

We are welcoming you who are present today on behalf of the members of the subcommittee and, of course, the umbrella committee, the Special Committee on Aging.

Our concern here this morning is with the American system of long-term care. Nursing home problems have been a concern of mine for many years. I have visited nursing homes over the United States for a period of 10 years—have had occasion to discover the changes and advances that have been made, including attention by Members of the Congress, who have been studying this important subject matter.

Certainly this industry is part and parcel of the Federal Government because of the $2.5 billion in nursing home revenues incurred last year—two out of three of those dollars came from what we call public coffers—the majority being Medicare and Medicaid.

The nursing home industry as we know it, as we have read and heard it is under rather constant attack these days: Inefficiency, that the costs are excessive for the operation of the homes, and lack of proper care of those in such institutions.

I think the criticism very clearly is very extreme at times, but knowledgeable people in this field have stressed that many of these

points are valid, and there is a very real need for improvement in the system of nursing home care.

The care of those who are elderly and ill is a comparatively new science. I think in many ways it could be said to be a difficult science. There is a need for constructive hearings to permit us to learn from our neighbors of their systems, many of which are more advanced than our own efforts.

For these reasons and many others that could be stated we feel that today's meeting of the subcommittee is particularly timely and important. We are to hear from Dr. Lionel Cosin, clinical director of the geriatric unit, Oxford Hospitals, in Great Britain. Dr. Cosin is perhaps as knowledgeable in the gerontological field as anyone in the country. We hope to learn from Dr. Cosin, and I know we shall, the methods and techniques employed by European countries and particularly Great Britain.

Representative Pryor, join us here if you would, sir. I interject at this point that it is appropriate for Representative David Pryor to join us this morning, coming over from the House side. There is an article in the New York Times this morning, focusing attention on this matter that we are considering today. I hope we can provide you with time to comment on this article.

To come back to you, Dr. Cosin, I am happy you are here. You have a reputation which has been well earned, and you are renowned on an international scale. More than that, your service on an international scale has been of very high performance.

And now, Mr. Bill Hutton.

STATEMENT BY WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Hutton. My name is William R. Hutton, and I am executive director of the 3 million member National Council of Senior Citizens. We have worked closely for some years with the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging.

And it gives me great pleasure to introduce to this committee today one of the most distinguished members of the National Advisory Council of the NCSC: Dr. Lionel Z. Cosin, one of the world's leading geriatricians.

His systems of progressive patient care have been introduced not only throughout Britain but in many other countries of the world.

We are indeed fortunate that the Subcommittee on Long-Term Care has been able to set up this hearing at this time to take advantage of Dr. Cosin's great experience, while he is on a temporary visit.

Last year, while on a sabbatical, he worked at Cherry Hospital, North Carolina, introducing the progressive patient-care techniques that he first began to use in England a quarter of a century ago. He found that the patients in North Carolina were able to benefit quickly from this type of care, just as the aged patients in England did.

I believe what Dr. Cosin has to say to this committee will be extremely helpful to our lawmakers and others who are looking for the proper alternatives to our present inadequate systems in America.

STATEMENT BY DR. LIONEL Z. COSIN, CLINICAL DIRECTOR, UNITED OXFORD HOSPITALS GERIATRIC UNIT; AND CLINICAL DIRECTOR, RIVERMEAD REHABILITATION UNIT, UNITED KINGDOM

Dr. LIONEL COSIN. Mr. Chairman and members of the committee, my curriculum vitae, in considerable detail, is in the hands of the committee staff,* and perhaps I may be permitted to introduce myself briefly in these terms:

I am clinical director, United Oxford Hospitals, geriatric unit, United Kingdom; and clinical director, Rivermead Rehabilitation Unit, United Kingdom. I have lectured and worked in this field in many countries. For the past 2 years, I have been a member of the National Advisory Council of the National Council of Senior Citizens, under whose auspices I appear here today.

I sincerely appreciate the opportunity to appear before this committee which has done so much good work in seeking to study the problems of long-term care in America.

These days are days in which the question of delivery of health care for all Americans, young, middle-aged and old, very much concerns all in the Nation.

Senator RANDOLPH. Let me interrupt, Dr. Cosin. What are the limits of middle-aged? What age groups are covered and has this changed or varied?

Dr. COSIN. Up to 65 years. It has retained its definition.

Senator RANDOLPH. Although we are considering problems in the long-term care today and this generally concerns those 65 and over, we should give some attention to the problems of those who are 50 to 65. This age group is growing very rapidly and is confronted with a devastating set of problems, and ultimately they will make up the members of our community who will be recipients of our long-term care.

Dr. COSIN. Yes, of course you are right. We must face the problems of this age group, taking them as they occur chronologically. By early attention, perhaps we can prevent major health catastrophies which are damaging to the patients as well as expensive to treat.

The introduction of Medicare and Medicaid have already had considerable influence on the patterns of care in the United States. The spiralling costs of much of America's current systems of delivery of care are being questioned and the search for alternatives which offer improved quality of care and yet promise to cut down the staggering acceleration of costs is now at hand.

60 PERCENT OF RESIDENTS DO NOT BELONG IN NURSING HOMES

Representative PRYOR. Pardon me, Dr. Cosin, may I interrupt? We often hear the statistic quoted that as much as 60 percent of the current residents in nursing homes do not belong in the institutions. I wonder if you would care to comment or confirm those figures.

Dr. COSIN. Well, I cannot really confirm the statistics but I can accept the premise. In England we treat the elderly in their homes. Our

*Retained in committee files.

emphasis is on the community rather than on the isolated institutions. Logically, a great number of your nursing home patients could be returned to the community if you followed the example of the United Kingdom and that is what I want to tell you about today.

I have been deeply involved in geriatric medicine now for well over a quarter of a century. In the many visits I have made to America over these years—including my lectures at over 18 U.S. universities—I have tried to tell the success story of progressive patient care utilizing the sociomedical approach for the solution of sociomedical problems.

I believe this technique offers the best hope for America to tackle the immense problems in health care of the aged which result from growing numbers of older Americans—from 4 million over 65 at the turn of the century to over 20 million over 65 today.

Unless America decides to seek solutions now, the situation in long term care will continue to deteriorate as America's over 65 population grows to 30 million by the end of the century.

Senator Moss and the members of this committee have sounded many warning bells in recent times—and I have read of the excellent work to focus public attention on these problems by Representative David Pryor in the House of Representatives.

I hope that what I have to say today before this committee will prove useful to lawmakers, to those in the nursing home industry, and those in the medical profession who are willing to accept change for the better.

Senator RANDOLPH. Dr. Cosin, I am sorry, but unfortunately I have a conflicting committee meeting on minerals and fuels which is very important and deals with a crucial problem. Everything, you see, is a crisis in the United States. I must appear at this committee meeting.

I would like to thank you for appearing before this committee today. I also know that your words and advice will be very useful as we pursue this inquiry. As I leave, Representative Pryor, I hope that in crossing from the other side of the Capitol, you will feel free to question in your own way.

Dr. COSIN. Perhaps the best way for me to begin this testimony—which will be oral, include some visual aids in the form of slides, and offer additional data for the record—is to start with a brief examination of the results of good care, clinical and financial.

Oxford geriatric unit (part of university teaching hospital at Cowley Road Hospital)

	Beds
Service for acute	189
Elderly long term	40
Care (nursing home provision)	50
Psychogeriatric	16
Total	295
Population served	350,000
Beds per 1,000	0.85
Psychogeriatric 0.3 / U.K. N.H.S. allocation 1.2	1.5

	Beds per 1,000
East Berlin	7.6
France	4.0
United States	5.0 to 8.0

Representative PRYOR. Excuse me, Dr. Cosin, this figure of five to eight beds per thousand in the United States, does this include psychiatric beds?

Dr. COSIN. No, it doesn't; it only includes nursing home beds.

Sweden, which had only two beds per thousand is now moving up to four beds per thousand and hopes to achieve that in 1993.

Representative PYROR. I have heard the figures somewhere that 60 percent of those confined to nursing homes actually do not belong in institutionalized care, actually do not belong in nursing homes. I have also heard that many many of these people could come back from the nursing homes. Is this basically a proper figure, 60 percent?

Dr. COSIN. I can't confirm the figure but I would agree with the hypothesis. I would agree that there are many people——

Representative PYROR. They just don't have any other place to go, is that right?

Dr. COSIN. Well, I'd go a little bit further than that. This is a result of inadequate and sometimes bad planning in patient care. We've got to come down to the responsibility of the physician, of planning patient care on a short term and a long term basis.

Now, if he cannot accept this responsibility, other steps have to be taken.

But certainly, from my own experience in North Carolina, where I visited quite a number of places there, first, we were able to recycle back into the community by providing a program of continuing care under existing legislation as it was in 1970. And my attention was drawn to the problems of putting people in nursing homes when quite frankly they had no right to be there.

I was asked to speak about one case. A very young man, age 60, which is young today, who was sufficiently unwise as to have evidence of a stroke for 48 hours. This correct diagnosis was made, and he was moved to a nursing home. The symptoms of the stroke cleared up very rapidly.

But because he had had a stroke, and had unfortunately only $600 a month, it was exceedingly difficult for him to get out. He was competent in every respect, even to reading the Wall Street Journal. That may be evidence of incompetence.

But here is an example—one swallow doesn't make a summer—but here is an example of the sort of failure to deal with what I'm going to describe to you as a pattern of progressive patient care.

So we've got Sweden rising from two beds per thousand to four beds per thousand. I think this is evidence of social backwardness, in that one requires a certain number of beds to deal with a certain number of problems as they develop on a dynamic basis.

STATISTICS

If we deal with these problems on a static basis, you will never have enough beds. It's impossible. And as you increase the number of beds, the quality of the service decreases immeasurably. You then have to decide on a factual basis what is the mean, the median level, at which we should operate to provide the appropriate type of service at the appropriate time in the development of the clinical problems in a community.

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Scotland, being a little more profligate, requires two beds per thousand compared with the English with 1.5, including psychogeriatric care.

So we get a fair pattern of the number of beds per thousand of the general population. This, of course, is not to say that this applies to people only of pensionable age; shall we say, over the age of 65.

And small variations of these figures might well be appropriate, but we will not go into these today.

In this Oxford geriatric unit comprising 189 acute beds, acute and rehabilitation beds; 40 resettlement or extended care, which would be comparable to your nursing home position and psychogeriatric beds as well; we were able in 1969 and 1970 to admit 1,746 patients, 1,342 of which were discharged and 369 died.

We have four "day-hospitals" which give 500 treatments a week to 300 patients. And 300 patients is another hospital in itself.

It is very important to note that with these people whose average age on admission was 82 years, the average length of stay—I will demonstrate some statistics on the length of stay, the decreasing length of stay over the last 20 years—but in 1969, the average length of stay was 35.9 days.

We then broke down the number of patients who had been treated, into three sections: Those who had been treated for less than 60 days, those who had been treated from 60 to 365 days, and those who had been treated for over 365 days.

The number who were treated for less than 60 days was 87, the number between 60 and 365 was 86, and the number over 365 including psychogeriatric long-term care was 52.

How much did this cost? Is it feasible? Is it reasonable?

We then discussed the turnover of the acute unit, which amounted to about 1,800 patients, 1,350 of which had been discharged back to their own homes, and 369 of which had died, average age of admission being 82, and the fact that we run four day-hospitals giving 500 treatments a week to 300 patients, another hospital in itself.

It's very important to ascertain the length of stay, and for this we've got a table going back over 20 years, pointing out the stay as less as the efficiency of operation increased. So that the average length of stay in 1969 was 35.9 days—36 days, 7 weeks. And we subdivided the number of patients according to their length of stay, on the last day of the year.

The number of patients who had been treated for less than 60 days is 87. From 2 months to 12 months was 86. And the number of patients who had been in over a year and whom we can, therefore, perhaps define as long-term care, was 52 only.

It's important also to measure the efficiency of operation in financial terms. And we won as a result of improved patient care a system of decreasing costs. So the costs in the main part of the acute hospital is £67 a week or $23 a day.

In the geriatric unit itself, it's fallen to £46 a week, which is just about 70 percent of the acute hospital cost, remembering the short length of stay.

But when we come down to the concept of the halfway house, halfway between the hospital and the community, the cost has fallen to 21

percent of the acute hospital stay, remembering that many elderly people also come from acute hospitals.

And when you examine the daily hospital service with 300 patients, the 5-day week program costs 13 pounds. But because we reduced the number of tendencies consistent with the patients' current needs, which may change, each patient requires only 1.71 days of a 5-day week. So a 1-day hospital place keeps three people going in the community.

So the actual cost is reduced to 4 pounds per case per week which is 6 percent of the acute hospital charge. And we can discuss the treatment including medical and nursing in the day hospital.

It's very cheap because we use the patient's own bed at home.

It would be interesting then to examine the efficiency perhaps of the Oxford geriatric unit by measuring the number of patients who had been in over 1 year. At the beginning of the program in 1950 there were 370 beds and we had 330 cases over a year's time. In 1964 we had reduced the number of beds from 370 to 300 to reduce overcrowding. But the number of cases that had been in over a year had fallen from 330 to 74.

In 1969 with a further reduction to 290 beds, the number of cases over 365 days had fallen from 74 to 52. This also takes in the large proportion of psychogeriatric cases.

If we are talking about short-term care or long-term care we must measure this and it must be factual. It is no good talking about long-term care unless we quantify this quite clearly. So that we quantified the number of patients in the various categories during 1970, and the large table on page 4 that you have—I gave you a large number of figures which is an actual measure of operational efficiency. And you see that on the last day of December 1970 the number of patients who had been in for over 365 days in the main hospital was 31. And that the actual average cost of that—and there's only one way of costing and that is the appropriate daily cost of the facility—in other words, 70 percent of the main acute hospitals.

The average costs of those patients in hospital days was 941.76 and 723.27. The lower female cost will be explained by the fact on page 5 that we run a mental health annex—mental health, not mental disease annex—for the small number of patients who need longer term care—this is entirely female—it was 50 beds. Only 24 of these had been used by patients with length of stay over 365 days, and the average length of stay was 992.19 days. In other words, 1,000 days. In other words, 3 years.

