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

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

Data on size of family are available for old-age and survivors insurance beneficiaries from field studies made in 1941–44, but not for recipients of old-age assistance. The insurance data suggest that individuals in two-person families bulk larger among beneficiaries than among the aged as a whole, with a corresponding greater or lesser deficiency of persons in families of other sizes. This characteristic conforms to the pattern among insurance beneficiaries of a higher ratio of married persons and of persons in their own establishment.

Summary

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

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

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

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

Commercial Nursing and Boarding Homes in Philadelphia

By Margaret K. Bishop*

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

There are chronically ill persons in every age group, but by far the majority are concentrated in the upper age brackets. In 1940, 7 percent of the city's population were in the ages 65 years or over, and the proportion is showing a steady upward trend. Moreover, the present lack of facilities for caring for nonacute illnesses of younger persons is developing an increasingly larger group of chronically ill in the older age levels. More than 90 percent of the public assistance recipients in commercial nursing homes are over 65 years. Thus, while the problem of caring for the chronically ill must be closely, but not exclusively, identified with care of older persons, constructive emphasis must be laid simultaneously on prevention of chronic illness by early diagnosis, treatment, and adequate care.

Nonprofit institutions care for only a small fraction of the aged population, because of the scarcity of such institutions and their restrictions on admission. Some of these homes operate on a contractual basis that automatically excludes recipients of public assistance. Many are limited with respect to church affiliation or race. Few will accept nonambulatory persons or persons with chronic or progressive ailments. Philadelphia has only 4 nonprofit institutions for the chronically ill, with a bed capacity of about 500. Practically no hospital accommodations exist for the chronically ill of any age group. The few available facilities are limited to caring for persons suffering from particular diseases, such as rheumatic fever, cancer, and so on.

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

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

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taurant, day in and day out. For such persons the social worker has no alternative but to attempt to obtain admission to commercially operated homes. Often the recipient is not willing to accept this plan, but no other community resources exist to meet very real needs.

The present study was undertaken by the Philadelphia County Board of Assistance to survey the city's facilities for sheltered care, analyze the needs and characteristics of recipients in commercial homes, and inquire into needs for sheltered care among recipients then living in their own homes. Agency visitors filled in questionnaires for each commercial boarding home represented in their case load, for each recipient in a home, and, on a selective basis, for recipients who needed home care. A committee of the Council of Social Agencies, in collaboration with which the present study was conducted, had recently completed a study of commercial nursing homes. Since the data from this study were available for this report, questionnaires on nursing homes were not included in the agency study.

Commercial Nursing Homes

Under Pennsylvania law a license is required to operate a nursing home "for persons requiring care, treatment or nursing by reason of sickness, injury, infirmity or other disability." The Department of Welfare is charged, on receipt of application for a license, with making a thorough investigation "as to the character, financial responsibility, and qualifications of the applicant . . . the adequacy of the facilities of the home to furnish the type of care and service specified in the application, the sanitary and fire protection facilities, and any other matter or thing which the department may deem proper." Licenses are issued for a year and may be renewed yearly following reinvestigation. Representatives of the Department of Welfare may inspect the home and its records and interrogate the inmates at any time. Staff limitations in the Department of Welfare have greatly curtailed the possibilities of constructive work with the commercial homes in maintaining standards and improving services. The Department is also handicapped in its supervision of nursing homes by its recognition of the shortage of homes in the face of increasing need for sheltered care, and is therefore reluctant to eliminate any existing resource by too rigid insistence on high standards.

The consequence of these circumstances, coupled with the fact that the proprietors are operating the homes as a business and that the recipient's monthly payment to the home is usually $40 or less, is that the caliber of care provided by the homes generally leaves much to be desired. Only about half the homes have a registered nurse regularly on duty; the remainder have nurses with varying degrees of training or no nurses at all. Most homes employ less than 3 untrained workers, equivalent to 1 for every 9 or 10 patients. Only 6 homes have physicians in attendance, while others have physicians on call or expect the patient to have his own physician. The adequacy and suitability of the meals served to ill and elderly patients in several homes have been questioned repeatedly.

