Nursing Homes: Public and Private Financing of Care Today

by FRED R. BROWN*

Developments in the financing of nursing-home care and the present status of certain government and private programs for this purpose are reviewed in the following pages. The Social Security Administration has an interest in nursing homes not only because many public assistance recipients are nursing-home patients but also because nursing homes have become an important medical resource for all older persons and, therefore, for the steadily increasing numbers who are aged beneficiaries of old-age, survivors, and disability insurance. This review is intended to provide a basis for assessing progress to date and in the future toward solving one of the most difficult problems in the field of medical economics.

ONE aspect of the current interest in problems of the aged is the increasing attention that is being given to patterns and standards of institutional care. The pressures for reexamination of practices and attitudes with respect to institutional care come from several sources. The rising costs of medical care, and particularly of hospital care, have led to clearer differentiations between the services and facilities needed in short-term illnesses and those appropriate to long-term conditions. Increasing awareness of the social needs both of the aged and of younger persons has encouraged a more careful assessment of the particular types of services needed by different individuals and a recognition of the importance of social services in medical as well as in nonmedical settings.

As a result, there is extensive current experimentation with a wide range of arrangements and measures for the care of persons who are not able to be completely independent. The advantages of care in the individual's own home, provided adequate home services are available, have become generally accepted in theory if not fully carried out in practice in many communities. Public welfare agencies and other public and private agencies are increasingly looking to boarding homes and foster homes to provide the most satisfactory living arrangements for certain groups of aged persons who cannot remain in their own homes.

In recent years, also, a tremendous growth has occurred in the number of nursing homes, varying from essentially residential institutions to intensive medical-care facilities. This article is concerned primarily with nursing homes as medical-care facilities and with the problems of financing care in nursing homes.

In a relatively short span of years, nursing homes have attained an important position among medical-care institutions. Evidence of growth is found in the statistics on these homes, such as the number of beds and patients and financing. Widespread attention is currently being focused on possible measures to improve and expand nursing-care facilities, to develop better management and regulatory techniques, to improve the content of patient care, and to develop adequate sources for financing care.

It is significant that about half of all patients in nursing homes receive some public assistance support for their care and that an increasing portion of the medical care utilized by old-age, survivors, and disability insurance beneficiaries is furnished by nursing homes. One provision in the 1950 amendments to the public assistance titles of the Social Security Act requires that each State, to receive Federal funds for assistance payments to persons in institutions, must designate an authority to establish and maintain standards for these institutions. The States have made rapid progress under the impetus of this provision, and the congressional purpose of extending State responsibility for standards of care in nursing homes and in other institutions has, in large measure, been achieved. In 20 States the public welfare department has authority for setting standards, and this function is therefore closely related to the public assistance program. In other States, the health agency is the standard-setting authority, operating in cooperative relationship with the public assistance agency.

Whether or not it has standard-setting responsibilities, the welfare department, through its administrative measures and services, usually exerts considerable influence upon the scope and quality of the nursing-home care that is provided to those patients receiving public assistance support; inevitably this influence extends to the care provided to other patients. In all States considerable influence is exerted through the administration of the assistance programs by county social work staff, actively aided by medical personnel. Public welfare agencies often participate in the assessment of a recipient's medical and social needs and offer aid through counseling and referral so that he may receive medical and other services in his own home or be placed in the most appropriate care facility (for example, a boarding home, a foster home, or nursing home). Such aids are of a continuing nature to meet the changing needs of the recipient. In some States (including Illinois, Maine, and New York), certain staff members are assigned to specialize in handling the nursing-home caseload. Many States make special studies of the nature and quality of nursing-home care in connection with arriving at a basis

* Division of Program Research, Office of the Commissioner.

for a scale of payment; these studies have some effects beyond their immediate purpose. In some States (Illinois and Kansas, for example), the public welfare agency is an active contributor to the training of nursing-home personnel.