So that we now have to—not compute, because that's a bad term—we have to identify the actual cost of the different proportion of actual patients and the number of hospital-bed days they require in the progressive patient care program.

What we've done on page 4, is try to identify the fact that roughly about 1 percent of the admissions over any 1 year are going to cost in toto about 3 years, about 1,000 hospital-bed days.

I would like now to introduce into the record a special paper which has been prepared by an extremely skilled American nurse who has served for the past 2 years in England and is currently based at our hospital at County Road, Oxford.

This is it, sir. Can I introduce this?

Representative PRYOR. Certainly.

A NURSE'S PERSPECTIVE

Sister Thelma Wells was trained at the Massachusetts General Hospital, Boston, was a graduate student of Case Western Reserve University, Cleveland, and has worked as staff nurse at the Midtown Nursing home in the summer of 1969.[1]

Sister Wells, as you see in the records——

Representative PRYOR. Pardon me. Midtown? Where is that now?

FROM THE FLOOR. It's in Cleveland.

Dr. COSIN. Cleveland, Ohio. Sorry.

Sister Wells says frankly in her document that she believes the average age patient in England receives better care than the average patient in America. She supports her belief.

Which she illustrates with examples. And perhaps I might be permitted to quote her.

"1. In America, there are few community support services to help maintain the aged patient in his own environment"—your main point. "In England each local authority health service is required to supply the following supports which the aged utilize: Chiropod service, podiatry, meals on wheels, home help service, occupational therapy, recuperative holidays, residential homes for mental health, home nursing, health visiting, ambulance service, day centers and clubs, and residential accommodation. Even though such services may vary in strength from community to community, the geriatric practitioner can rely on the support being basically available."

"2. The American family caring for an aged relative has few supports in either the community or the hospital system. The English family in the same circumstances has not only community supports but also the growing reality of flexible hospital admission"—and I would like to stress this term she's introduced herself—"flexible hospital admission plans for the aged."

"Cowley Road Hospital has such flexible plans in practice to relieve families of heavy or sudden increasing care pressures. These are holiday admission, short-term admission and floating beds." A matter I will go into a little later—"Holiday admissions assure the family that the aged patient will be admitted to the hospital during the family's planned vacation."

We are now commenting on a paper submitted by an American nurse who was trained at the Massachusetts General Hospital and who has worked at the Case Western Reserve University and also incidently, though she seems not to mention it here, came from a postgraduate nurse training program at Oxford. And when a senior nursing post became vacant she applied. And she was appointed. She was very good. She's there now as a matter of fact.

So that I'll point out that the Cowley Road Hospital has such flexible plans in practice to relieve families of heavy or sudden increasing care pressures. These are holiday admissions, short-term admissions and floating beds.

Holiday admissions assure the family that the aged patient will be admitted to the hospital during the family's planned vacation. I might

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[1] See appendix Item 2, p. 1405.

interject that we admit about 120 patients a year for holiday admissions.

"A short-term admission program provides for intermittent 2 week admission of the aged patient." Again I may interject, where social stress is deemed to be rising in a community, a social worker recommends that this bed be kept under control by arranging free admission from 7 to 14 days every 4 months.

Now, this makes a great difference in the family, one in actual relief and, two, in the ability to communicate patterns of stress in the community and in the family.

"The floating bed plan"—which is one of my innovations; I claim guilt for that—"is a scheduled admission every 2 weeks for either 3 days and 2 nights or 4 days and 4 nights." So that the actual degree of community and family stress is being assessed all the time. We are in a position to ascertain currently without any bureaucratic innovation at all—this is a medical and sociomedical process that does not require any governmental or administrative approval. It would appear that the doctor-patient relationship in socialized medicine has something to offer.

"In addition there is the day hospital"—of which we have four, as I've told you, in which 300 patients are being treated all of the time—"a unit combining medical and nursing care, physical and occupational therapy with a noon meal for the aged." This is under the administration of a therapeutic dietitian.

Third, Miss Wells comments: "The whole health care system in America seems to be ill designed for the aged." This is the comment of the American nurse at Oxford. "The practice of full medical assessment, rehabilitative treatment, and continual followup for the aged does not seem to me to be a reality. For example, unfortunately I have had little American experience with physicians who were either concerned about the causes of confusion and incontinence, or planned rehabilitative treatment for such problems. 'He's old. It's to be expected' seems to be the frequent American health system attitude."

Then she goes on: "Community support services for the aged are in America few, in England many. In my actual American nursing experience, aged patients without families or with inadequately supporting families are placed in nursing homes. I believe that many of them could be maintained in their own environment with community support services. To my knowledge, the most consistent source of community care for the aged in America is the very overworked Visiting Nurses' Association. With few supporting services, it is only logical that the aged are sent to nursing homes or subsist in their own homes. There is fear among some aged that seeking any aid means a nursing home placement because the health system discovers their meager ability to live alone.

"It was reported in a cooperative study done at the Massachusetts General Hospital that in 1 month, 375 patients were referred from the hospital. Of these, 266 were referred to nursing homes, 104 to the Visiting Nurses' Association, and 45 to chronic disease hospitals. Kelleher and Shaughnessy, in a study of nursing homes in Massachusetts, found that patients were admitted primarily for long-term skilled nursing care, and/or because the patient lived alone and could not

maintain himself independently in the community. Certainly, many of these latter patients do not need nursing home care, but rather community support services.

"In my nursing experience at Cowley Road Hospital, most of the aged patients that I care for go home. In 1969, Cowley Road Hospital admitted over 2,000 patients with an average age of over 70"—it's over 80, actually, 82. "Of the discharges that year, 62 percent went home. Only 5 percent went to nursing homes or long-term institutions." And her complete paper I've submitted to you, sir.

Waste and Effort

I would like now to draw attention to an article I wrote after my North Carolina experience, on what I term as waste and effort.

Now, I wouldn't have you believe that everything in the British garden is wonderful while health care in America is not so. Frankly, the economics of any hospital system in the United Kingdom is still much cluttered by wasteful obsolescence. So much of the national health service's finances seem geared to maintaining an inefficient service—although we are changing that—sustained only by a meager annual increment to cope with the inflationary trends, while little constructive thought seems to be given to the financial incentives of replacing unplanned obsolescence either by planned obsolescence and new buildings geared not only to higher standards of patient care but also to greater economy of running. And this will be my major theme.

My impression of the U.S. hospital economics do not impress me any better, as each hospital, whether municipal or private, is either paid for out of tax money or various insurance schemes which merely pass on any increased costs by increased insurance payments.

This leads to a vicious circle of increased inefficient usage as a result of unnecessary use of inpatient facilities instead of outpatient use as in Britain, with resultant overcapitalization. In nearly every major city of the United States, there are too many hospital beds which must have high bed occupancies to balance the budget.

Low Efficiency Bed Utilization

This low efficiency in bed utilization is balanced by high bed occupancy of short-stay patients. This, together with the less advanced demographic picture in the United States compared with the United Kingdom (9.4 percent of the population over 65 instead of 12.5 percent, accounts in large part for the shorter patient-stay. The higher British average patient-stay may be evidence of greater efficiency in use (the 25 percent of inpatients unnecessarily in United Kingdom hospitals may be much lower than the U.S. figures), and also evidence of a higher percentage of older patients in "acute" beds (about 50 percent of medical inpatients in the United Kingdom are over 60, compared with an estimated 20 percent in the United States.) There is need in the United Kingdom to treat and keep older patients in acute beds because the number of chronic-sick and geriatric beds is 58,000, or one bed per 1,000 of the beds for over 65. Although the aim for national health service, as I told you, was 1.2 for geriatric plus another 0.3 for psychogeriatric care, making 1.5 in all. And this should be adequate or more than adequate.

There is no need to keep older patients in acute beds in the United States because there are already five beds per 1,000 of nursing home beds of very diverse and variable standards, but on the whole low, in addition to an undefinable number of municipal hospital beds and State mental hospital beds.

For example, Allegheny County, with a population of 1,500,000 in 1960 when I was there, in which Pittsburgh is situated, has Kane County Hospital for the chronic sick, of 2,200 bends, which itself provides for 1.5 beds per 1,000. After 18 months of being open, the beds were already filled, and there was a long waiting list stacking up already. This is the same problem of providing custodial care to the chronic sick.

Of course, we all agree in this committee that there are no chronic sick, only the chronically neglected. Let the chips fall where they fall; they fall on many shoulders.

In North Carolina in 1969, there were—oh, I'm sorry—in addition to the five nursing home beds per 1,000, a mental hospital of 1,200 beds, and acute hospital beds in addition that I could not count.

In North Carolina in 1969, there were 6,000 nursing home beds, 9,000 rest home beds; and of 11,000 State mental hospital beds, it is assumed that 3,000 were occupied by the elderly and chronic sick. Thus, there are about 3.5 beds per 1,000, leaving out the 20,000 acute hospital beds.

Thus, the U.S. acute hospital never need keep elderly patients, who may be financially embarrased, sufficiently long to increase the average length of patient-stay, but pass them on.

The British acute hospital supported by no nursing home beds comparable in percentage proportion is also inadequately supported by departments of geriatric medicine or even department of chronic diseased. Of course, we're very fortunate. We can't afford to build too many beds. This is an advantage, financial and clinical.

Thus the American figures of average length of hospital stay are managed to be low while the British figures are kept high by the partial failure to implement and utilize fully active departments of geriatric medicine such as those that exist at Oxford. Sunderland, St. Andrews and perhaps another 15 or 20.

The Medicare utilization committees meant to reduce patient stay, may do so and result in worse patient treatment.

The picture of American industry is of ruthless replacement of inefficient equipment. This is not the picture of American hospitals which display the latest innovative technical procedures which do not last long, but no overall picture of operational efficiency, although they can be justified sometimes in relation to high standards of individual patient care and relatively low building and furnishing costs; but this itself is questionable.

In an economy which is ataxically struggling with inflation while grasping out for affluence careful measurements should be sensibly made so that the future economies of operation can be achieved at stated intervals of 3, 5, 7 and 10 years.

Representative Pryor. Would you yield right there for a question? In the British system how many of the homes would be proprietary homes? I'm talking about the nursing homes themselves?

Dr. Cosin. Let's take the Oxford area of a third of a million people, there are not more than four, five. They comprise about 200 beds and these are for the higher income families.

The number of nursing homes that are provided and subsidized by the local government is nil.

Representative Pryor. You are aware, I'm sure, that 90 percent of our nursing homes today are proprietary or profit oriented institutions. And it's my own feeling that our Government today is encouraging the proprietary nursing home, encouraging the profiteering in nursing homes, and is offering the incentive for the wrong types of individuals from our communities to come into the nursing home industry.

We're not encouraging the community nursing home, not encouraging the nonprofit—say the church oriented or related groups, the fraternal organization—to come in with their assets and their creativity into the nursing home field.

You may want to touch on that later.

Dr. Cosin. I wonder, Congressman, if we're not perhaps appreciating the fact that there are two problems here. One is the booming health industry which is doing pretty well. And two, the quality of patient care. Now, I would postulate that these two factors are not necessarily linked. They may be in a very large part dislinked. But this is a very peculiar statement to make. I think we've got to differentiate these two quite separate problems. Whether we can by some method or other connect the two is what we're looking at, and addressing ourselves to this morning.

Nursing Home Profit Incentive Basis

Senator Percy. I wonder if you could expand a little more on this question. Do you feel there's a basic conflict with nursing homes being set up on a profit basis? Is it possible to run 90 percent of our 25,000 nursing homes on a profit incentive basis and have adequate care? And rather than differ from our distinguished Congressman, I have found in my own city of Chicago, Ill., the correlation between profiteers exploiting the elderly and the lack of services being provided is very great indeed. In fact, I've made so many charges that I'm addressing the Metropolitan Nursing Home Association of Chicago at its annual meeting on Thursday.

I'm going to walk into the lion's den. I'm going to confront these people with my concerns and just ask them the question: Is the proprietary system compatible with good care? Every penny they put into that person comes right out of the patient's own pocket. Is it consistent to run homes that way? We don't run hospitals that way. And you don't run your nursing homes that way.

Dr. Cosin. Well, we have no nursing homes at this time. But, Senator, I'm going further and deeper than the question. I'm asking——

Senator Percy. I don't want to have you get so deep, though, that you don't answer the question.

Dr. Cosin. I'm asking what part of long-term and short-term health care and nursing homes on a nonprofit or profitmaking basis, should occur? I will be showing statistics to show that it is minimal. In other words, is not the direction for health care for the elderly in this coun-

try already focusing in an entirely wrong direction? I'm questioning the whole pattern of patient care for the elderly.

Senator PERCY. You're questioning the existence of the entire 25,000 nursing homes?

Dr. COSIN. Yes.

Senator PERCY. Whether profit oriented or not, as to whether that type of structure is the right way for us to go?

Because they do care for a very small percentage, about 5 percent, of the elderly.

Dr. COSIN. Yes, I'm questioning this altogether, and seeking to quantify the numbers of patients who need long term caring, if other alternatives, appropriate community developments, take their place. We reckon it's about 1 percent in any 1 year, a fairly low number altogether, which in Oxford is taken care of by the National Health Service.

Now, those 52 long-term patients in Oxford, I would not disagree with them being in a nonprofitmaking nursing home. But 52 out of 350,000 people—65,000 over 65—this is some measurement of what I think can and should be.

I had some comparable experience last year in North Carolina. So it's certainly applicable to a part of the United States, and certainly applicable to the United Kingdom which I'm responsible for.

Senator PERCY. I wonder just as long as we've had this pause, whether or not it wouldn't be good to best utilize your time—perhaps to put the rest of your testimony in the record.* I know that everyone has copies of it and we can probably speed read a little faster than we can follow it. I've finished it. I think most people have finished it. And perhaps we could just use this time for questioning by Representative Pryor and myself. You have a floating bed system and he—Representative Pryor—has a floating office system. [Laughter.]

