*Robert E. Burger*

# Who Cares for the Aged?

Misleading assumptions have produced the American "solution" for the problems of the aged—nursing homes, old people's homes, and retirement villages. But are we dealing with their real social and medical needs—involvement and rehabilitation?

APPROXIMATELY one of every ten Americans is over sixty-five, and the proportion is increasing every year. Two-thirds of these Americans suffer from some chronic condition—high blood pressure, arthritis, diabetes, or other afflictions. Yet there are only about 30,000 institutions of all kinds designed to take care of them—with enough beds to handle only one out of fifty. The majority of the aged, in addition, do not qualify for either Medicare or Medicaid. The *median* annual income for the single person over sixty-five is $1,055, and 30 per cent—single or married—live in poverty. Their families, therefore, must be able to pay what amounts to half of a normal take-home wage per month for even the most limited care.

THE financial dilemma posed by nursing homes reflects a more fundamental question. What is the place of the aged in America? Most Americans have accepted the assumption that the aged are better off by themselves. We seem to believe that their medical needs are different, and that they can be treated more efficiently as a group; that their interests and their sensibilities are protected when they are among others of their own age; and that they live longer, happier lives away from the pressures of the competitive, youthful world. All of these assumptions are fundamentally incorrect, but the pressures leading to them are easy to understand. We have not been able to face the basic medical need of the aged—rehabilitation. A definitive study in 1966 of 2,000 public-welfare patients of New York nursing homes concluded that, "extensive rehabilitation of aged residents in nursing homes is neither practical nor socially productive. . . . Maximum rehabilitation efforts should be applied earlier, and in other sites than nursing homes." We have habitually viewed the nursing home not as a place for rehabilitation at all, but as "the last resort" for a "difficult" older person. Thus, the basic technique of rehabilitation—keeping the patient active—has been systematically precluded by the way such homes are

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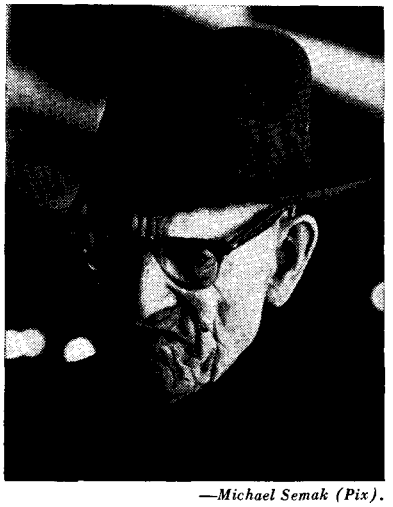
—Michael Semak (Pix).



—Michael Semak (Pix).

—Eric L. Brown (Monkmeyer).

**"Most Americans have accepted the assumption that the aged are better off by themselves. . .**

filled and financed. Bedridden patients receive a higher welfare payment, require less attention, and seldom leave.

The rapid industrialization of America has also stripped our aged of the responsibilities and functions they possessed in an agrarian society. Unproductive, they soon feel unwanted. And so the pressures for separation from society grow on both sides, a tendency that seems to have psychological validity among younger and younger age groups. The executive "retires early" because his fifty-ish age level has put him out of contention for a promotion. The blue collar worker buys a condominium in a "retirement village" (minimum age, once fifty-three, is now down to forty-five), because his grown children have no real contact with him.

These psychological pressures, working to widen the gap between the old and young, have received unexpected impetus from another source. The miracle that has made old age possible for many more Americans has also made it more frustrating. Modern medicine has increased the life expectancy for American men from forty-nine years in 1900 to almost seventy years today. Yet the life expectancy for men at the age of sixty-five is fourteen additional years, compared to thirteen in 1900. We have prolonged life in general, thereby creating a larger group of the aged; but we have not prolonged the life of the aged. Worse, we have not made the life of the aged meaningful or in any sense self-sufficient. Instead, we have placed most of the burdens of health care on the shoulders of the aged and their families.

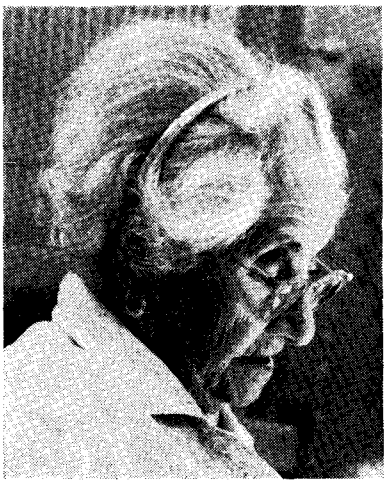
The American "solution"—nursing homes, homes for the aged, rest homes, retirement villages—begs the question of whether the aged are better off away from society. We have been able to hide the problem of the impossible demands of medical attention for the aged only by putting the aged who are ill out of public sight.