Definitions

Nursing care outside the general hospital is provided in facilities that vary widely with respect to the services offered and thus with respect to the type of patients who can receive the care appropriate to their needs. Several large categories of these facilities, although similar to nursing homes, are ordinarily considered to be more closely related to hospitals. Mental illness, tuberculosis, and certain other types of chronic illness requiring continuous care of a hospital nature are, generally speaking, appropriately treated in one of the specialized types of hospital or sanatorium rather than in a nursing home. Other facilities that are sometimes called "nursing homes" include many that do not provide any professional medical services but offer only residential services. Thus the homes are too diverse for any single designation to be applied to all of them.

A suggested solution to this difficulty of definition has resulted from the deliberations of the National Conference on Nursing Homes and Homes for the Aged, held in Washington from February 25 to 28, 1958, under the auspices of the Public Health Service. A section report of the conference recommended that four distinct classifications of services be considered as the basis for distinguishing the service content of these homes:

1. Residential services encompassing housing, food, and other domiciliary needs.
2. Personal care, including help in such daily activities as walking, dressing, feeding, bathing, getting in and out of bed, and taking medication of a type usually self-administered.
3. Nursing care encompassing those services that require technical nursing skills.
4. Multiple services covering all the types of care listed above but emphasizing social and group-work services, psychiatric and physical rehabilitation, and the like.

Under this classification scheme, a facility would not be called a "home" but a residential facility, a personal-care facility, a nursing-care facility, or a multiple-service facility. At each succeeding level, the facility provides all the services included in the less comprehensive facility. These designations are somewhat different from those in the classification scheme previously suggested by the Public Health Service in its 1954 national inventory of nursing homes: (1) skilled nursing home, (2) personal-care home with skilled nursing, (3) personal-care home without skilled nursing, and (4) sheltered home.[1] In effect, the more recent proposal would place the nursing home having a significant rehabilitation program in a distinct classification, and all other facilities offering skilled nursing care would be in another single category.

This article is principally concerned with nursing homes offering skilled nursing care—in other words, nursing facilities and multiple-service facilities. It is recognized, however, that personal-care facilities and residential facilities cannot be entirely omitted in an overall review of nursing-home developments, despite the limited extent of the medical content of the services in these two categories. Actually, from time to time the occupants of these homes may develop intensive medical needs, which the homes may endeavor to satisfy.

Classification schemes may have special significance with respect to the financing of nursing-home care. It would be desirable if the amounts to be paid for the care could be related in advance to the kinds of medical services provided. Use of an accepted method of classifying by medical service levels would make such a relationship possible. Thus, a patient who could be readily classified with respect to his need for nursing-home care could more easily be placed in a home classified as capable of satisfying this need without unduly exceeding it. Furthermore, when a public or private agency is financing the care, one possible method for determining the amount of payment would be use of a scale of rates based on facility classifications.

[1] Jerry R. Solon and Anna Mae Baney, "Inventory of Nursing Homes and Related Facilities," *Public Health Reports*, December 1954.

Number of Homes and Beds

In connection with the hospital and medical facilities construction program under title VI of the Public Health Service Act, as amended (the Hill-Burton program), the Public Health Service compiles data from the annual State inventories of medical-care facilities. The nursing homes in the inventories are expected to meet this definition in the Public Health Service regulations:

> A facility which is operated in connection with a hospital, or in which nursing care and medical services are prescribed by or performed under the general direction of persons licensed to practice medicine or surgery in the State, for the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who do require skilled nursing care and related medical services. The term "nursing home" shall be restricted to those facilities, the purpose of which is to provide skilled nursing care and related medical services for a period of not less than 24 hours per day to individuals admitted because of illness, disease, or physical or mental infirmity and which provide a community service.

Employing this definition of a "skilled nursing home," the States reported a national total of 221,435 existing nursing-home beds as of January 1, 1958. Of these beds, 113,019 were considered acceptable and 108,416 were considered not acceptable because of fire hazards or health reasons. In the aggregate, the States considered that they needed 2.59 beds per 1,000 population, or a national total of 435,686 beds. These needs were determined by each State within the Hill-Burton allowances—from a minimum of 1 nursing-home bed per 1,000 population up to 4 beds per 1,000 population where the combined nursing-home and chronic disease hospital beds would not exceed 5 per 1,000 population. To replace unacceptable beds and provide the needed new beds, according to the State plans, construction or renovation of nursing-home facilities with 322,667 beds would be required. The possibil-

ity that this estimate is too conservative is suggested by a recent study based on inquiries to physicians. According to the study, about 4 nursing-home beds per 1,000 population would be necessary if accessibility to care were no longer to be limited by inability to pay for it or by shortages in facilities.[2]