And I think we might best utilize your time by asking some questions.

Dr. COSIN. I've got a lot of slides to show.

Senator PERCY. I'd be the last one to be against pictures, having been in the business all my life. But I notice this is an Eastman-Kodak projector.

I have a couple of questions I'd really like to ask you and, regretfully, I have the President's scholars coming in to question me for 40 minutes at 11:45. So I just have 35 minutes. Could we use maybe—how long would these slides take?

Dr. COSIN. They'd take about an hour, sir. I'd be happy to discuss with you any questions you'd like to ask.

TRAINING FOR GERIATRIC CARE IN ENGLAND

Senator PERCY. First, I am very much interested in the field of geriatrics. What incentives, if any, do you use in England to get professional people to go into this field?

Some people comment that it's a rather depressing field to go into. There is no incentive to go into the field and there are not enough people going into it. What do you do about stepping up the number

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* See appendix item 1, p. 1399.

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of people who can go into this field? We have 20 million aging Americans today over 65, 40 million in 20 years. How are we going to provide for them if we don't have the professional people around? How does England do this?

Dr. COSIN. First of all, the national health service in 1948 decided the only way to deal with providing hospital care was to subdivide each area into district general hospitals. Perhaps we can see the second slide because this just mentions it.

For each area of Britain comprising about one-third of a million people there is a district general hospital of about 1,000 to 1,500 beds. Now, the Ministry of Health, therefore, is in charge of this. We see that the Ministry of Health has decided that it will have two patterns of actual care, the teaching hospital and the regional hospital boards, each hospital board being responsible for servicing several hospitals.

Now, each hospital management committee is responsible as you see for a district general hospital of 1,000 beds which I told you about. But basically the district general hospital is responsible only for short-term care. But this is all right if there is a supportive cooperating department of geriatric medicine. Which provides in Oxford through a pattern of progressive patient care, continuing care, rehabilitation, research. And this is a coordinated department as well as a therapeutic department.

We see it has access to all hospital departments for nursing from the district hospital pool. Social service from the district hospital pool, and a psychogeriatric department. And this has been in existence—not very well organized to begin with—for 20 years. And we are developing it all along. Having established a department of geriatrics, the Ministry of Health then had to establish consultant specialists in geriatrics. Now, this is the basis of the problem.

Senator PERCY. And do you see that same comparable status in this country?

Dr. COSIN. I see no indication of it at all. I see no evidence of interest in the teaching hospital.

LICENSING NURSING HOMES IN ENGLAND

Representative PRYOR. What would be the system in England for licensing nursing homes?

Dr. COSIN. Both nursing homes—there are a very small number of nursing homes—and the equally small number of rest homes are the licensing responsibility of the municipality of the local authority. A Social Welfare Department would license the homes. The nursing homes are licensed by the Medical Health.

Representative PRYOR. Would that be the same in the licensing of hospitals? Or is it different?

Dr. COSIN. No; the hospitals are not licensed. They are a direct responsibility of the Ministry of Health, but there's always someone going round identifying standards. And we have additionally a hospital advisory service who do not license. But what they do do is come and visit a physician, an administrator, a nurse administrator and a nursing sister. And they will go round interviewing patients, relatives, and the staff. And at the end of a few days they get a very good picture. They first meet with the hospital staff. They meet with all the

hospital staff afterwards. They go back to the Minister and say, This is what we found. This is what we recommend. And then there is a followup 3 months later. And they will report to the Minister that this is being done, this is not being done. They are defective. They're doing a good job of work.

Representative PRYOR. Has the system proved to be effective in England for raising the standards and quality of care? Has this been an effective system?

Dr. COSIN. I think this is a good effective system, yes. Certainly.

Senator PERCY. You mentioned in your testimony that the American family who is caring for the elderly does not receive the supportive services that that same family would be receiving in England. You mentioned the meals on wheels, occupational therapy and so forth. Are these supportive services paid for by the Government? Are they provided by voluntary organizations, or what provisions are made to finance them?

Dr. COSIN. Senator, the testimony I was reading was that of Thelma Wells,* the American nurse.

I wouldn't entirely agree with her after my North Carolina experience. Because if as we did in North Carolina, gave support—not the same depth of support—but some support in continuing care and responsibility, we found many North Carolina families very helpful.

I do not think necessarily the fault is the fault of the family or the community. It's in large part the fault of the organization and the provision of the care.

To return to your question, Senator, most of the provision of community services is by the local authority or the municipality. Some of this is Central Government supported, sometimes a half, 50 percent. But for instance, one of the most important aspects of continuing patient care and community support is the transportation service.

Well, now, we have in Oxford eight or nine full-time city ambulance cars for six to 12 people provided for by three local authorities. They get a 50 percent grant from the Central Government. But these nine vehicles are at the disposal of the rehabilitation and day hospital service.

Most of the services are either totally provided by the local authority. Sometimes a subsidized voluntary effort, meals on wheels for example, or podiatry. But in large part this is a local authority responsibility with very good voluntary support.

But I must point out that in North Carolina I had very good voluntary support. We were able to provide two day hospitals out in the community, one out of near the Outer Banks and the other in Goldsborough itself.

And this became possible very largely by voluntary responsibility and support, and not by any kind of Government funds or community mental health services.

TRAINING FOR STAFF AND AIDES

Representative PRYOR. Doctor, in this country most of the personnel in our nursing homes are untrained, and in many instances, I'm afraid,

* See appendix item 2, p. 1405.

unqualified. Nurses aids, being paid the minimum wage. Now, what have you done in England to bring in trained personnel to care for aged?

Are you doing something in England at this time that we should know about that possibly we can do? Is there anything you can tell us?

Dr. COSIN. Could we have the fourth or fifth slide on progressive patient care. That's it.

This is a patient flow chart of the Department of Geriatric Medicine of the United Oxford Hospital.[1] And what we do, we solve this problem by saying that a person in need of 24-hour nursing service must get it in intensive or intermediate care.

In other words, these continue to be a responsibility of a trained staff and trained aides adequately supervised. We are geared optimistically on the basis of rehabilitation and recovery, in part or in whole. We did mention that we were going to replace the term "chronic sick" by "chronic neglected." Now, if we fail to get these patients at the right time in the development of the illness—and there again the acute general hospital is in part to blame. Let's not forget that. They initiated that. Then a heavier load is put on too weak a system so that the system itself, even if it wanted to do a good job of work, becomes overworked or has to provide additional resources.

At that stage in the development of the rehabilitation program, they should not meet. The whole thing is phased incorrectly. As you see in this picture, we've got intensive, intermediate, and minimum care. And this is a progressive patient care system. Now this has replaced the entire, the whole custodial care package.

And if you look at the bottom you'll see that we've got four progressive care wards comprising 100 beds, two rehabilitation wards comprising 75 beds. The difference between quick stream and slow stream is very important. Quick stream costs about 25 hospital bed days and slow stream as such is going to cost me 120 to 180 days. But it's my business to know this because I know exactly what's going to happen and how many hospital bed days I need to mobilize next year.

Then you come to the halfway house which is minimal care and finally you come to a long-stay ward. And almost all of these patients are intermediate care but are cared for.

So really, you're still in a pattern of very short-term stays, doing or not doing what needs to be done. And the transfer of the total responsibility.

Now, I maintain that this magnifies your problems enormously. The long-stay homes in the profit business are still not held entirely to blame. They are obviously to blame for the quality of standards; but something has to be done.

MISUSE OF DRUGS AND TRANQUILIZERS

Senator PERCY. As a corrolary question, talking about bed-stay presentations, we have in Illinois a "point system." I am not sure the same system works in other places, but the system for how much the

[1] See chart 1, p. 1415.

nursing home, for instance, receives. The homes receive a "bonus," a monthly allowance, for bed-classed patients. Therefore, there's an incentive to keep the patients in bed rather than to get them out and rehabilitate them. There seems to be some backwardness in the system.

Now, the homes can keep the patients in bed in a number of ways. I have observed people tied into bed. They can keep them there by drugs, and we have evidence, I think, of a good deal of misuse of drugs in this country for the elderly, as well as at every other age level.

What kind of a problem, then, do you face in England on the use of drugs? Are they used or misused in this way in order to keep down a patient? The more they are doped up the quieter they are and the more they stay in bed, and the less chance they have to rehabilitate themselves. The rehabilitation process is just given up.

Whereas what is actually needed is more trained people for rehabilitation. The elderly may have a number of years of useful active life still left if they are given rehabilitative help.

Dr. Cosin. I can't agree with you more, Senator. I think there is a gross overuse of drugs. I think there is a failure on the part of internal medicine to identify problems which result in disturbed behavior in elderly patients. Many of these are chest respiratory problems, and they could need antibiotics. Very often the best basic drug is an antibiotic or oxygen. And very often the worst drug is a tranquilizer which may make the condition far worse.

And this we found in North Carolina, and eliminated very largely the use of tranquilizers. And this does involve patience on the part of the attending staff. I do feel that perhaps they're not needed so very much, but the whole institutional subculture neglects the problem—they do depend on certain drugs.

But this is where far better training has to be done in identifying the problems so that we can eliminate the utilization of many drugs other than drugs for heart failure, for anemia, for recurrent chest conditions, which are in a different category.

Definition of Mental Illness

Representative Pryor. In the United States we seem to have a great difficulty over the years in establishing a proper definition of mental illness regarding the elderly. How can we decide when an elderly person is mentally ill or senile? What is the difference there and how are you approaching the problem in England?

Dr. Cosin. Well, I approached it at Oxford many years ago by saying, really, we will take nearly all of the mentally ill people. A very large proportion of them are suffering from advanced organic disease which needs an—needs a department of internal medicine oriented with psychiatric orientations. It doesn't need a psychiatric department for internal medicine.

And this again is what we attempted to do in Carolina. For instance, none of the patients help themselves for reasons often of physical inability. But in quite a short period of time in the State mental hospital where 40 to 50 patients each day are now out of the hospital environment and into a rehabilitation environment. Now, this again, is the problem, that rehabilitation is thought to be a gimmick.

But really rehabilitation is the basis, broad medical treatment, early identification of clinical problems, progressive patient care, care on a rehabilitation basis. This is the answer to all of this.

So that ultimately you are left with almost no bedfast patients to go outside the hospital system. And so many of your elderly will respond well to a careful, thoughtful type of environment

Very often the confused elderly pick up their confusion, their first symptoms of violence and agitation, from the anxious, occasionally violent environment. We have quite a good system of identifying these problems earlier in North Carolina. We found really that if there was an agitated old person, they surely should be first admitted to a good program of care. They were then exposed to progressive patient care, intensive care, intermediate and minimal.

They often went into the hospital, or stayed at home too long, the situation would deteriorate, so seriously sometimes with the exposure to tranquilizers.

This draws attention to the fact that this is a specialty program that has to be taken seriously. A psychiatrist with the best will in the world has not all the internal medicine and physical rehabilitation skills that are necessary.

The psychotic and psychiatric manifestations, the manifestations of disturbance, are readily not that important because that will settle down with good nutrition, good biochemical balance, a good sensible environment. And don't forget that the acute hospital by reason of the stress built into it, is an anxious environment where everyone is anxious and a little bit agitated.

In fact, I think there's a good case for giving the tranquilizers to the staff and leaving the patients alone.

Representative PRYOR. I talked to a drug firm salesman recently, and he told me how to sell—the hottest selling item that he has are tranquilizers for nursing homes. Some 80 to 90 percent of the items he sold were to nursing homes, in the form of tranquilizers.

Dr. COSIN. These ease the problems of the attendant staff. You know have very simple elementary treatment; feeding, and I maintain that every elderly patient should be responsible for their own feeding. They may take longer, but it is their benefit to make it possible for them to do so.

PERCENTAGE OF ELDERLY IN MENTAL INSTITUTIONS

Senator PERCY. Our staff would be most interested in determining whether the percentage of the elderly that are in mental institutions is the same as it is here in this country. Here, around 30 percent of all persons in mental institutions are the elderly. Do you have any idea of what it is in England?

Dr. COSIN. We've been essentially dealing with about 80 to 85 percent for many years. With that point in view, sir, I can answer this with a published paper that we've published in the International Journal of Social Psychiatry in 1957, where a multidisciplined approach consisting of myself, a clinical psychologist, a physician and a psychiatrist, an occupational therapist, did identify the proportion of elderly patients—confused, agitated patients—who came to the Oxford geriatric unit.

And the psychiatrist had the impression that the cases were being treated by the department of psychiatry at Oxford, and had to admit that they were nearly all being treated by the Oxford geriatric unit.

These problems are not necessarily psychiatric. There is a proportion of patients with affective psychoses. But they will respond so very often to general measures. You need medication in some of these patients, admittedly. You want to get them off of it, though, as soon as possible. But also some additional statistics I can let you have, were in a 12-month followup period, where we were doing six times the amount of work as the mental hospital was doing.

Senator PERCY. Could I interject one further question, please, then I'll have to leave you? We are very interested in what your recommendations would be concerning the inspection of hospitals, intensive care and extended care institutions. Can you compare your inspection system in England with what we have in this country?

Our system seems to be pretty spasmodic. It flairs up because there is some sort of scandal, and then it settles down and everybody goes back to business as usual, until another scandal comes out.

Is there a steady spot-checking, a steady inspection system, to maintain uniformly established standards?

Dr. COSIN. I think each State has a—in Maryland, for example, each State has appropriate staff on its public health staff and on its welfare staff, as well as its nutritional staff and its fire-prevention staff.

Senator PERCY. In England, how is it done?

Dr. COSIN. This is done largely by spot checks and the hospital advisory service.

Senator PERCY. I do want to thank you very much, and I am terribly apologetic that the schedule was short this morning on my part. But you have a very dedicated Member of the Congress here, and we're delighted to have you with us, and I thank you very much.

Dr. COSIN. Thank you so much.

PATIENT CARE FOR TERMINAL ILLNESS

Representative PRYOR. Doctor, how do you handle terminal illness in England? Are they prescribed drugs, or do you more or less isolate them? Do they take care of themselves, or are they given an increased amount of medical attention? Or would the medical attention be lessened because of the status of their condition and the fact that there will be no recovery?