The latest fad in the stock market, according to financial columnist Sylvia Porter, is the nursing home business. Even before Medicare was voted in, such firms as Holiday Inn and Sheraton Hotels were planning nursing home chains. At least seven chains are now publicly owned and, according to *Business Week*, "most have become high fliers." Federally financed programs are obviously behind this boomlet, as they are responsible for the construction of housing for the aged in low-income redevelopment projects. Tax laws have also made church-sponsored old-age apartment complexes financially feasible. It would seem that, although the cost to the individual family may still be high, care for the aged is catching up with the medical and environmental problem.

A basic misconception, however, clouds the issue. Medicare covers only a small minority of the aged—those who require post-hospital care for a maximum of 100 days. In the language of the bill, Title XVIII of the Social Security Act of 1967, a Medicare patient is one who needs "extended care" in a "medically oriented" facility. "Extended" means extended from a hospital, not extended in time or extensive in nature. The idea of Medicare was to take old people out of hospitals when they cou'd be treated adequately in a nursing home near a hospital before going home. Medicare pays $16 a day for room, board, and medical care to the nursing home, for each qualified patient. It is not intended to provide a solution for old people who wish to retire from society.

THE nursing home chains touted in financial circles have been developed merely for the specialized need of providing hospital-related, short-term care. It is a sad commentary on the standards of nursing homes prior to Medicare that such a wide-open market exists for facilities that meet even the nominal requirements of Title XVIII. To qualify under Medicare, a home must have a

—*Brooks (Monkmeyer).*



—*Irene B. Bayer (Monkmeyer).*

—*Monkmeyer.*

**. . . that they live longer, happier lives away from the pressures of the competitive, youthful world."**

physician and a registered nurse "on call" around the clock—and, since the home must be affiliated with a hospital in the first place, this presents no problem. The physical-therapy specialists required by Medicare would also be only a matter of cost, not availability.

In the strictest sense of the phrase, these Medicare facilities are nursing homes. Yet the expression has been used so loosely in the past that a new nomenclature has been felt necessary. Such homes are officially referred to as "medically oriented nursing homes."

Non-medically oriented nursing homes, a contradiction in terms, make up the market for long-term or terminal care of the aged. Such facilities, as well as the more aptly described rest homes and homes for the aged, benefit from another provision of the 1967 Social Security Act, Title XIX. Dubbed "Medicaid" but usually confused with Medicare, this legislation is far broader in application and depends on matching programs established state by state. The Medicaid program is really nothing new as far as the aged are concerned, nor, in many cases, does it increase the level of care for the aged offered in state welfare programs. Institutions are paid about the same amounts under Medicaid as they were under previous programs (a basic rate of about $300 a month per patient), but more of the money now comes from Washington. Medicaid simply provides a financial base for medical assistance to citizens of all ages who fall in certain income categories. Residents of New York State are familiar with the comprehensive program initiated by Governor Rockefeller under the Medicaid program, which directly affects about one out of ten people in New York City. Besides dramatizing the skyrocketing costs of providing adequate medical care for the general public, Medicaid initially gave promise of establishing some kind of uniformity and enforceable standards among participating doctors and institutions.

—Brooks (Monkmeyer).

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Yet Medicaid has proved to be toothless in regulating the institutions that are subsidized by this law to care for the aged. "Welfare" or "MAA" (Medical Assistance to the Aged) patients and the homes that will take them are still the responsibility of *state* licensing agencies. This was assured by powerful lobbying by nursing home associations in writing key provisions of Medicaid. For years, state authorities have grappled with the problem of how to regulate substandard homes for the aged when strict enforcement would bring only further hardship on their patients. When threatened with being closed up for persistent violations, operators of ragtag homes shrug, "What do you want us to do—throw them out in the street?"

Of the roughly 30,000 institutions offering long-term care for the aged, more than half make no pretense of offering adequate nursing care. The law in most states requires a registered nurse or a licensed practical nurse to be in attendance eight hours a day at homes that care for MAA patients. But the standards for a "practical nurse" hardly measure up to the demands of aged patients with both psychological and medical problems. The shortage of registered nurses for good paying jobs in hospitals suggests the quality of care offered by registered nurses in nursing homes—whose average salary breaks down to $2.40 an hour. Practical nurses average $1.65, and the national average for all employees in nursing homes is less than $1.25. "Nurse's Aide" has become almost a meaningless designation in the trade, yet it is constantly used by nursing home operators to rationalize their fees. If a licensing agency finds that a home is ignoring the requirement of having a professional nurse on duty, a "grace period" is extended until the situation can be remedied. Some homes have been in "grace periods" for a year at a time. The Oregon Board of Health only expressed the common dilemma when it stated, "It is a hoax on the public to call these institutions for old people 'nursing homes' when there is no nursing service."