In Philadelphia, as in many other cities, nursing homes have multiplied in recent years. More than half the nursing homes accepting public assistance recipients in this city have been in operation 5 years or less. In almost all instances the owner is in direct charge of the home.

Except for one Jewish home, all the nursing homes are nonsectarian. A few exclude all cases which are not ambulatory, and a number do not admit blind or senile patients. The exclusion of alcoholic, mental, and cancer cases is almost universal. The need for nursing home care for indigent Negroes is practically unmet. Only three homes now accommodate Negro recipients of assistance, although Negroes constitute one-fourth of the old-age assistance case load in the city.

Recipients' Payments to the Home

Rates in the nursing homes range from a monthly maximum of $258 to a minimum of $29. Private rooms are available in 14 homes at rates ordinarily excluding assistance recipients. Semiprivate accommodations (2, 3, or 4 beds per room) are offered by 20 homes, and dormitory rooms (5 or more beds per room) by 17. It has frequently been reported that a higher payment to the home seems to make little difference in the service rendered, except that private or semiprivate rooms are available only to those paying the higher rate.

Approximately one-third of the patients in the nursing homes are dependent on public aid, and three-fourths of this group pay $40 or less for their care. By its present policy, the agency's payments to old-age assistance recipients are limited to five items of basic maintenance—food, shelter, fuel, clothing, and incidentals—although it is recognized that other subsistence needs exist and that nursing care may be such a need. Recognizing the difficulties experienced in obtaining this care within the range of the assistance payments, agency policy permits the use by the

Table 1.—*Resources (assistance and other) of recipients in nursing homes, by amount of the recipient's monthly payment to home*

Total resources	Total	Number of recipients making specified payment to nursing home											
		$25–29	$30–34	$35–39	$40–44	$45–49	$50–54	$55–59	$60–64	$65–69	$70–74	$75–79	$80 or more
Total	346	1	9	39	219	8	34		7	11	4	4	10
$25–29	1	1											
30–34	8		8										
35–39	1			1									
40–44	257		1	38	218								
45–49	6				1	5							
50–54	35					3	32						
55–59	2						2						
60–64	7								7				
65–69	10									10			
70–74	4									1	3		
75–79	5										1	4	
80–84	1												1
85–89	3												3
90–94	1												1
95–99													
100 or more	5												5

recipient of personal resources to meet the deficit over and above the payment.

The majority of recipients in the nursing homes receive an assistance payment of $40 a month which is claimed in toto by the home (table 1). Certain proprietors return a dollar or two to the recipient for personal purchases, but frequently the assistance check is turned over routinely to the home, leaving the recipient who has no other resources completely penniless. This situation is responsible for much dissatisfaction among the inmates of nursing homes.

About one-third of the recipients have some resource that supplements their assistance and makes it possible for them to meet the charges of the nursing home.

Source of Income	*Percentage distribution of recipients*
Total	100.0
No income other than grant	64.0
Relatives and friends	25.0
Federal insurance benefits	3.4
Agencies, including churches	4.2
Pensions	1.4
Other	2.0

General Conditions in Nursing Homes

The homes and the adequacy of care they provide vary widely. Most of the homes were reported to be adequately clean, to offer reasonably good meals, and to provide such recreational facilities as books, radios, living rooms, and porches. The range of situations may be exemplified by the following excerpts from the survey workers' reports.

Food was cooking on the stove when I went through. It looked ample and heavy. The patients were clean. The home is crowded, and some of the furniture needs replacement, but it all appeared clean. There are attractive grounds and porches. People were sitting in the yard and on the porch looking as though they were enjoying themselves. The men have a sunny room for recreation. When I was there they were listening to a broadcast of a ball game. The proprietress investigates all patients before she takes them. If they are to come from a hospital she goes down to the hospital and talks with the patient and decides what they will pay and if they will be suitable for her place. She also talks to the doctor and gets his orders for the patient. If the patient is coming to her from his own home she goes to see the patient in his home.