Dr. COSIN. We would refuse to identify a series of patients suffering from terminal illness. So many people with terminal disease are physically and mentally competent for a long period of time. They are living a full life in a community setting.

One of the greatest risks for a patient with terminal care is staring at the ceiling. It's a very serious thing to offer to a patient. So many of these patients, as soon as they are diagnosed with cancer, are put in a bed, and they ought to carry out some clinical experiments on the management of the elderly patients with malignant disease.

I had a young lady of 72, who had a mastectomy done because of a growth in her breast. And she had a spread of the growth 3 years later inside the chest. And she would say to us—she was sent to us by the

acute general hospital for terminal care. And she had radiotherapy. But she came in under progressive patient care, and she very quickly got to minimal care. In other words, there was a factual determination of the individual current picture of competence at any one moment in time. We insist on this, in not identifying pathological disease alone, not identifying it as terminal illness at all.

Well, she did very well, and she said: "Doctor, there is one thing I would like." She knew the diagnosis. She said: "There is one thing I would like and that's to be in a room by myself." I had then 11 single rooms, pretty poorly equipped rooms where we put people in independent care. And I said to her, yes, why, that's all right. I'll give you a room, but no nursing attention. You make your own bed. You make your own breakfast. You go over for two meals to the main unit. And you keep your linen clean. She did very well, thoroughly enjoyed this.

About 6 weeks later, she said: "Doctor, can I go home to live alone"? Well, there were risks involved, but this patient was motivated to self-help and self-support. So we said yes, as long as she came up to the day-hospital 1 day a week.

And then she had another flareup and had to come in again. And the whole process was repeated again. Because although the cancer had spread, factually she was just as competent. And this happened yet a third time over the course of 15 months. And although she was very frail, she said: "Can I go to an independent room"? And again I said, if you want to go there you are independent. She went on making her own bed, making her own tea. We are addicted to tea in England—one of the major addictions. And I was called and told that she had collapsed. She went into liver failure, which we knew. And she was immediately admitted into intensive care where she died 4 days later, 4 days after having made her own bed.

Now, how do you indentify terminal care? I could have stuck her in a bed, got her to look at the ceiling, given her lots of drugs, given her nursing aides, given her nursing attention, none of which were indicated. And I think one has got to be very careful in identifying these problems. Because clinically we can do much to ease patients and to help patients.

Many patients with actual metastizing disease come up to the day hospital once a week. Well, why not? But if you propped them in an institution and leave them there, what more cruel thing can you do?

Representative PRYOR. In one particular State that I know of—and this happens in many States, I think—because of the overcrowded conditions of mental hospitals, many of the mental patients are now what I call "farmed out" to nursing homes. And let's take a situation like this where you have a 100-bed nursing home and there are 50 beds occupied by what we would call the elderly population. Maybe they would be recuperating from an operation, a custodial type situation. And then all of a sudden there is an influx of 50 mental patients who have just been sent there from the State mental hospital.

What does this do? This, what might be called integration. What does this do to the nursing home patient and to the mental patient who has just been transferred there psychologically and socially? What affect does it have on each group?

Dr. Cosin. And to the staff. I think you're doing the most damage to the staff, clearly. You are dropping standards of care, quite clearly. The quantity of care and the quality of care.

Again, I would draw your attention to the difference between episodic care—that's 7 days in the hospital and out and no one cares a damn—and continuing care where there is a continuing responsibility.

Now, in North Carolina we did this in the year I was there. We did not send people to nursing homes, but we said to relatives, if you want your grandmother or mother-in-law here for 7 or 10 days, we were able legally to readmit them and send them out again.

Now, this was a supported program where we were being provided a hospital service on a continuing care basis. But if you go and draft a very large number of additional nursing problems—they aren't anything else—into an independent institution which is already overstressed, undertrained, badly oriented, and not very well directed, it can be catastrophic. It's a wholly bad thing to do.

Too Much Money Resulting in Neglect

Representative Pryor. I must leave very shortly. What would you say would be the main problem with the American system of elderly care? Would it be lack of training? Would it be lack of money? What would be the main problem today in the elderly care field?

Dr. Cosin. Too much money resulting in lack of training which causes neglect.

Representative Pryor. Too much money?

Dr. Cosin. Too much money resulting in neglect.

Representative Pryor. That's a very interesting thought, and I'm inclined to agree with you. Most of the—what I call—the industry, the nursing home industry specifically, says that all they need is more money, more and more and more money.

But my impression is different.

Dr. Cosin. They should have less and less. Less and less places. You have far too many places. You cannot have other than neglect with the poor personnel resources, and the personnel resources as more and more patients come in get worse and worse.

What is the main point in what you're dealing with in the way of age? The number of dedicated which is small and the number of women in need of employment in the field between the ages of shall we say 25, and 50.

But the proportion, the number of them, within the industry is a very finite one. And if you go beyond that point by having more patients, it's inevitable, and no one has identified the optimum number that a given geographic area with a given population with a given proportion of people over the age of 65 can really cope with after that. It's chaos. Organized chaos.

Representative Pryor. I would like to make a statement for the record which expressed my appreciation for allowing me the honor and opportunity of coming down this morning over to the Senate side to visit with you and to hear your message this morning.

It has meant a great deal to me, and I am sure it's meant a great deal to elderly care inasmuch as we try to find some solutions. It's been

a great honor for me and I wish to thank you and the committee and its very competent staff.

Dr. COSIN. Shall I go on?

Mr. ORIOL. Dr. Cosin, I think that in a minute we will give you a few moments recess to look over your presentation and select those parts that you think are essential for our record at this point, and which can be supplemented by written testimony.

I have one question I'd like to put to you right now and hope that it might crystallize what we've heard so far.

Dr. COSIN. As long as it's not, "Have you stopped beating your wife?" I don't mind.

NO NATIONAL POLICY ON LONG-TERM CARE

Mr. ORIOL. At the conference in Anne Arbor which you attended last week, everybody present seemed united on the thought that we don't have a national policy on long term care in the United States. I take it you agree with that?

Dr. COSIN. Yes; I do.

Mr. ORIOL. What I'd like to get straight in my mind right now is how much of what you're describing here today is unique to hospital—how much of it is the national policy of the United Kingdom, and how much of it do you feel you have not yet achieved on a national basis?

Dr. COSIN. There are about 10 or 15 geriatric units in different parts of the country that are all running in this same pattern, which have more or less the same levels as far as the provision of services. And this is a coordination problem, a communication problem. It means having good relationships with housing authorities, with Federal authorities, with welfare authorities. The slides you will see show how we integrate our services.

I think in England you've got a department of geriatric medicine in every general hospital service. The Ministry of Health will not pass plans for new hospitals in the district general hospital unless there is a plan for a department of geriatric medicine.

The Ministry of Health has recognized the fact that psychogeriatric care should now move out of the State mental hospital into the department of geriatric medicine.

It's like your President Truman had on his desk. The buck stops here. And of course, he was right. But the buck has got to stop somewhere. And I think the department of geriatric medicine has in one way or another to take on this responsibility.

You can't push it around all over the place. You can't necessarily blame nursing homes for turning around. They shouldn't be put in that position of temptation anyway.

Mr. ORIOL. You're talking about the United States?

Dr. COSIN. I'm talking about the United States.

LACK OF PLANNING RESULTING IN NEGLECT

Mr. ORIOL. You feel there are too many dollars flowing out? But why do too many dollars cause a lack of planning resulting in neglect, as you indicated?

Dr. COSIN. Because there is no planning. The whole thing is amorphous. Someone wants to build a 100-bed nursing home. All they need is 100 patients. But you can always get 100 neglected patients who haven't been properly assessed medically, psychologically and socially, treated by the appropriate means of rehabilitation, resettled into the appropriate community situation, not in a nursing home, and given a continuing program of care and responsibility.

What are we doing when we bring one patient up to the day hospital? Affecting a wide system—treating a patient—but also affecting a wide system of intercommunication. What are we doing when we say, "Well, we'll take grandma in for 2 weeks so you can have a vacation?" There is a great deal of interchange of thought going on.

This is the point, you see. Here the whole thing is episodic. Seven days and you're out. Out where? Well, it doesn't really matter as long as they're out. Because there is no continuing clinical or sociomedical responsibility. This is the basic difference.

And if you've got more money you merely complicate the problem, because you really go and get another 100-bed nursing home and thereby with your given level of age, you now bring in unsuitable or unsatisfactory people who come into this for other reasons that I'm not competent to comment on.

Mr. ORIOL. As you know, there is a lot of discussion in this country and debate on our national health insurance or national health security program. What changes under our system, perhaps using some aspects of your system, what changes would we have to make in our long-term care resources to make ready for national health security program?

Dr. COSIN. Well, I think you've got to draft a staff as soon as possible, long-term training projects for physicians, attempt to recognize the status of physicians in this type of work.

Mr. ORIOL. You would make geriatrics a specialty in this country?

Dr. COSIN. Who's going to do this? Physicians, sociologists, or clinical psychologists? It's no good complicating the word by gerontologists. What is the discipline that is going to be responsible for this? Unless you have the appropriate clinical knowledge you're going to miss things. I mean, I have my own caseload. I have to give clinical sessions. I have two jobs. You can't do it without the appropriate aspects of internal medicine.

Mr. ORIOL. You also pointed out that this has to be done at the right time. I believe you commented that in the United States the people were not getting to this position in time.

Dr. COSIN. Well, this is the other part of it, that by and large the elderly are the least well endowed financially. Some of them are all right; others are not. But even if they were they aren't necessarily getting into the right stream of appropriately coordinating and organizing services.

TRAINING PROGRAMS RESPONSIBILITY OF TEACHING HOSPITALS

So that I think the first thing you must do is to contemplate going into various parts of the country and starting training programs. And this I would assume to be the responsibility of the teaching hospitals. I've seen no evidence to support that, let me say. But this surely is—

if not it has to be done with much more difficulty without the teaching hospitals.

We are training nurses in post-graduate nursing. We're training physicians in post-graduate geriatrics. There are other units in the United Kingdom who train physicians in this kind of work.

But it is as far as I know not being done here. There are only two or three competent geriatric programs that I know of. One is in Salt Lake City. I don't know of anything on the northeast coast.

You see, research has its place. I would say research in action, has a larger place. I think we've got to consider how much we should deploy to research. I then would like to identify also how much research we should put into action effectively to our clients in need, because most of them are in need. They're not getting anything at all.

Mr. ORIOL. Dr. Cosin, we've interrupted your presentation unmercifully. Do you want a few minutes recess now. Do you?

Dr. COSIN. No, no; we can sweep on because we're getting toward lunchtime.

Mr. ORIOL. Fine.

Dr. COSIN. I wanted to introduce into the record a paper by me, "The Identification of Problems in Long-Term Care Hospitals,"[1] which looks at the whole of this, and which might be helpful. It was written in 1967.

I want to introduce into the record a paper on "Geriatric Rehabilitation."[2] This was given—this was read before the International Conference of Physicians in London in September, 1947. I see no reason to alter a word of it.

I want to introduce a paper written by the Canadian Hospital in September of 1952 on "Hospital Care for the Elderly."[3] And perhaps I can read the first paragraph of this.

"There are many pessimistic views concerning the hospital treatment of the elderly which stem from poor organization, both past and present in this branch of sociomedical work. It fails primarily to provide facilities for rehabilitation of the elderly. Interestng research problems on available pathological material are no doubt important. However, when the cost of hospital care rises to staggering levels"—this was written in 1952—"the first concern must be to provide the maximum benefit to each and every inpatient, regardless of age, in the minimum of time. There is little point in organizing purely medical units for the solution of sociomedical problems."

"By using the sociomedical approach for the solution of sociomedical problems I find that the average duration of stay—and this is 25 years ago—for all geriatric patients admitted to a geriatric unit should be between 40 to 50 days in the first 6 months of hospital stay."

This has been considerably reduced as you'll see in the paper on statistics.

"Permanently bedridden patients needing more than 6 months of full nursing care should form 3 to 5 percent of the admissions." This I would reduce to about one-half of 1 percent or less today. "Long-

[1] See appendix item 3, p. 1409.
[2] See appendix item 4, p. 1411.
[3] See appendix item 5, p. 1412.

stay patients who are frail and physically disabled or senile-confused should again be a low percentage."

"Current medical opinion concerning the callousness of relatives is not entirely borne out in my experience."—This is 1952.—I'd use Carolina in 1970 to confirm that statement.

"It is possible to resettle about 50 percent of all ordinary admissions in their own homes or hostels."—We would push this up today to 70 percent—"while 35 to 40 percent will survive less than 6 months after admission."

Incidentally, in 1946 and 1947 the percentage of those who died, average age on admission 72 years, was 38. At Oxford in 1969 average age on admission not 72 years but 82 years, the percentage who died was not 38 but 24 percent. The earlier you deal with these problems, the corollary would appear to be, the more optimistic you can be.

But if you send people to a nursing home to lie and to die, and to lie until they die, this now inevitably will be the case. But this is chronic neglect. My answer to that is like that English humorist paper Punch in their advice to those about to marry. Their advice was "don't."

Some of the audience would agree with this, I believe.

"The problem of hospital care of the aged can be solved adequately by the organization of units designed primarily in the interests of these patients and not in the vested interests of medical research, psychiatry, geriantology or even geriatrics. Basically, this problem is not medical; it is numerical. The solution must also be satisfactory numerically before large new ventures involving capital expenditures which may be unnecessary are commenced." Which is what I've been saying.

"Previous organized systems which neglect the institutional needs of the elderly are unsatisfactory. Statistics support the fact that a unit designed and used primarily in the interests of each and every old person is more successful. In these units the facilities for research, work in the area of malignant disease, the relief of pain, and metabolic and vascular dysfunction can and will be organized in the interests of the patients." This is not in the interests of the medical care industry, the health industry.

I'd like to introduce that, sir. And then I think we'd better run through these slides pretty quickly, don't you think so.

(Beginning of slide presentation.)