In 1956, the latest year for which an ownership summary was made by the Public Health Service, 217,600 nursing-home beds met the Public Health Service definition. As indicated in table 1, somewhat more than 63 percent of the nursing-home beds are under proprietary auspices. (It is assumed that most of those whose ownership was reported as "unknown" are also proprietary.) The data also show that the average proprietary home has about 23 beds, which is less than the average for all homes —28 beds. Many of the proprietary nursing homes have been established only recently; according to the survey of 13 States made jointly in 1953–54 by the Public Health Service and the Commission on Chronic Illness, half of them had been established within the previous 4 years.[3]

If a broader definition of a nursing home were used, the national number of available beds would, of course, be greater. The Public Health Service national inventory indicates that as of 1954, excluding 80,000 beds in 9,000 sheltered homes, there were 370,000 beds in 16,000 nursing homes offering services at least to the level of "personal care"; 260,000 had some skilled nursing, and 110,000 did not. The American Nursing Home Association has conducted an independent survey, which indicated that in August 1957 there were 392,303 beds in 17,455 nursing and convalescent homes. Sixty-seven percent of all beds reported in the survey were in homes under proprietary auspices.

The relative significance of these estimated national totals can be better understood when a comparison is made with the data from the Public Health Service summary of State medical-facility inventories of January 1958. A total of 693,000 existing beds was reported in general hospitals and 736,000 in mental, tuberculosis, and chronic disease hospitals.

Patients in Nursing Homes

Nursing homes are predominantly devoted to the care of aged persons, and a relatively high proportion of the patients are women. In the 1953–54 survey made by the Public Health Service and the Commission on Chronic Illness, the median age of all patients in proprietary nursing homes was 80 years. Of all the patients, 90 percent were aged 65 or over and fully one-fourth were aged 85 or older. Two-thirds of all the patients were women.

More than 1 percent of the entire population aged 65 or over resided in proprietary nursing homes at the time of the survey. Nursing-home patients aged 85 and over represented more than 6 percent of the entire population of this age group. Only 4 years earlier the 1950 Census showed that the total number of persons aged 65 or over in proprietary nursing homes and in proprietary homes for the aged was only three-fourths of 1 percent of all aged persons in the population.[4]

Generally speaking, nursing homes cater to patients needing long-term care in facilities offering less in the form of medical services than a general hospital. In the 1953–54 survey, the average period that patients had been in these homes up to the survey day was 1 year. Nearly one-fifth of the patients had been in their present nursing homes for 3 years or more.

Cost of Nursing-Home Care

Because the nature of the care furnished in nursing homes is varied, the costs and charges for care are also matters of considerable variation. The cost of furnishing care, especially in proprietary institutions, is hard to determine, partly because the basic information is often not available and also because of the noncomparability of accounting methods. Steps to improve and standardize nursing-home accounting procedures, however, have been taken in some States. Since charges made to patients are more easily ascertained, surveys have usually covered charges rather than costs. In the 13 States covered by the 1953–54 survey, the median monthly charge for private paying patients was $187 in proprietary homes and $116 in voluntary nonprofit and public homes. The total charge for the care of patients receiving part of their support through public assistance payments was $127 a month in proprietary homes and $98 a month in voluntary nonprofit and public homes. Among proprietary homes, median monthly charges were shown to vary from $90 to $200, depending on the locality. Charges ranged from $130 a month in homes with fewer than 10 beds to $187 for homes with 50 or more beds.

Homes with more than one staff member per bed had a median monthly charge of more than $300, and homes with one staff member or less for every 6 beds had a median charge of $98. According to the survey report, the data indicated a median monthly charge of about "$160 for patients who need nursing care of a type which could not be expected to be provided at home."