The report on another home was as follows:

I was present while the supper tray was being served. The platters were scanty. Patients did not appear too clean. The house was not clean; bathrooms were filthy, and the nurse who showed me around kept apologizing for the appearance of the house. There was a rather depressing atmosphere in this home. Most of the patients were confined to their rooms, which were not too cheerful.

Commercial Boarding Homes

For purposes of the study, "boarding home" was defined as " a home not licensed as a nursing home, operated for profit, accommodating three or more adult persons unrelated to the person in charge, at least one of whom is a client of a social agency."

Commercial boarding homes, as well as nonprofit and nursing homes, restrict their admissions; bedridden, alcoholic, and mental cases are types of applicants most frequently excluded. House-bound and room-bound persons are accepted in most homes, but ambulatory persons are preferred. More than half the boarding homes will accept white persons of either sex, while several others limit their admissions to white men or to white women. Only three of the boarding homes studied admit Negroes. In general, the homes are nonsectarian.

The distinction between nursing and boarding homes sometimes rests on the rather fine line of the possession or nonpossession of a license. Some boarding homes provide medical care, have graduate nurses resident or on call, and care, at least temporarily, for bedridden patients. Several boarding homes that have been unwilling to accept bedridden cases have permitted persons to remain who have become bedridden during their residence. Probably a significant number of persons in boarding homes would benefit by nursing home care. The shortage of nursing homes and the higher rates charged for such care force ill and disabled persons to live under arrangements that fail to provide them with the type of care which they need.

In most of the boarding homes the inmates are ambulatory, although many do not go outside the home regularly. They have sought boarding care because they are lone persons, incapable of caring for themselves, or because they have no relatives who are willing or able to undertake their care.

The homes have been in operation for periods ranging from 40 years to less than a year; half were established within the past 5 years. They have a capacity of some 500 persons; more than half care for 10 persons or less. At the time of the study there was a 25-percent vacancy rate, which undoubtedly reflects in part the difficulties experienced in obtaining maintenance staff. Six homes have no private rooms; the other 36 have private accommodations for 155 persons, at monthly rates ranging from $130 to $26.09. Semiprivate rooms, containing 2, 3, or 4 beds, were available in 31 homes, with slightly more than 2 as the average number of beds in each room. A maximum charge of $130 was made for semiprivate rooms, and a minimum charge of $26. Only 3 homes had dormitories, that is, rooms containing more than 4 beds. Of these, a mission home offered accommodations with 15 beds per room, ranging from $29.25 a month to no charge, and the other 2 rented dormitory beds, with an average of 5 beds per room, at a maximum charge of $40 and a minimum charge of $27.83.

Recipients' Payments to Boarding Homes

The scale of payments to boarding homes is lower than that in nursing homes, since residents need less care.

Table 2.—*Resources (assistance and other) of recipients living in boarding homes, by amount of the recipient's monthly payment to home*

Total resources	Total	Number of recipients making specified payment to boarding home							
		Less than $20	$20–24	$25–29	$30–34	$35–39	$40–44	$45–49	$50 or more
Total	210	7	3	7	32	80	68	7	6
$15–19	1	1							
20–24									
25–29	3	1		2					
30–34	11	1	2	2	6				
35–39	12	3		1	7	1			
40–44	162	1	1	2	19	75	64		
45–49	12					2	3	7	
50–54	5					2	1		2
55–59									
60–64	1								1
65–69	1								1
70–74									
75–79	1								1
80–85	1								1

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

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

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

General Conditions in Boarding Homes

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

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

Most of the homes offer a limited number of services in addition to shelter and food. Many care for personal laundry, while a few provide clothing and such services as shopping and mending. Recreational facilities are made available in the form of books, games, and radios, and in access to outdoor space, porches, and living rooms. In most homes, medical care is provided on a temporary basis, through attendance of physician, visiting nurse, or graduate nurse on call, but in extended illnesses the patient is usually removed to a hospital.