(See charts 1 to 5, pp. 1415–1419.)

Mr. ORIOL. The committee is in recess, subject to the call of the Chair.

(Whereupon at 1:30 p.m. the hearing was recessed subject to the call of the Chair.)

APPENDIX

ITEM 1. PREPARED STATEMENT OF DR. LIONEL COSIN, CLINICAL DIRECTOR, DEPARTMENT OF GERIATRIC MEDICINE, UNITED OXFORD HOSPITALS, UNITED KINGDOM

PRESENTATION OF THE PHILOSOPHY, STRATEGY AND PRACTICE OF TOTAL PATIENT CARE WITH AN ANALYSIS OF COST AND RESOURCES

Mr. Chairman and members of the Committee, my curriculum vitae, in considerable detail, is in the hands of the Committee staff,[1] and perhaps I may be permitted to introduce myself briefly in these terms:

I am Clinical Director, United Oxford Hospitals, Geriatric Unit, United Kingdom and Clinical Director, Rivermead Rehabilitation Unit, United Kingdom. I have lectured and worked in this field in many countries. For the past two years I have been a member of the National Advisory Council of the National Council of Senior Citizens under whose auspices I appear here today.

I sincerely appreciate the opportunity to appear before this Committee which has done so much good work in seeking to study the problems of long term care in America.

These are days in which the question of delivery of health care for all Americans, young, middle-aged and old, very much concerns all in the nation. The introduction of Medicare and Medicaid have already had considerable influence on the patterns of care in the United States. The spiralling costs of much of America's current systems of delivery of care are being questioned and the search for alternatives which offer improved quality of care and yet promise to cut down the staggering acceleration of costs is now at hand.

I have been deeply involved in geriatric medicine now for well over a quarter of a century. In the many visits I have made to America over these years—including my lectures at over eighteen U.S. universities—I have tried to tell the success story of progressive patient-care utilizing the socio-medical approach for the solution of socio-medical problems.

I believe this technique offers the best hope for America to tackle the immense problems in health care of the aged which result from growing numbers of older Americans—from 4 millions over 65 at the turn of the century to over 20 millions over 65 today.

Unless America decides to seek solutions *now*, the situation in long term care will continue to deteriorate as America's over 65 population grows to 30 millions by the end of the century.

Senator Moss and the members of this Committee have sounded many warning bells in recent times—and I have read of the excellent work to focus public attention on these problems by Representative David Pryor in the House of Representatives. I hope that what I have to say today before this Committee will prove useful to lawmakers, to those in the nursing home industry, and to those in the medical profession who are willing to accept change for the better.

Perhaps the best way for me to begin this testimony—which will be oral, include some visual aids in the forms of slides, and offer additional data for the record—is to start with a brief examination of the results of good care, clinical and financial.

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[1] Retained in committee files.

Oxford geriatric unit (part of university teaching hospital at Cowley Road Hospital, U.S.)

	Beds
Service for acute	189
Elderly long term	40
Care (nursing home provision)	50
Psychogeriatric	16
Total	295

Population served		350,000
Beds per 1,000		0.85
U.K. N.H.S. Allocation	1.2	1.5
Psycho Geriatric	0.3	

	Beds per 1,000
East Berlin	7.6
France	4.0
United States	5.0 to 8.0
Sweden	(4.0)
Scotland	2.0

STATISTICS

1969–70 figures of admissions—1746; Discharges—1342; Deaths—369.
4-day hospitals give 500 treatments per week to 300 patients.

Length of stay of patients (cumulation of monthly analysis)

Average length of stay in 1969 was	35.9
Number of patients treated for less than 60 days*	80+7
Number of patients treated between 60 to 365 days	70+16
Number of patients in need of over 365 days	27+25

* Excluding floating beds—hospital beds days.

FINANCIAL ANALYSIS OF COST PER PATIENT TREATED

United Oxford Hospital:

	Percent
Main, acute hospital ($23 per day)	100
Geriatric unit £46 per week	69
Half Way House £14 per week	21
Day Hospital (5 Day week) £13 (£4 per case)	6

COMPARATIVE STUDY OF LONG STAY NEED IN OXFORD GERIATRIC UNIT (OVER 365 DAYS)

	Cases	Beds available
1950	330	370
1964	74	300
1969	52	290

UNITED OXFORD HOSPITALS

GERIATRIC UNIT, COWLEY ROAD HOSPITAL

[Length of stay of patients at the end of each month, 1970 (excluding floating beds)]

	0 to 60 days		60 to 365 days		365 days and over		Total days	
	Male	Female	Male	Female	Male	Female	Male	Female
January	28	53	25	34	12	14	65	101
February	30	62	19	43	12	13	61	118
March	27	58	20	49	11	12	58	119
April	30	56	23	45	12	14	65	115
May	29	49	23	46	13	13	65	108
June	25	54	22	50	14	13	61	117
July	30	45	23	50	15	11	68	106
August	35	41	24	44	16	10	75	95
September	28	43	27	54	16	8	71	105
October	16	42	31	58	14	13	61	113
November	24	40	28	48	16	15	68	103
December	36	51	22	36	16	15	74	102

UNITED OXFORD HOSPITALS—Continued

GERIATRIC UNIT, COWLEY ROAD HOSPITAL—Continued

[Average length of stay of patients (365 days and over) at the end of each month, 1970 (in days)]

	Male	Patients at end of month	Female	Patients at end of month
January	891.50	12	664.85	14
February	946.35	12	702.41	13
March	979.0	11	747.41	12
April	966.50	12	722.35	14
May	946.76	13	754.86	13
June	941.14	14	782.61	13
July	939.14	15	734.63	11
August	931.18	16	798.30	10
September	948.75	16	832.50	8
October	1,037.07	14	693.46	13
November	980.31	16	612.06	15
December	994.43	16	634.86	15

Note: Average length of stay of patients (365 days and over) as on Dec. 31. 1970 shown in days (male, 941.76; female, 723.27).

GERIATRIC UNIT, LONGWORTH HOSPITAL

[Length of stay of female patients at the end of each month, 1970]

	0 to 60 days	60 to 365 days	365 days and over	Total days
January	6	18	23	47
February	12	15	23	50
March	6	12	27	45
April	8	11	26	45
May	12	10	23	45
June	10	13	24	47
July	5	18	23	46
August	8	17	24	49
September	8	16	25	49
October	0	20	26	46
November	4	20	24	48
December	7	17	24	48

[Average length of stay of female patients (365 days and over) at the end of each month, 1970 (in days) (figures in parentheses denote number of patients at the end of each month)]

January	1,002.32 (23)
February	1,059.00 (23)
March	996.47 (27)
April	983.61 (26)
May	944.08 (23)
June	948.45 (24)
July	1,002.14 (23)
August	1,004.62 (24)
September	1,007.04 (25)
October	1,010.69 (26)
November	964.08 (24)
December	983.79 (24)

Note: Average length of stay of patients (365 days and over) as on Dec. 31.1970 shown in days (female, 992.19).

A NURSE'S PERSPECTIVE

I would like to introduce into the record a special paper which has been prepared by an extremely skilled American nurse who has served for the past two years in England and is currently based at our hospital in Cowley Road, Oxford.[2]

Sister Thelma Wells was trained at Massachusetts General Hospital, Boston, was a graduate student at Case Western Reserve University, Cleveland, Ohio and worked as a staff nurse at Midtown Nursing Home in the summer of 1969.

Sister Wells says frankly she believes that the average aged patient in England receives better care than the average aged patient in America.

She supports her belief through a number of points which she illustrates with examples. Permit me to quote her.

[2] See appendix item 2, p. 1405.

"1. In America there are few community support services to help maintain the aged patient in his own environment. In England each local authority health service is required to supply the following supports which the aged utilize: chiropody service, meals on wheels, home help service, occupational therapy, recuperative holidays, residential homes for mental health, home nursing, health visiting, ambulance service, day centers and clubs, and residential accommodation. Even though such services may vary in strength from community to community, the geriatric practitioner can rely on the support being basically available.

"2. The American family caring for an aged relative has few supports in either the community or the hospital system. The English family in the same circumstances has not only community supports but also the growing reality of flexible hospital admission plans for the aged. Cowley Road Hospital has such flexible plans in practice to relieve families of heavy or sudden increasing care pressures. These are holiday admission, short term admission, and floating beds. Holiday admissions assure the family that the aged patient will be admitted to the hospital during the family's planned vacation. A short term admission program provides for intermittent two week admissions of the aged patient. The floating bed plan is a scheduled admission every two weeks for either three days and two nights or four days and four nights. In addition there is the Day Hospital, a unit combining medical and nursing care, physical and occupational therapy with a noon meal for the aged.

"3. The whole health care system in America seems to be ill-designed for the aged. The practice of full medical assessment, rehabilitative treatment, and continual follow-up for the aged does not seem to me to be a reality. For example, unfortunately I have had little American experience with physicians who were either concerned about the causes of confusion and incontinence, or planned rehabilitative treatment for such problems. "He's old. It's to be expected." seems to be the frequent American health system attitude. "*Community Support Services to the Aged Patient:* America—few, England—many.

"In my American nursing experience aged patients without families or with inadequately supporting families are placed in nursing homes. I believe that many of them could be maintained in their own environment with community support services. To my knowledge the most consistent source of community care for the aged in America is the very over-worked Visiting Nurses' Association. With few supporting services it is only logical that the aged are sent to nursing homes or subsist in their own homes. There is fear among some aged that seeking any aid means a nursing home placement because the health system discovers their meager ability to live alone.

"It was reported in a cooperative study done at the Massachusetts General Hospital that in one month 375 patients were referred from the hospital. Of these, 266 were referred to nursing homes, 104 to the Visiting Nurses' Association, and 45 to chronic disease hospitals.[3] Kelleher and Shaughnessy in a study of nursing homes in Massachusetts found that patients were admitted primarily for long-term skilled nursing care and/or because the patient lived alone and could not maintain himself independently in the community.[4]

Certainly many of these latter patients do not need nursing home care but rather community support services.

"In my nursing experience at Cowley Road Hospital most of the aged patients that I care for go home. In 1969 Cowley Road Hospital admitted over two thousand patients with an average age of over seventy. Of the discharges that year 62% went home. Only 5% went to nursing homes or long term institutions."[5]

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[3] "Patient Care in Nursing Homes," Journal of the American Medical Association, Vol. 200, No. 2 (April 10, 1967), 154.

[4] Rita Kelleher and Mary Shaughnessy, "Report of a Fact-Finding Survey of Massachusetts Nursing Homes," (New York: National League for Nursing, 1966), 105.

[5] The remaining percentages are: died 18%, referred to acute services 6%, referred to mental hospital 1%, referred to a half-way house 7%, and 1% lost through mathematical rounding.

WASTE AND EFFORT

Now I would not have you believe that everything in the British garden is wonderful while health care in America is in a mess.

Frankly, the economics of any hospital system in the United Kingdom is much cluttered by built in wasteful obsolescence. So much of the National Health Service's finances seem geared to maintaining an inefficient service sustained only by a meagre annual increment to cope with inflationary trends while little constructive thought seems to be given to the financial incentives of replacing unplanned obsolescence either by planned obsolescence and new buildings geared not only to higher standards of patient care but also to greater economy of running.

My impression of the U.S. hospital economics do not impress me any better, as each hospital, whether municipal or private, is either paid for out of tax funds or the various insurance schemes which merely pass on any increased costs by increased insurance payments. This leads to a vicious circle of increased inefficient usage as a result of unnecessary use of In-patient facilities instead of Out-patient use as in Britain, with resultant over-capitalisation. In nearly every major city in the U.S. there are too many hospital beds, which must have high bed occupancies to balance the budget!

This low efficiency in bed utilisation is balanced by high bed occupancy of short stay patients. This together with the less advanced demographic picture in the U.S. compared with the U.K. (9.4% of population over 65 instead of 12.5%) accounts in large part for the shorter patients stay. The higher British average patient stay may be evidence of greater efficiency in use (the 25% of In-patients unnecessarily in U.K. hospitals may be much lower than the U.S. figure), and also evidence of a higher percentage of older patients in "acute" beds (about 50% of medical In-patients in U.K. are over 60 compared with an estimated 20% in the U.S.). There is need in the U.K. to treat and keep older patients in acute beds because the number of "chronic sick" and Geriatric beds is 58,000 or 1 bed per 1,000 of the beds for 65+. There is no need to keep older patients in acute beds in the U.S. because there are already 5 beds per 1,000 of "Nursing Home" beds of very diverse and variable standards, but on the whole low, in addition to an undefinable number of Municipal Hospital beds and State Mental Hospital beds.

For example, Alleghany County (1½ million) in which Pittsburgh is situated has Kane County Hospital for the chronic sick of 2,200 beds (1.5 beds per 1,000) in addition to the 5 Nursing Home beds per 1,000, a Mental Hospital of 1,200 beds, and acute hospital beds in addition. In North Carolina (1969) there were 6,000 Nursing Home beds, 9,000 Rest Home beds, and of 11,000 State Mental Hospital beds it is assumed that 3,000 were occupied by the elderly and chronic sick. Thus, there are about 3.5 beds per 1,000, leaving out the 20,000 Acute hospital beds.

Thus the U.S. acute hospital never need keep elderly patients, who may be financially embarrassed, sufficiently long to increase the average length of patient stay but pass them on. The British acute hospital supported by no Nursing Home beds comparable in percentable proportion is also inadequately supported by adequately equipped Departments of Geriatric Medicine or even Department of Chronic Disease.

Thus the American figures of average length of hospital stay are managed to be low while the British figures are kept high by the partial failure to implement and utilise fully active Departments of Geriatric medicine as at Oxford, Sunderland, St. Andrews, etc. The Medicare "Utilisation Committees" meant to reduce patient stay, may do so and result in worse patient treatment.

The picture of American industry is of ruthless replacement of inefficient equipment. This is not the picture of American hospitals which display the latest innovative technical procedures which do not last long, but no overall picture of operational efficiency, although they can be justified sometimes in relation to high standards of individual patient care and relatively low building and furnishing costs, but this is questionable.