In a study made in Florida in 1955, the costs of acceptable care in two types of facilities—nursing homes and boarding homes—were developed. One cost level, $156.50 a month, was for "care with adequate diet and nursing care in nursing homes for the average patient." The other cost level, $176.39 a month, was for "care for an acutely ill person."[5]

Table 1.—*Skilled nursing homes and beds in these homes, by type of ownership, July 1, 1956*

Type of ownership	Homes		Beds		Beds per home
	Number	Percent	Number	Percent	
Total	7,801	100.0	217,577	100.0	27.8
Proprietary	6,023	77.2	137,188	63.1	22.8
Nonprofit	666	8.5	33,825	15.5	50.8
Public	386	5.0	32,073	14.7	83.1
Unknown	726	9.3	14,491	6.7	20.0

Source: Public Health Service.

[2] Isidore Altman, "The Need for Certain Types of Medical Facilities in Pennsylvania as Estimated by Physicians," *The Pennsylvania Medical Journal*, October 1957.

[3] Jerry Solon, Dean W. Roberts, Dean E. Krueger, and Anna Mae Baney, *Nursing Homes, Their Patients and Their Care* (Public Health Service Publication No. 503, Public Health Monograph No. 46), 1957.

[4] Jacob Fisher, "Trends in Institutional Care of the Aged," *Social Security Bulletin*, October 1953.

[5] Ferne Hobson Britt and Margaret H. Jacks, "Cost of Care of Aged and Infirm Residents in Florida Nursing and Boarding Homes," *Public Health Reports*, Aug. 1956.

Usually the available summary reports do not clearly identify the costs of providing nursing-home care in facilities under voluntary auspices, such as fraternal and religious organizations. Costs for the nursing-care services provided by these homes are not segregated from the costs of the domiciliary services offered to residents not in need of active medical care. In 1955, however, 55 domiciliary and nursing homes reporting to the Council of Jewish Federation and Welfare Funds indicated average costs (for nursing and domiciliary services) of about $1,855 per resident a year or $155 a month.[6] The average annual cost per person in 1956 in 52 domiciliary and nursing homes reporting to the Board of Hospitals and Homes of the Methodist Church was $1,302 or $109 a month.[7] These cost levels are indicative of the average cost of care in homes offering only domiciliary services to a considerable portion of their residents. In contrast, the average monthly cost of care in 1956–57 was $246 in a voluntary "home for incurables" offering considerable nursing care to 182 long-term patients.

In a recent survey made by the Federal Housing Administration on the financing of a number of nonprofit homes for the elderly (including those giving residential and infirmary services), expenditures per resident ranged from $826 to $2,705 a year, or from $69 to $225 a month.[8]

Costs for care in government-operated nursing homes tend to approach those in the lower portion of the cost range for voluntary homes. In a survey made in Pennsylvania, 58 counties reported that the average cost per resident in their county homes and hospitals in 1956 was between $60 and $105 a month.[9]

[6] Council of Jewish Federations and Welfare Funds, *Yearbook of Jewish Social Services*, 1956.

[7] *Statistical Summary of Institutions Affiliated with the Board of Hospitals and Homes of the Methodist Church, Year Ending December 31, 1956.*

[8] Federal Housing Administration, *Report of the Industry Advisory Committee on Housing for the Elderly*, May 1957.

[9] A Faculty Committee of the University of Pennsylvania, *A Survey and a Statement of Principles on Tax-Supported Medical Institutional Care for the Needy and the Medically Needy of Pennsylvania*, 1957.

Sources of Financing

There are several major sources for the financing of care in nursing homes. Important developments in the financing of care through the public assistance programs and through voluntary insurance are discussed in some detail in this section. Financing by direct private payments, by philanthropic and organizational contributions, and by public medical care programs (in addition to public assistance) are other important sources about which data are insufficient for any detailed description.

Public assistance.—Highly significant as sources for financing nursing-home care are the Federal, State, and local funds expended under the public assistance programs. About half the patients in nursing homes are recipients of old-age assistance, aid to the blind, or aid to the permanently and totally disabled. A few recipients of aid to dependent children or of general assistance are in nursing homes. Some nursing-home patients have only part of their care financed from public assistance since they have other income resources or receive help from relatives or others. In the joint survey of 1953–54, about 20 percent of the nursing-home patients receiving public assistance made additional payments for their care.