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

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

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

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

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

With respect to another home it was reported:

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

Characteristics of Recipients in Both Types of Homes

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

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

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

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

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

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

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

Age and Marital Status

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

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

Most of the recipients living in homes are single or widowed (table 4). Although very few married persons were living in the commercial homes at the time of the study, a very real social problem is presented by elderly couples who are not able to care for themselves completely and are not able to pay for continued and expensive care. Some other cities have taken cognizance of this situation by building apartment houses with small quarters especially designed for elderly persons and common services available at low cost. This arrangement permits privacy, independence, and comfortable living, pending the day when nursing care becomes necessary. It means a prolongation of home life for elderly people who are unable to cope with the expense and difficulty of maintaining their homes under the usual ill-adapted conditions of the ordinary rented house or apartment.

Period of Dependence on Public Assistance

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

Records of long-term cases show clearly the reason for continuous dependency. Recipients are solitary persons or have relatives who cannot assist them, and they are incapable of any effort in their own behalf—as, for example, an elderly woman whose only relative is a daughter in the Home for Incurables; a lone senile woman of 85; a diabetic woman who has had one leg amputated, is so senile that she fails to realize that she is a recipient, and has only one relative, a son with a large family who is usually unemployed or earns very little; a lone man, whose adopted daughter does not give him any financial help.

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

Interval since first authorization	Percentage distribution of recipients in—					
	Nursing homes			Boarding homes		
	Total assistance	Continuous assistance	Intermittent assistance	Total assistance	Continuous assistance	Intermittent assistance
Total recipients	346	246	100	210	163	47
Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
Less than 1 year	1.7	2.4	-----	1.9	2.5	-----
1–2	12.4	17.1	1.0	11.5	13.6	4.4
3–4	12.2	13.0	10.0	14.9	15.4	13.0
5–6	17.9	17.9	18.0	16.8	17.3	15.2
7–8	20.2	21.5	17.0	18.3	17.9	19.6
9–10	19.7	15.5	30.0	18.3	19.1	15.2
11–12	10.7	8.5	16.0	12.0	10.5	17.4
13 or more	5.2	4.1	8.0	6.3	3.7	15.2

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

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

Period of Residence in Homes

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

Health

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

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

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

mobility of recipients is indicated in table 7.

Life in the Homes

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

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

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

Life in the nursing and boarding homes is ordinarily a restricted existence, with little that is constructive or even pleasurable and entertaining. In present circumstances, however, the homes are performing a real function. While it is easy to criticize the operation of the homes, and there is undoubtedly much that is subject to valid criticism, the following points should be kept in mind: (1) The standard of living of the home is definitely higher than that of the former scale of living of many recipients. If it were not for the commercial homes, many persons would be receiving little or no care in conditions of real squalor. (2) The homes are not philanthropic institutions but business enterprises. The homes that cater to public assistance recipients cannot afford to offer a very high standard of living for $40 a month per person. Certain obvious abuses that exist currently could be corrected, however, if community pressure were exerted to improve standards and supervision. (3) If the ill or disabled person is forced to live in the uncongenial surroundings of a commercial home, it is because the community has not made provision for this particular group of its members.

Need for Nursing and Boarding Care

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

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

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

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

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

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

Conclusions

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

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

The dilemma of the indigent chronically ill person occurs so frequently as to form an almost standard pattern. Acute manifestations of the disability bring the patient to the hospital, where treatment restores him to his "normal" condition. At this point the hospital is anxious that he should be discharged, so that his bed will be available to a person in need of active medical care. Because of the patient's need of continuing nursing or custodial care, his lack of resources, and the inadequacy of facilities to meet his needs, he is frequently kept in the hospital beyond the point of need for hospitalization. A vicious circle then develops. Overcrowding of hospital facilities sometimes limits the admission of incipient cases that cannot be treated until the period of therapeutic possibilities has elapsed, tending to create a new group of the chronically ill. Such procedures are obviously uneconomical, both financially and from the standpoint of human values. The obvious solution lies in the provision of adequate facilities for the care of the increasingly large population of senile persons, the chronically ill, and disabled persons of all types and age groups.

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

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

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

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