In an economy which is ataxically struggling with inflation while grasping out for affluence careful measurements should be sensibly made so that future economies of operation can be achieved at stated intervals of 3, 5, 7, and 10 years.

In an industry (the English National Health Service) spending $2,000,000,000 per year not to do this can only be due to the influence of an effective bureaucracy, technically and financially capable of managing this enormous task of simple housekeeping. Thus it is fair to say that different national economies in different stages of development with different rates of increase or decrease in the G.N.P. need to be geared to different proportions of utilisation of disposable materials, maintenance costs, new building costs and labour costs. There is one proviso. The need of patients for bedside nursing care, helped by accurate methods of measurement by computer monitoring or automation cannot and should not be reduced. Thus nursing staff and, to a lesser degree, doctors and other auxiliaries must have every minute of their time away from patient care reduced to a minimum. Nor must inaccurate statements that a substitute such as monitoring, is wasteful in financial terms be allowed to upset this decision.

Even in hospital capital building the effect of inflationary trends should be considered. Every hospital building complex begins to depreciate before its doors open because it is planned for only one purpose. Where part of hospital buildings can be planned for normal housing this can always be seen to appreciate in value like other normal housing.

In 1964 I pointed out that knowing that medical and nursing staff have not been trained to recognize the rate of return of individual physical and social competence but take it for granted, and realising that at least 25% of acute hospital beds are occupied by In-patients who should be at home, the Ministry of Health or the Treasury, should surely insist that at least 30% of beds should be in blocks of apartments or flatlets that could be used by large groups of patients and relative who should not be in need of any bedside nursing care.

The suggestion of the Halfway House for Geriatric patients, average age 80 years, was made by me in 1950 to the Board of Governors of the United Oxford Hospitals, and provided by the National Corporation for the Care of Old People in 1956. This has proved invaluable for patients at a quarter of the cost of patients in the acute general hospital (Radcliffe Infirmary), and one-third the cost of the acute Geriatric wards at Cowley Road Hospital, Oxford.

This normal housing accommodation would fit in with the whole concept of Progressive Patient Care so that a small expensive intensive care unit could be easily altered or replaced when necessary at much lower cost. The most frequent end result of hospital discharge of inpatients is a normal life style of physical activity. If this obvious finding could be reflected into new hospital building, any variation from it could be easily adjusted by using excess staff accommodation or by adding small numbers of beds for Intensive Care. Excluding the short length of stay of patients in Intensive Care for the demographic factor of an increasing aging population should inevitably give rise to a slightly *increased* period of patient stay in *hospital* beds over the minimum with a carefully watched period of stay in Half Way House or residential beds.

A scientifically managed patient service should demonstrate a spectrum of short stay in Intensive Care due to rapid improvement or early demise, a longer period of stay in Intermediate or Rehabilitation wards for elderly or disabled people in need of rehabilitation and resettlement, and a much greater use of Out-patient facilities. There should also be a total reduction of In-patient beds for younger age groups.

This, however, needs understanding, dynamic scientific management (deplorably absent in bureaucratic circles) and education of doctors, nurses and other staff in the scientific and efficient utilisation of hospital facilities to restore physical and social competence in the shortest period of time to those who have lost it, and to place those who have not lost social or physical competence in the appropriate *residential* situation immediately.

This will save nurses for bedside nursing, permit efficient measurement of change in homeostatic, biochemical and pathological processes by more automation and monitoring, and at the same time reduce cost of capital building. Thus the cost of maintenance amortization and depreciation should be replaced in part by appreciation of the normal housing content section of the National Health Service.

FINANCIAL ANALYSIS OF ANNUAL COSTINGS

COWLEY ROAD HOSPITAL

Year	Average available staff beds	Average bed occupancy (percent)	Number of in-patient days	Number of cases	Average stay per case days	Total net expenditure (in and O.P.s) £	Cost per in-patient day £.	s.	d.	Cost per case £.	s.	d.
1947	260			240	286							
1950-51	250	97.0	88,177	463	190	111,474	1.	4.	8.	234.	16.	8.
1951-52	248	98.4	89,810	731	125	120,650	1.	7.	0.	169.	4.	2.
1952-53	249	99.0	90,129	929	97	129,672	1.	8.	9.	137.	8.	5.
1953-54	241	97.96	86,176	1,033	83	137,033	1.	10.	10.	128.	9.	0.
1954-55	236	97.2	83,826	1,109	76	147,501	1.	14.	3.	129.	8.	8.
1955-56	222	98.1	79,874	985	81	154,898	1.	17.	6.	152.	0.	8.
1956-57	213	97.8	76,142	957	80	163,099	2.	2.	11.	163.	16.	8.
1957-58	214	95.0	74,178	1,065	70	183,005	2.	5.	5.	158.	2.	11.
1958-59	206	96.0	72,124	1,120	64	195,192	2.	10.	1.	161.	2.	7.
1959-60	183	95.0	63,510	1,189	53	206,257	2.	19.	7.	159.	7.	11.
1960-61	191	95.8	66,894	1,162	57.6	216,606	3.	0.	3.	173.	7.	4.
1961-62	202	98.0	72,103	964	74.8	226,742	2.	18.	0.	216.	14.	4.
1962-63	191	97.0	67,588	900	75.1	246,889	3.	7.	1.	251.	14.	11.
1963-64	171	96.0	60,125	868	69.3	279,055	4.	4.	7.	292.	18.	3.
1964-65	172	97.1	60,884	1,003	60.7	315,816	4.	13.	8.	284.	6.	2.
1965-66	209	97.0	73,709	1,498	49.2	375,595	4.	13.	0.	228.	13.	7.
1966-67	204	96.8	72,161	1,725	41.8	402,586	5.	3.	11.	217.	7.	6.
1967-68	196	95.3	68,386	1,453	47.1	426,487	5.	17.	0.	275.	5.	11.
1968-69	185	94.6	63,843	1,470	43.4	418,344	6.	11.	0.	284.	11.	8.
1969-70	181	95.0	62,629	1,746	35.9	451,245	7.	4.	0.	258.	9.	0.

Note: No financial adjustment for inflation has been made.

ITEM 2. WHAT TO DO WITH THE AGED PATIENT*?

A Nurse's Perspective of Selected Aspects of Geriatric Care in America and England

(By Thelma Wells, R.N., S.R.N., B.Sc., MSc.N., Certificate in Geriatric Nursing)

My perspective of American geriatric care is based on the following experiences:

Student nurse (1959-62)—Massachusetts General Hospital, Boston.

Staff nurse, general medicine (1962-63, 1964-65)—Massachusetts General Hospital, Boston.

Part time staff nurse, part time clinical instructor, full time baccalaureate student Boston University and Massachusetts General Hospital, Boston (1965-68).

Graduate student, Case Western Reserve University (1968-70)—Cleveland, Ohio.

Staff nurse, Midtown Nursing Home (summer, 1969)—Cleveland, Ohio.

My perspective of English geriatric care is derived from the following experiences:

Staff nurse (1963-64)—Westminster Hospital, London.

Geriatric course nurse (Sept. 1970-March 1971)—Cowley Road Hospital. Oxford.

Sister, B Ward (currently)—Cowley Road Hospital, Oxford.

What To Do With the Aged Patients*?—A Nurse's Prospective of Selected Aspect of Geriatric Care in America and England

It is my belief that the average aged patient in England receives better health service care than the average aged patient in America. I support my belief through the following points which I will later discuss with examples.

* Aged patient—to be understood as the frail elderly, partially ambulant or wheelchair bound, who needs supervision in some activities such as bathing, assistance in other activities such as shopping or cleaning and general surveillance such as in medical care.

1. In America there are few community support services to help maintain the aged patient in his own environment. In England each local authority health service is required to supply the following supports which the aged utilize: chiropody service, meals on wheels, homes help service, occupational therapy, recuperative holidays, residential homes for mental health, home nursing, health visiting, ambulance service, day centers and clubs, and residential accommodation. Even though such services may vary in strength from community to community, the geriatric practitioner can rely on the support being basically available.

2. The American family caring for an aged relative has few supports in either the community or the hospital system. The English family in the same circumstances has not only community supports but also the growing reality of flexible hospital admission plans for the aged. Cowley Road Hospital has such flexible plans in practice to relieve families of heavy or sudden increasing care pressures. These are holiday admission, short term admission, and floating beds. Holiday admissions assure the family that the aged patient will be admitted to the hospital during the family's planned vacation. A short term admission program provides for intermittent two week admissions of the aged patient. The floating bed plan is a scheduled admission every two weeks for either three days and two nights or four days and four nights. In addition there is the Day Hospital, a unit combining medical and nursing care, physical and occupational therapy with a noon meal for the aged.

3. The whole health care system in America seems to be ill-designed for the aged. The practice of full medical assessment, rehabilitative treatment, and continual follow-up for the aged does not seem to me to be a reality. For example unfortunately I have had little American experience with physicians who were either concerned about the causes of confusion and incontinence, or planned rehabilitative treatment for such problems. "He's old. It's to be expected," seems to be the frequent American health system attitude.

In England it is normal practice for the hospital care of the aged to be under the authority of a specially trained and appointed geriatrician. Sheldon wrote in 1968 that there were over 100 such geriatric units in Great Britain.[1] In them, one of which is Cowley Road Hospital, full medical assessment, rehabilitative treatment, and continual follow-up for the aged is a reality.

In the following paragraphs expansion and examples of the difference between American and English geriatric care in regard to community support services, family support, and the health care organiaztion will be given.

Community Support Services to the Aged Patient: America—few; England—many.

In my American nursing experience aged patients without families or with inadequately supporting families are placed in nursing homes. I believe that many of them could be maintained in their own environment with community support services. To my knowledge the most consistent source of community care for the aged in America is the very over-worked Visiting Nurses' Association. With few supporting services it is only logical that the aged are sent to nursing homes or subsist in their own homes. There is fear among some aged that seeking any aid means a nursing home placement because the health system discovers their meager ability to live alone.

It was reported in a cooperative study done at the Massachusetts General Hospital that in one month 375 patients were referred from the hospital. Of these, 266 were referred to nursing homes, 104 to the Visiting Nurses' Association, and 45 to chronic disease hospitals.[2] Kelleher and Shaughnessy in a study of nursing homes in Massachusetts found that patients were admitted primarily for long-term skilled nursing care, and/or because the patient lived alone and could not maintain himself independently in the community.[3] Certainly many of these latter patients do not need nursing home care but rather community support services.

In my nursing experience at Cowley Road Hospital most of the aged patients that I care for go home. In 1969 Cowley Road Hospital admitted over two thou-

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[1] J. H. Sheldon, "Geriatrics Around the World," in *The Care of the Geriatric Patient*, E. V. Cowdry, ed., (St. Louis: C. V. Mosby, 1960), 396.

[2] "Patient Care in Nursing Homes," *Journal of the American Medical Association*, vol. 200, No. 2 (April 10, 1967), 154.

[3] Rita Kellesher and Mary Shaughnessy, *Report of a Fact-Finding Survey of Massachusetts Nursing Homes*. (New York: National League for Nursing, 1966), 105.

sand patients with an average age of over seventy. Of the discharges that year 62% went home. Only 5% went to nursing homes or long term institutions.[4]

	Cowley Road Hospital 1969 Percent
Discharged	62
Long-term care	5
Died	18
Acute hospital	6
Mental hospital	1
Half-way house	7
Total	99

Several case histories may provide examples of care.

Mrs. M., an example of average use of support services. age: 81.

Diagnosis: osteoarthritis of knee, isohemic heart disease, congestive cardiac failure, diabetes mallitus, cataracts.

Social: lives alone in apartment, son looks in daily.

Support services: home help once a week; district nurse occasionally; day hospital twice a week; meals on wheels.

Mr. S., an example of almost maximum use of support services. age 75.

Diagnosis: congestive cardiac failure, cerebral vascular accident, paranoid behavior.

Social: lives alone. wife left him two years ago and since then he has been receiving increasing support.

Ability: ambulant with an aid, feeds self, needs help dressing, incontinent and regularly impacted.

Support services: home help six times a week; district nurse twice a day; day hospital three times a week; meals on wheels; floating bed; health visitor.

In my opinion both of these patients would most likely be institutionalized in the United States.

The basic lack of support services for the aged is extremely important in America. For example the lack of transportation for the aged impedes the utilization of existing health services and the exploration of new approaches in care.

One of the major problems in care of the aged in Cleveland was getting the patient to the health service. Local transportation stopped two blocks from the Out Patient entrance. If the aged patient couldn't use local bus service then private taxis were used with untrained and frequently unwilling taxi drivers responsible for assisting the frail. Very occasionally ambulances were used. The average aged patient had to be quite fit and enormously determined to get to the care facility at all.

Most workers in geriatrics agree that day hospitals are valuable components of patient care.[5] Yet a basic stumbling block to their development in America is the lack of a transport system to get the aged there. Since day hospitals are designed for those aged who need large amounts of continual health service assistance, special transport is needed.

Special transport services are available to the aged in England. The number of geriatric day hospitals has more than doubled in the last ten years.[6] In 1969 Cowley Road Hospital Day hospitals had an attendance of 26.574, a very full utilization of a 65 patient area. Previous case histories show the use of the day hospital in the planning of care.

Family Support: America—little; England—much

When I was nursing at Massachusetts General Hospital there were persistent stories that some families brought their aged relative with a vague complaint to the emergency ward on a Friday evening and disappeared for a weekend, a week, or forever. I never investigated these stories but I knew many families caring for very difficult aged relatives. I saw the strain those families were under and the paucity of support the health system provided. It would not surprise me if those stories about the emergency ward were true.

Shanas and others in a comparative study of the aged in Great Britain, America, and Denmark found that all three countries had an uneven develop-

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[4] The remaining percentages are: died 18%, referred to acute services 6%, referred to mental hospital 1%, referred to a half-way house 7%, and 1% lost through mathematical rounding.

[5] J. C. Brooklehurst, "The Geriatric Day Hospital," (London; King Edward's Hospital Fund, 1970).