A survey made by the Bureau of Public Assistance of the Social Security Administration showed that in early 1957, out of the 45 States reporting, 43 had specific provisions for money or vendor payments for nursing- or convalescent-home care in one or more of the public assistance programs. Data were obtained from some of the States on the percent of recipients in nursing and convalescent homes and on expenditures. In 24 States, 5.6 percent of all old-age assistance recipients, in 18 States 4.2 percent of those receiving aid to the blind, and in 20 States 7.2 percent of the recipients of aid to the permanently and totally disabled were in nursing homes or convalescent homes. Payments made to and in behalf of recipients in nursing or convalescent homes made up 9.7 percent of all old-age assistance payments in these States, 7.4 percent of payments to the needy blind, and 7.2 percent of the payments under aid to the permanently and totally disabled.

For the reporting States, total monthly assistance payments for nursing-home patients averaged $113.73 in old-age assistance, $113.82 in aid to the blind, and $128.17 in aid to the permanently and totally disabled. Among these States the averages ranged from $29.75 to $116.15 in old-age assistance and from $64.09 to $187.93 in aid to the permanently and totally disabled. The amounts received by the nursing homes were somewhat higher, on the average, because of the additional payments from the patient, his relatives, or others.

About 65 percent of the total assistance payments to recipients of old-age assistance in nursing homes were money payments; that is, payment made to the patients, who made payment in their turn to suppliers of the care they received. The other 35 percent was paid in the form of vendor payments directly to the suppliers of the services—to the homes, various medical practitioners, and others who supply the medical services.

The regulations of the Bureau of Public Assistance currently permit the States to divide nursing-home care into its components (board and room, nursing services, drugs, and so on), and a different method of payment (money or vendor) may be used for each component. At least three States—New Mexico, Pennsylvania, and Washington — make a money payment to the recipient for some items of his nursing-home care and pay the vendor for the other items.

In most States the rates of payment for the nursing-home care of public assistance recipients are set either on a statewide basis or locally by applying the method established by the State agency. New York, for example, requires the counties to establish rates in accordance with specified criteria and subject to State approval. At least some New York counties require periodic cost reports from nursing homes caring for public assistance recipients. Minnesota and West Virginia use an established maximum rate applicable to all nursing-home care. Some States have different maximum rates based on the type of facility, as in New Mexico,

which makes a distinction between public and private homes. At least four States—Illinois, Massachusetts, Pennsylvania, and Washington—have set up categories of care, and a scale of rates is tied to these categories. The facilities that offer the care are similarly classified.

Health insurance.—Although health insurance coverage for nursing-home care is not a widely developed benefit, some insurance plans either include such benefits explicitly in their contracts or pay for nursing-home care through special arrangements. Several Blue Cross plans, for example, include provisions for such a benefit as part of the basic plan or as part of a rider that may be purchased optionally. As of January 1958, three plans had certificates that provided for care in nursing homes or in convalescent hospitals, and two plans covered care in convalescent hospitals only. One plan's definition of a convalescent hospital allows for payments in those nursing homes offering care with a high medical service content. One other plan specifically covering care in a nursing home states that its benefit is for care immediately following discharge from a hospital for the remaining days of the hospital-benefit period, but the nursing-home benefit can be received only once during the life of a certificate. Payments in this plan range from $5 a day to $8, depending upon the nature of the hospital benefit (semiprivate room or ward). Still another plan has somewhat similar provisions except that it pays for 80 percent of the cost of care in contracting convalescent or chronic disease hospitals; it pays 60 percent of the cost but not more than $25 a week in noncontracting institutions. One plan allows up to $6 a day in a contracting nursing home under the provisions of its "prolonged illness certificate," which pays benefits after the basic certificate allowances have been exhausted. Medical payments under the "prolonged illness certificate" are limited to a total of $5,000.

Information is scanty on the levels of utilization of nursing-home benefits in Blue Cross plans, partly because this type of benefit has been offered only recently. One plan, however, reported that the nursing-home days used annually were less than 5 per 1,000 members and hospital days about 930 per 1,000 members. About 75 percent of the persons receiving nursing-home care were aged 65 or over.

Benefits for nursing-home care are not commonly included in insurance company policies. A new type of policy—major medical expense insurance—is intended to cover the expenses of extended and costly illness and in some instances provides reimbursement for the cost of nursing-home care. In other major medical expense policies, however, care in nursing homes is explicitly excluded as a benefit. Since major medical expense coverage is usually obtained through group arrangements connected with employment, this form of insurance for the aged, retired persons who make up the overwhelming majority of nursing-home patients is not extensive.

Expenditures for Nursing-Home Care

The data available for estimating national expenditures for nursing-home care do not permit precise estimates. The information that is available is frequently difficult to interpret because the distinction is not clearly made between those expenditures devoted to providing care that is primarily residential and personal and those expenditures directed toward providing care that is, in a major sense, medical. Nevertheless, some reasonable approximations of these expenditures can be made, and these estimates are useful for an understanding of the magnitude of the amounts involved.

In the fiscal year 1956–57, it is estimated that more than $625 million was spent for care in nursing homes of all types of ownership and providing all levels of care (including sheltered care only). Since this estimate covers some levels of care that are not substantially medical in character, a more appropriate expenditure estimate, for the present purpose, would be one that is confined to care in those homes offering skilled nursing care. Such an estimate for 1956–57 would cover care in the 7,800 skilled nursing homes, with 217,000 beds, that were included in State plans approved under the Hill-Burton program and that the State agencies responsible for the inventories therefore considered to be medical facilities that meet a somewhat exacting definition.

Expenditures from all sources for care in skilled nursing homes in 1956–57 amounted to at least $320 million. Since the nature of the available data usually permits only a lower-limit estimate to be made, the estimate of $320 million probably understates somewhat the total amounts actually spent. The amounts from each source that enter into this estimate of total expenditures for skilled nursing-home care are discussed separately, with expenditures from government sources considered first.

Available information on public assistance expenditures in the year ended June 1957 (before the effective date of the 1956 amendments to the Social Security Act providing for separate matching funds for medical care) indicates that approximately $125 million was paid in behalf of public assistance recipients in skilled nursing homes of all types of ownership. This total includes payments of all sorts—"basic" payments, and money and vendor medical payments. Public assistance payments made in behalf of recipients in institutions broadly designated as "nursing and convalescent homes" were considerably greater—an estimated $200 million.[10] There is no basis for estimating the portions of these expenditures that were derived from Federal, State, and local sources.

In addition to expenditures through the public assistance programs, some public funds are spent for the direct support of publicly operated skilled nursing homes (including the nursing-home or infirmary care in public residential facilities) and for support grants to nonpublic institutions. Difficulties in making this estimate arise from the practice of including expenditures for public nursing homes in the reports of expenditures for public hospitals or for public welfare institutions, without separate identification of the expenditures for skilled nursing homes. On the basis of the

[10] An estimated $195 million was spent for the same purposes in 1955–56. See Division of Program Research, *Research and Statistics Note No. 3*, 1958.

available data, however, it is estimated that more than $10 million was spent in 1956–57 by State and local governments for care in public facilities of this type, in addition to public assistance payments for patients in the public homes.

Private expenditures for skilled nursing-home care in homes under all types of auspices in 1956–57, either in full payment of the charges or in combination with other sources of financing, are estimated to have been about $175 million. Since medical care insurance played only a small part in these payments, it may be assumed that nearly all private financing was derived from the income, savings, or other resources of the patients themselves and from contributions by relatives or other interested persons.

Care for a considerable number of patients in skilled nursing homes is financed through the organized support of fraternal, religious, labor, and other groups and through philanthropic contributions. These expenditures are not readily separable, however, from the financing of the broader programs of domiciliary services and medical care. On the basis of available financial and utilization data from skilled nursing homes operating under a variety of voluntary nonprofit auspices, it is estimated that the national annual expenditures for this purpose in 1956–57 from philanthropic contributions and from organizational sources was at least $10 million.