[6] Ibid, 12.

ment of community care services but that the development in America was relatively smaller than in the other two countries.[7] Another finding of the study was that 45% of the aged in Great Britain live with family, compared to 35% in the United States.[8] Perhaps some of this difference is due to a lack of family support services.

At Cowley Road Hospital support of the family is considered to be of prime importance. It is felt that families must assume the responsibility of aged relative care but that hospitals must assess the family's strain and intervene with planned support when the family's ability is either temporarily or permanently lessened.

Case Histories

Mr. D., an example of temporarily increased family strain with increased hospital support—age: 82.

Diagnosis: cerebral vascular accident, parkinsonism, painful arthropathy, bizzare behaviour.

Social: lives with married daughter who also cares for a teenage daughter and a lodger.

Support services: has had home help, district nurse, day hospital, and floating bed; the family indicates that they don't think they can manage much longer. Current support—five days a week day hospital and every other weekend floating bed; the family indicates that they don't think they can manage much longer.

Mr. S., an example of current family support with a plan to increase support as needed—age: 76.

Diagnosis: cerebral vascular accident, epilepag, old myocardial infarction, chronic bronchitis, hyperuricenia.

Social: lives with wife of low intelligence and social behaviour difficulties. There is also an eight year old child and occasionally another daughter with her two children.

Support services: day hospital twice a week; floating bed; intermittent admissions when the family strain or Mr. S's care increases.

Health Care System: America-designed for acute care; England-provides for geriatric continual care

In American cities frequently the only source of medical care for the aged is through the admitting clinics of a large teaching hospital. I recall my experience in an Out Patient Department in Cleveland. The large influx of patients to the clinic necessitated brief history taking. The slightly deaf, slow to comprehend, even slightly muddled aged certainly was unable to convey the subtleness of his complaint in the time available with the doctor. Diagnostic tests were performed away from the admitting clinic. The aged patient had to find his way through a maze of corridors to the blood lab, E.C.G. lab, and X-ray all in different areas. To complicate the travelling further the aged patient had to return to a financial area to have each slip stamped for Medicare. If he received a diagnosis that required medication, the aged patient waited for a small number to light close to the ceiling. Everything about the whole process assured that if the aged patient could give a succinct history, find the diagnostic test areas, get his slips stamped properly, and receive his medication he really was quite fit. What happened to those who didn't complete the process is anyone's guess.

In England progressive geriatric centers provide patient-paced and continual supervision of care. One case history shows the average program at Cowley Road Hospital.

Mrs. G.—age: 92.

Diagnosis: rheumatoid and osteoarthritic for many years, mild cerebral vascular accident, anosmia.

Social: lives with son and his wife.

Original support service: occasional district nurse.

Association with Cowley Road Hospital: Seen in the Out Patient Assessment Clinic at the request of her General Practitioner who felt she was becoming increasingly confused and incontinent. Admitted for 37 days, 6 days on the assessment and acute ward and 31 on the fast moving rehabilitation ward. Discharged home, able to commode self independently, orientated.

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[7] Ethel Shanas, Peter Townsend, Dorothy Wedderburn, Henning Friis.

[8] Poul Milhj, and Jan Stehouwer. "Old People in Three Industrial Societies" (London: Routledge and Kegan Paul, 1968), 450.

Follow-up with the district nurse and day hospital twice a week.

Three months later collapsed at day hospital. Admitted as disorientated and doubly incontinent. Treated on the acute assessment unit with intravenous fluids and antibiotics. Confusion began to decrease in four days. In 10 days she was noted to be orientated and asking for the commode even at night. Discharged home after 45 days. To continue with district nurse and day hospital twice a week.

One month later collapsed again at day hospital. Admitted with confusion and incontinence. Diagnosed as a chest infection. Treated with oral fluids and antibiotics. Continent in six days, confusion lessened but mental ability less than on former admissions.

Discharged home after 15 days with district nurse and day hospital twice a week.

It is my belief that if Mrs. G. were in the United States she wouldn't have been seen in an assessment clinic for rehabilitation, that she wouldn't have followed closely by the health service, and that if she survived her first admission, she would not have been returned to the community.

Mrs. G. in America would have most likely become bedridden with all the complications of pressure sores and further incontinence. Her son and his wife would have finally dispaired and put her in a hospital that would probably dispair as well and Mrs. G. would end up slowly dying in a nursing home. Instead Mrs. G lives in England. She went home again.

She waved goodbye but we expect to see her again for she needs continual supportive care.

ITEM 3. THE IDENTIFICATION OF PROBLEMS IN LONG TERM HOSPITALS

(By Dr. L. Z. Cosin, February, 1967)

The policy of custodial care in former years was an humanitarian attempt to cope with permanent disabilities due to chronic disease and financial stress by providing shelter, comfort and the appropriate cultural and religious background. It was partially successful in achieving these objectives as long as the numbers of elderly and younger disabled in need of these services was not large, and the appreciation of the value and function of rehabilitation was unknown.

During the last two decades however the value of rehabilitation in this field has been appreciated more fully, while the revolution in medical treatment has made services more effective for young and old alike, thus facilitating survival and recovery, with the occasional possibility of rehabilitation and resettlement.

Meanwhile, the number of retired people in the U.S. has grown to nearly 20,000,000 and will increase by 1985 to 25,000,000. One measurement of the rate of disabilities largely affecting elderly people is the number of strokes in the U.S. which has been estimated to be between 500,000 and 800,000 per year; 75% of these patients will survive the first episode of illness. I have considered the logistics of meeting this rapidly increasing social and medical problem, (Statistical Analysis of Geriatric Care: Proc Roy Soc. Medicine, 1948; A Statistical Analysis of Geriatric Rehabilitation, J. Gerontology 1953), as a result of which I have formulated a policy of management of the social and clinical problems, to assess the prognosis of survival of recovery, of rehabilitation and of resettlement of elderly and disabled patients.

These have been carried out in England (Orsett Hospital 1945–8, Langthorne Hospitals 1948–50 and the Department of Geriatric Medicine of the United Oxford Hospitals 1950–70).

This program has also been used in the reorganization of the Malben Custodial Care Program in Israel—in 1954 and in Morocco, for the elderly Jews many of who were isolated after the departure of many young Jewish families to Israel in 1963.

Because of the great and growing load of disabled elderly it is essential to redefine the function of any large therapeutic unit so that it can effectively carry out a major program of medical rehabilitation as early as possible—in the development of the natural history of the diseases and disabilities in a community setting, rather than pursue a program of static institutional care.

The original system of custodial care is self-defeating, because even if it were possible to build sufficiently rapidly to provide the number of additional institu-

tional beds required, the financial load would become increasingly burdensome while the increased numbers of experienced and trained nurses, auxiliary nurses, practical nurses, physiotherapists, occupational therapists and other auxiliary staff could never be trained or recruited.

The alternative of providing a more active medical program with some rehabilitation but no planned resettlement and Continuing Care Program, and attempts to provide other types of residential accommodation on an ad hoc basis is likely to provide additional service for some patients. But the unstructured functioning of institutions now about to be faced with increasing requests to treat more cases sooner from short stay "Episodic Care" hospitals and the inability to carry out this responsibility sufficiently early, will result in many elderly patients failing to reach the appropriate rehabilitation milieu in time. Thus the stream of long stay cases from the short stay hospital and the community will increase, preventing the development of a balanced program of service to the elderly in the community and short stay hospital. In this way many potentially remediable conditions, social as well as medical will become irremediable and result in a progressive increase in the number of those patients needing permanent care.

However the alternative that I recommend and have used successfully in differing countries and cultures, is the attempt to deal with the social and medical problems of elderly patients as early as possible in a community or short stay hospital so that the majority can still be rehabilitated and resettled before the remediable phase passes ineluctably into the irremediable.

By this means those favoured patients in good modern institutional care do not benefit unduly at the expense of miserable, neglected old people in substandard housing with little available extramural care. The strategy of care for elderly patients then must be to deploy available resources of expertise, finance and appropriate facilities so that an active program of Institutional Treatment, Rehabilitation and Resettlement is integrated with the needs of the short stay hopsital, to prevent deterioration of elderly patients in the latter; to utilize the major part of the institution for rehabilitation and appropriate extended care programmes before the financial benefits of Medicare and Medicaid are exhausted; to provide in addition to the program of Rehabilitation and Progressive Patient Care for ill and disabled patients, a balanced program of Continuing Care to ensure adequate Health Standards largely on an extramural basis; to provide an adequate quota of institutional and sheltered therapeutic accommodations for those disabled mentally ill patients in need of permanent institutionalization. None of these are realistic goals unless we are in a position to accurately measure the number of hospital, institution and residential "bed-days" required to balance this program.

At Oxford in 1966, of about 1800 admissions of elderly patients of average age 82 years about 1760 required 35 hospital in-patient days, and a continuing care program in the community, while 35 needed permanent stay which in each case would average 1300 in-patient days. The proportion of each of these groups of patients will indicate the efficiency and success of a balanced program of institutional and extramural care and management.

The program of continuing care at the Oxford Geriatric Unit includes:

1. Good Medical and social follow-up system for discharged patients, in extramural care.
2. The promise of immediate unplanned readmission for medical or social reasons.
3. Where social stress is found to be rising in the community to arrange the short stay readmission for 2 or 3 weeks every 3 months on the advice of the social worker or public health nurse.
4. Annual holiday readmission to give relative relief and support.
5. Day hospital attendance for from 1 to 5 days a week for treatment, diagnosis and reasons of family relief. The average in 1967 was 1.71 days per patient per five day week.
6. In addition the "Floating Bed" program provides regular short term readmission for 2 or 3 nights every 2 weeks with consecutive day hospital attendance. By this program there is additional family relief and increased patient care by using one institutional bed to keep 5 to 6 patients comfortable and secure in the community.
7. Full utilization through the Department of Social Service, of municipal and voluntary agencies' resources to strengthen the extramural part of the Continuing Care Program (Visiting Nurse, Public Health Nurse, friendly

visiting, Social clubs, Meals on Wheels, Domiciliary Occupational Therapists and Physiotherapists.)

In an American context it would be essential to work out the integration of a comparable program of Continuing Care when Rehabilitation and Resettlement had been implemented. In this would be included:

1. Deployment of institutional staff into patients' homes in appropriate cases of Home Care Program.
2. To the extramural program of Home Care must be added the reinforced and strengthened domiciliary services on a voluntary and statutory basis.
3. Appropriate sheltered and low cost housing projects must be available to complement other therapeutic programs. (See Israel Program).

By combining a policy of social engineering, through the dynamic quadruple assessment, by modifying architectural methods to produce functional living units, by the development of expertise in staff, and by the logistical deployment of resources in areas of relative shortage it should be possible to attack the problems in areas of absolute shortage and produce a balanced program of extramural, hospital and institutional care that promises to deal far more effectively with the urgent and current needs of so many deprived, neglected and poor elderly folk.

In conclusion by understanding and compensating for shortage of expertise more than finance we should aim to conserve and deploy our resources so that each elderly patient in need of a moiety of comfort, happiness and loving kindness will stand a far better chance of receiving these attributes of a possibly humanitarian society, which may still be concerned with human values.

ITEM 4. GERIATRIC REHABILITATION[1]

(By L. Z. Cosin, F.R.C.S.[2])

Nurses to attend the aged sick are very scarce, and likely to remain so. It therefore behooves us to diminish the number of aged patients needing much nursing care. This can be achieved by geriatric rehabilitation.

For many patients over sixty years of age progressive deterioration is inevitable, but others may be expected to improve—rapidly or slowly. With an active approach to the problem more and more can receive treatment in bed preparatory to the restoration of assisted or unassisted ambulation. By including this method of treatment at Orsett Lodge Hospital during a recent two-year period, we found that of 780 patients over the age of sixty, 45 per cent were rehabilitated, while 35 per cent died and only 10 per cent remained bedfast after six months. (Transfers and more recent admissions account for the remainder.)

AIMS AND METHODS

During the late war we saw how the group encouragment provided in rehabilitation units of the Armed Forces and industry accelerated individual recovery. In these units there were facilities for occupational therapy, physiotherapy, and remedial exereises, with a cheerful and happy environment. This solution suggests that every patient of whatever age and disease needs a hopeful environment for his well-being or recovery; without it convalescence is delayed or deferred indefinitely.

The chief factor in geriatric rehabilitation is the visible improvement of other patients similarly incapacitated, while efficient medical and surgical care are very important subsidiaries. The rehabilitation of our aged patients must begin on admission to hospital, so that the physical and mental deterioration induced by long-continued recumbency does not take place. Tacit acceptance of a poor prognosis—not always accurate—has been responsible for many avoidable deaths from pulmonary embolism, in the bedfast.

The aim of geriatric rehabilitation is to restore the maximum degree of painless movement by means of active physiotherapy and remedial exercises, resulting in the maximum of personal independence; we can no longer be satis-

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[1] Read before the International Conference of Physicians in London, September 1947. Reprinted with permission from the Lancet, London, Nov. 20, 1947. P. 804.

[2] Medical Superintendent, Orsett Lodge Hospital, Essex County Council, Essex, England.

fied with merely removing pain. If the patient reaches a stage of weight-bearing, assisted or unassisted, so much the better. Utilising simple physiotherapy for a sufficiently long period the proportion of patients, who are bedfast, can be dramatically reduced. No longer do we label our patients irremediable, incurable, chronic or senile; instead we make a prognosis based both on diagnosis and on an assessment of the particular person's physical capacities. We recognise that deterioration inevitably accompanies certain irremediable diseases, and that a time must come when the patient will have to remain in bed throughout the 24 hours; but it is surprising how long this point can be postponed. Many patients with advanced malignant disease are happier and complain less of pain when encouraged to get out of bed for a part of each day to help themselves. With a few exceptions, in which I include the final inevitable deterioration, the inability of a permanently bedfast patient to feed and generally look after himself is to be regarded as a medical reproach.

FOUR CATEGORIES

Using this method we can recognise that most aged patients fall into certain broad categories.