Construction of Facilities

The differing types of nursing-home care tend to allow great variability in the type of facility considered appropriate for such care. Consequently, there is extreme variation in the cost of creating these facilities through new construction or through renovation. Some facilities have been constructed at a cost reported to have been as little as $3,000 per bed, excluding land but including equipment. Other recently constructed facilities have cost as much as $12,000 or $14,000 per bed. Costs ranging from $5,000 to $10,000 per bed (exclusive of land) are frequently cited as permitting construction and equipment of facilities of high standard.

Three Federal programs have a bearing upon the availability of funds for nursing-home construction, equipment, or improvement. In addition, State and local governments may provide funds for construction of public and nonpublic facilities in conjunction with the Hill-Burton program or through independent programs.

Hill-Burton program.—The hospital and medical facilities construction program under title VI of the Public Health Service Act, as amended, is administered by the Public Health Service in the Department of Health, Education, and Welfare. Through this program grants are made to the States for surveying and planning the development of their medical facilities, including nursing homes. Grants are also made on a matching basis to assist in the construction of public and voluntary nonprofit medical facilities. The grants are conditioned upon a demonstration of need as shown by the State plan and upon the facility's compliance with certain standards, including equipment and construction standards. Since the 1954 amendments to the act, nursing homes, hospitals for care of the chronically ill, diagnostic or treatment centers, and rehabilitation facilities have been eligible for such grants. The annual authorization for nursing homes is $10 million, but Congress has appropriated only $4 million for this purpose in each of the 4 years since the fiscal year 1953–54.

At the end of 1957, 99 projects, with 4,542 nursing-home beds, were approved for partial financing through Hill-Burton grants. Of these beds, 740 were in operation, 3,115 were in facilities under construction, and 687 had received initial approval. The total cost will be $48.4 million ($14.6 million from Federal funds); the cost thus averages $10,650 per bed.

Of the 99 Hill-Burton nursing-home projects, 66 have less than 50 beds and only 13 have 100 or more beds. Forty projects are for new facilities, and 59 are for additions or alterations to existing facilities. About 60 of the projects are affiliated with general hospitals.

Thirty-eight of the projects are under the auspices of a local government, one is under the auspices of a State government, and the remaining 60 projects are to be operated by voluntary nonprofit organizations.

Small Business Administration loans. — Privately financed loans would appear to be an important means for the financing of nursing-home facilities, but a number of reasons account for the generally limited availability of such loans. The principal reason is the prevalent belief among lenders that nursing homes are highly depreciable and that they are of a one-purpose nature. Among other reasons often cited are the lack of explicit standards of service and construction, the difficulty of foreclosing on a health facility where there would be opposing social pressures, the difficulty of insisting on strict business methods in a health facility, and the uncertainties arising from the existing high discontinuance rates among single-proprietor homes.

In recognition of the difficulties in securing commercial loans, the Small Business Administration instituted a program in August 1956 that has been providing loans on a participation basis, jointly with commercial lending institutions, to privately owned nursing homes operated for profit. The loans are made to applicants who show that the needed financing is not otherwise available. The funds may be used for new construction, expansion, or improvement or for working capital. To qualify for a loan, the nursing homes must meet the definition of a small business—that is, annual receipts cannot be more than $1 million. When the Small Business Administration is the sole lender, the maximum loan is $250,000, but the amount can be higher if there is an additional loan from a commercial lender. The entire loan must be proportionate to the owner's investment. The maximum duration of a loan is 10 years, and the borrower must demonstrate a successful record of earnings. The Small Business Administration's interest rates are usually 6 percent, but the agency may accept a lower interest rate that is set by the participating commercial lender.

Up to December 1957, the Small Business Administration had approved 32 loans to nursing and convalescent homes, and these loans totaled $1.3 million. New nursing homes and ad-

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Table 7.—*Old-age, survivors, and disability insurance: Number of monthly benefits withheld, by reason for withholding payment and type of benefit,*[1] *December 31, 1957*

Reason for withholding payment [2]	Total	Old-age			Wife's or husband's				Widow's or widower's	Mother's	Parent's	Disability
		Total	Male	Female	Total	Aged wife's [3]	Young wife's [4]	Husband's				
Total	359,458	209,608	158,657	50,951	47,777	41,129	6,144	504	11,092	78,447	86	12,448
Covered or noncovered employment [5] of beneficiary in United States or covered employment [5] of beneficiary outside United States	283,406	197,340	148,990	48,350	4,290	2,263	2,009	18	9,311	72,449	16	----
Noncovered employment [5] of beneficiary outside United States	501	341	292	49	31	26	5	0	24	105	0	----
Covered or noncovered employment [5] in United States or covered employment [5] outside United States of old-age beneficiary on whose earnings benefit is based	40,649	----	----	----	40,649	36,980	3,213	456	----	----	----	----
Noncovered employment [5] outside United States of old-age beneficiary on whose earnings benefit is based	71	----	----	----	71	62	5	4	----	----	----	----
Failure to have care of an entitled child	4,466	----	----	----	594	----	594	----	----	3,872	----	----
Benefit completely offset by workmen's compensation or another Federal benefit for disability, other than compensation payable by the Veterans Administration for a service-connected disability	10,927	----	----	----	0	----	0	----	----	1	----	10,926
Disabled person refused to accept rehabilitation services	3	----	----	----	0	----	0	----	----	0	----	3
Determination of continuing disability pending	672	----	----	----	0	----	0	----	----	0	----	672
Payee not determined	3,167	2,085	1,467	618	338	307	23	8	406	158	22	158
Administrative reasons	15,596	9,842	7,908	1,934	1,804	1,491	295	18	1,351	1,862	48	689

[1] Data for child's benefits withheld are not available.
[2] As provided for under section 203 of the amended act except for the reason "payee not determined," in which case benefit payments are accrued pending determination of guardian or appropriate payee.
[3] Wives aged 65 or over, and wives aged 62-64 with no entitled children.
[4] Wives under age 65 with 1 or more entitled children.
[5] Includes self-employment.

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ditions were financed by 28 of the loans. Included in these and in the remaining loans were some amounts for equipment, working capital, and debt repayment. Altogether, 669 additional beds have resulted from these loans.

Housing for the elderly.—The Federal Housing Administration has a program of housing for the elderly that was inaugurated in 1956. One phase of the program provides mortgage insurance to enable nonprofit organizations to provide multifamily rental accommodations. This type of housing may have infirmary, community dining, and recreational facilities. A loan may run for as long as 40 years and bear an interest rate of 4.5 percent, plus ½ of 1 percent for mortgage insurance. The maximum loan is $12.5 million, and the cost per actual dwelling unit may not exceed $8,100 ($8,400 for structures with elevators), not including congregate facilities.

The Federal Housing Administration's regulations with respect to the multifamily facilities allow for inclusion of treatment rooms, nursing stations, and other facilities for care of the physically handicapped or infirm. The emphasis, however, is upon housing that allows some privacy. At the end of 1957, 18 projects, providing 2,160 living units, were in process; they were financed by $17.4 million in insured loans.

Conclusions

It is apparent that the public and private measures initiated to finance care in nursing homes and to foster the development of improved and expanded facilities are in some instances already of considerable magnitude but that in others they have as yet had only a limited impact. It is also clear that the nursing home has a place of considerable importance among medical-care institutions today and for the future. The recent rapid growth in the number of nursing-home facilities and in the amounts expended for nursing-home care provides good reason to believe that this growth will continue for some time. In view of the substantial recent increases in medical care costs, particularly for hospital care, there is an understandable and widespread interest in the possibility of further development of the skilled nursing home as a means of providing high-quality but less costly care for patients not requiring the specialized services of a general hospital.

Financing is one important facet of the overall situation for which careful planning is an obvious necessity. Planning along other lines is, of course, also imperative. Licensing and regulation, the design of facilities, interinstitutional relationships, and the supply and training of personnel are among the other aspects demanding continuous attention. Research directed toward elevating the content of patient care is also most significant. Pivotal to all these considerations, however, is the problem of developing and improving the means of financing nursing-home care so that it will be available and adequate for those whose health needs can best be served in this type of medical institution.