1. Those patients who cannot provide their own feeding and residential arrangements but are otherwise fully competent to attend to their own needs. They feed themselves, dress themselves, and help about the ward. They require no night attention, are continent and are capable of completing light occupational tasks.

2. The frail ambulant who is in need of increased periods of rest but can usually cope for himself. (I am adopting the provocative attitude of including among these a large proportion of cases of senile dementia and cerebral arteriosclerosis; for the criterion of bedfastness should be a sufficient physical disability—a condition not obvious in most of these patients.)

These two categories need minimal nursing supervision and extra physical help, for which ward orderlies can be employed. Many of those in the first group should not be in an institution at all if they could be provided with suitable homes.

3. The physically disabled bedfast patient who feeds himself, generally looks after himself, and may be continent. This class of patient does not make a very heavy call upon our nursing service, and we should aim at reabling our bedfast patients into this group.

4. The physically disabled permanently bedfast patient who needs every nursing care and attention. In my opinion the number in this category, swollen by previous medical neglect, should and could be much reduced.

A good medical, surgical and nursing service alone will not reduce the proportion of bedfast patients to a minimum unless it embodies the principle of geriatric rehabilitation. In these days of rapid social change the revolt against recumbency must be made successful.

ITEM 5. HOSPITAL CARE FOR THE ELDERLY

[Reprinted from "The Canadian Hospital," September, 1952]

(By L. Cosin, M.D., Clinical Director, Geriatric Unit, The United Oxford Hospitals, Oxford, England)

Many pessimistic views concerning the hospital care of the elderly stem from poor organization, both past and present of this branch of sociomedical work. It fails, primarily, to provide facilities for rehabilitation of the elderly. Interesting research problems on available pathological material are no doubt important. However, when the costs of hospital care, in any unit, are rising to staggering levels, the first concern must be to provide the maximum benefit to each and every in-patient, regardless of age, in the minimum of time. Moreover, there is little point in organizing purely medical units for the solution of socio-medical problems.

By using the socio-medical approach for the solution of socio-medical problems, I find that the average duration of bedridden stay for all geriatric patients, admitted to a geriatric unit, should be between 40 to 50 days in the first six months

of hospital stay. Permanently bedridden patients, needing more than six months full nursing care, should form 3 to 5 percent of the admissions. Statistical evidence for this statement can be provided.

Long-stay annex patients, who are "frail ambulant" or "senile confused", should again be a low percentage of the admissions. The current medical opinion concerning the callousness of relatives is not entirely borne out in my experience. It is possible to resettle about 50 per cent of all elderly admissions in their own homes (or hostels) while 35 to 40 per cent will survive less than the first six months after admission. Further, it is possible to resettle 25 to 30 per cent of senile confused patients in their own homes, to be cared for by relatives, provided that their co-operation is maintained by a sympathetic and helpful medical attitude.

The problem of hospital care of the aged can be solved adequately by the organization of units designed, primarily, in the interest of these patients and not in the vested interests of medical research, psychiatry, gerontology or even geriatrics. Basically, this problem is not medical, it is numerical; the solution also must be satisfactory, numerically, before large new ventures involving capital expenditures, which may be unnecessary, are commenced.

Evidence that our previously organized systems, which neglect the institutional needs of the elderly, are unsatisfactory is overwhelming. Statistics support the fact that a unit designed and used, primarily, in the interests of each and every old person is more successful. In these units, the facilities for research, work in the treatment of malignant disease, the relief of pain, and metabolic endocrinological and vascular dysfunction, can and will be organized in the interest of the patients. First-class research workers can always go where the "material" is most plentiful.

If we approach the question of what to do with the elderly infirm with the viewpoint of "disposing of them", it will never be solved because of their increasing numbers. The problem of resettling and finding continued care for the elderly can be solved along the lines already mentioned.

The feeling of despair in the medical profession when faced with this problem which they feel is insoluble, (except along the lines of more and more overcrowded institutions for elderly "chronics"), must be replaced by a reasoned optimism concerning the possibilities of rehabilitation. As a result of rehabilitation, it may well be that the supposed deficiency of hospital accommodation is minimal or non-existent.

So many old people will continue to live their lives and die at home in the family group that, as other writers have shown, the greater burden will not be borne by hospitals at all.

In fact, it is most desirable to attempt further reduction, wherever possible, of accommodation for the elderly who are not in need of the fully organized and increasingly expensive hospital facilities.

The number of old folk, admitted to chronic and mental hospitals, while small as a percentage of the elderly population, is due to part to a failure to provide facilities in a field of preventive medicine not yet completely explored. As the geriatric unit explores this field, it is finding more and more examples of cases that can be discharged back to their own homes for greater or lesser periods of time. In selected cases, care by the family can be supported by community and local organizations until it is desirable, on medical or sociological lines, to readmit the aged person to hospital on a permanent or temporary basis.

Where permanent admission becomes inevitable and long-term care has to be associated with the provision of residential accommodation, then long-stay annexes will be needed for patients whose physical rehabilitation has been so arranged that they have achieved a maximum of physical independence. In this way the provision of extra hospital and nursing facilities can be entirely avoided; this may also be applied to that large proportion of confused sensile patients whose medical condition does not warrant full hospital care. If this type of accommodation can be arranged in existing hospital facilities greater economies would be effected. All hospital specialists would be expected to help in a unit of this type and with the continued care of the elderly. Indeed, it is desirable that all clinicians should continue to follow up and control the treatment of cases they have failed to cure but this should be made possible in existing facilities.

Any new building should be of the simplest type of construction, consistent with a reasonable level of residential care. A building of this type will need to

be reserved for the frail, ambulatory, and confused elderly patients, whose physical capacity fits them for such accommodation. This policy will be the most acceptable economically as it must be associated with very active attempts to rehabilitate and discharge the maximum number of elderly patients to their own homes.

In my view, existing fully staffed hospital beds will have to suffice for our needs for many years; thus the integration of medical, and surgical "acute" and "long-term" care will have to be more closely effected. Into this program can be fitted specific research and other projects desired. Any extra accommodation will have to be for that large class of elderly patients who are not in need of fully staffed hospital beds but who will continue to occupy them unless cheaper accommodation, attached to the hospital, is provided. This is especially applicable to the elderly patient who has obtained admission to a mental hospital.

The first steps in improving care for the confused or better orientated geriatric patient lies in the provision of facilities for full assessment of each patient's problem, including his pathological, psychological, physical and sociological status. On this basis, short-term admissions can be arranged with a view to utilizing every means possible to assist resettlement in their own homes or hostels run by local or voluntary authorities. Should their pathological or sociological status determine long-stay care on a residential basis, the great majority of these cases will be found to be capable, with good physical rehabilitation, of a degree of independence. In these cases, the need for organized hospital services or staff, usually thought essential for the "chronic sick" patient, would not be necessary. This will avoid the need for providing additional fully staffed beds for long-term bedridden patients.

Patterns of medical organization and research can be fitted quite easily into this program. The emerging pattern of future long-term care, on an institutional basis, will have to be orientated as much around the individual functional capacity of the elderly patient as around pathological or medical data.

CHART 1

UNITED OXFORD HOSPITALS DEPARTMENT OF GERIATRIC MEDICINE

PATIENT FLOW CHART

Mon. (T.F.)
Piped O_2
Piped Suction
Blood Transfusion
Surgical Services
Plastic S. Services
Psychiatric
Research
(24 hr. Nursing Service)
Path. Services
Biochemical Service
Accident Services
Urological Service
Dietetic Service
Social Casework

4 PROGRESSIVE PATIENT CARE WARDS (100)

COMMUNITY EXTENSION SERVICES

INTENSIVE CARE ZONE	INTERMEDIATE CARE FLEXIBLE ZONE	ZONE III	MINIMAL CARE ZONE IV
(P.T.)	T.F.	S.T. M.S.W. F.T.	P.T. O.T. S.T.

UNPLANNED READMISSION

PLANNED READMISSION

2 REHABILITATION WARDS (75)

QUICK		SLOW	
MIN. C.	INTERMEDIATE	INTERMEDIATE	MIN. C.

F.B.
D.H.

1 HALF-WAY HOUSE (40)

PLANNED READMISSION

VOL. HOME — MINICARE FAMILY HOME — MUN. HOME

F.B.
D.H.

1 LONG STAY WARD (35) 1 LONG STAY (M.H.) UNIT (50)

PLANNED READMISSION

INTERMEDIATE (CHAIRFAST)

PERM. BED

F.B.
D.H.

CHART 2

PLAN OF MEDICAL CARE OF ELDERLY IN OXFORD, U.K.

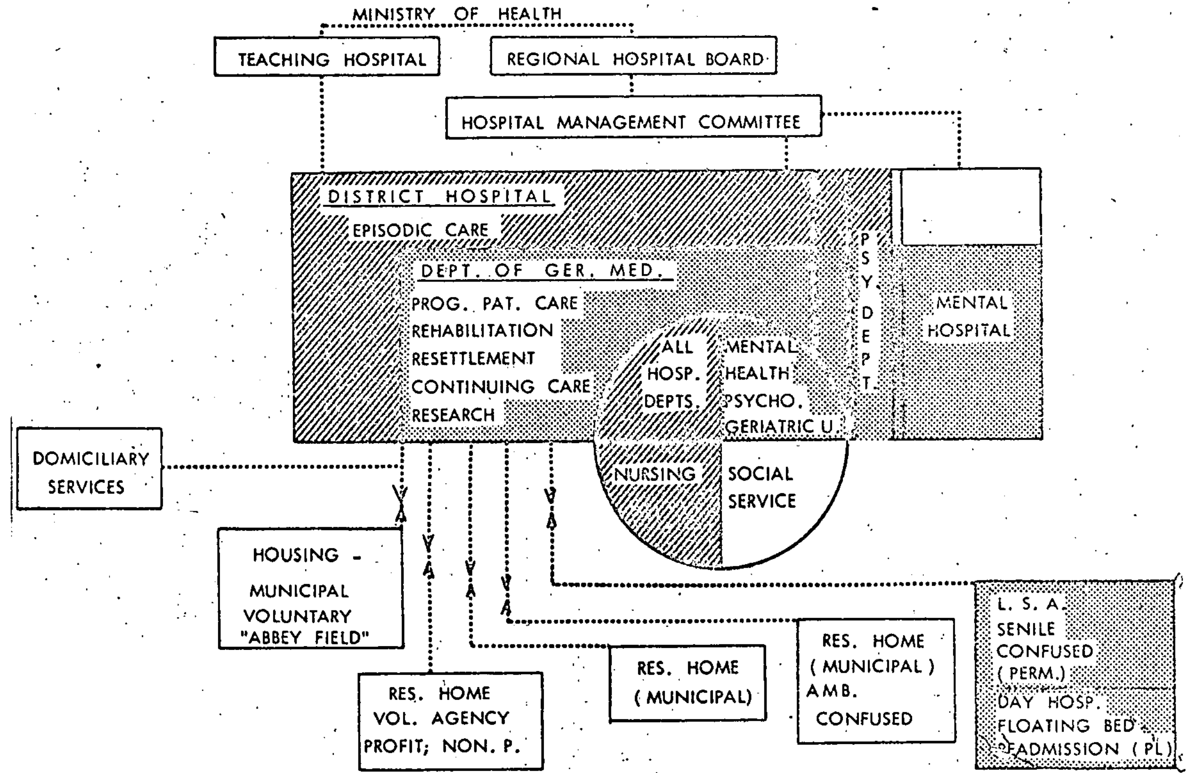

CHART 3

DOMICILIARY SERVICES

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DEPT. GERIATRIC MEDICINE (OXFORD)

1. FOLLOW (MED.-SOC.)
2. IMM. UNPLANNED READ.
3. PLANNED READMISSION
4. HOLIDAY READMISSION
5. DAY HOSPITAL – (THER. DIAG. FAM. RELIEF)
6. FLOATING BED
7. HOME CARE (MALE NURSE)
8. GERIATRIC HEALTH VISITOR
9. HALF – WAY HOUSE
10. M.D. ADVISORY SERVICE
11. M.D. PASTORAL SERVICE
12. M.D. PRIORITY SERVICE

VOLUNTARY AGENCIES

1. FRIENDLY VISITING
2. SOCIAL CLUBS
3. WORKSHOPS (PART TIME)
4. GROUP HOLIDAYS
5. DAY CARE (GOOD NEIGHBOUR)
6. YOUTH CLUBS & SCHOOLS
7. PODIATRY
8. MEALS ON WHEELS
9. NIGHT SITTER SERVICES
10. HOUSING SOCIETIES (NON PROFIT)
11. RED CROSS LOAN SCHEME

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GENERAL PRACTITIONER

STATUTORY AGENCY

1. AMBULANCE SERVICE
2. WELFARE DEPT. SUPERVISION
3. MENTAL HEALTH OFFICE
4. MEDICAL SOCIAL WORKER
5. HEALTH VISITORS (G.P. ATTACH.)
6. HOUSE MANAGER (NORMAL)
7. HOUSING (WARDEN)
8. WELFARE PHYSICAL AIDS
9. DOMICILIARY P.T.
10. DOMICILIARY O.T.
11. HOME HELP SERVICE
12. DISTRICT NURSE (HOME CARE)
13. HOUSING ALTERATIONS
14. PREVENTIVE HEALTH PROGRAM (RUTHERGLEN, EALING)
15. PODIATRY
16. MEALS ON WHEELS
17. DAY CARE (OLD PEOPLES HOMES)

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</table>

CHART 4

ANALYSIS OF 301 GERIATRIC (>60 YEARS) REHABILITATION PATIENTS

NUMBER OF PATIENTS

300 280 260 240 220 200 180 160 140 120 100 80 60 40 20

DEAD

DISCHARGED

LONG STAY ANNEXE

WARD (BEDFAST)

1 2 3 4 5 6

MONTHS AFTER ADMISSION

RETURNED TO WARD AFTER LONG STAY ANNEXE

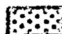
TRANSFERRED TO OTHER HOSPITALS 

CHART 5

OXFORD GERIATRIC UNIT

WARDS DESIGNED FOR INTERMEDIATE AND MINIMAL CARE