The hoax is perpetuated by individual states, however, in refusing to reorganize their agencies which regulate the field. And the $300 or more per month paid by the state for each welfare patient subsidizes substandard homes and spawns new ones.

At the other end of the medical profession, an equally destructive masquerade goes on. This is the practice of doctors setting up or sponsoring a nursing home to which they refer patients without disclosing their interest. Several years ago, Consumers Union termed this a "festering scandal that warrants prompt attention by the American Medical Association." The AMA, however, lobbies side by side with the American Nursing Home Association. Far from being attended to, this problem of conflict of interest has been openly dismissed by the new nursing home promoters. (Four Seasons Nursing Centers of America, Inc., is one of many developers who finance their homes by selling interests to physicians. Four Seasons reports that 50 per cent of its beds are often filled by referrals from their doctor-owners.)

Potentially more dangerous than conflict of interest is the moral and financial weight that the medical profession is throwing behind nursing homes as *the* solution to the problems of the aged. Rehabilitation is simply not a profitable field for investment.

IT can be argued that at least these new physician-sponsored homes are correcting the abuses that have plagued the industry for the last thirty years. Yet, for every new home with private rooms, a beauty parlor, a cocktail hour, and physical therapists (at $600-$900 a month), there are a dozen that exist by cutting all possible corners to make a $300 a month subsidy from the state profitable.

According to the National Fire Prevention Association, the most dangerous place to be in America, with respect to fire, is in a nursing home. Nursing home fires are especially terrifying because of the helplessness of their victims. The NFPA has stated that deaths resulting from these fires could be greatly reduced or eliminated if sprinkler systems were universally required. But in many states, such a regulation has been systematically opposed by nursing-home or homes-for-the-aged groups on the grounds that it would put many homes out of business. In the most disastrous fire in Ohio's history, a modern, concrete-block structure became a funeral pyre for sixty-three aged patients in 1963—yet the state association successfully blocked a sprinkler ordinance that might have made such a fire impossible.

A second abuse is the threat to health in general. Gerontologists tell us that one of the most dangerous treatments for non-psychotic seniles is enforced inactivity. Under the pressure of Medicaid payments (and other "welfare" payments before Medicaid), patients are confined to bed more often than necessary, to earn a $3 to $5 additional subsidy. They are also easier to deal with, pose less of an insurance hazard from falls, and are more permanent guests.

Mere confinement to a bed, moreover, is only the beginning of the health hazard to the patient. In the typically understaffed home, the patient is not turned in his bed often enough to prevent the dreaded decubitus ulcer (eu-

phemistically, a bedsore), an open wound which is as painful as it is difficult to arrest. The misuse of drugs, either to control patients or to cut expenses, is widespread and leads to irreversible medical problems that untrained help cannot be expected to handle. A less publicized abuse is the deprivation of those small conveniences and human activities that make up the stuff of life and, in many cases, are all that make life worth living. Food, for example, is a constant problem in the substandard home. In the states with admittedly the best nursing homes, the average spent per patient per day for food is 94 cents —and this is according to the homes' own figures supplied to justify the highest possible welfare rate. The patient's sense of purpose, or even the mere feeling of accomplishing something is absent—and this void is exploited by unscrupulous nursing home operators to cow the patients, to prevent exposure of other abuses, or to magnify their own importance. One of the most common complaints from visitors to nursing homes is the disregard for the privacy of patients. Operators often conduct an inspection tour for the benefit of prospective customers without the faintest apology to the dumbfounded patients on exhibition.

Perhaps the basic abuse is the insult to the patient as a person. Sometimes this occurs by intention. The notorious "life-care contract," for instance, amounts to an insurance policy, paid in advance by the patient or his family in a lump sum, and guarantees a bed as long as the patient lives. Whether he lives or dies, however, the money is in the hands of the person who stands to benefit from the patient's early demise. By stripping the patient of his will to live—through daily sniping, snubs, and slurs—a nursing home can kill a man. Even where life-care contracts are simply a reasonable bet by both parties, the unconscious resentment of a guest who is "overdue" cannot fail to have its effect.

In spite of numerous newspaper exposés, voluminous testimony at Congressional hearings, and an endless recitation of personal experiences by nurses, patients, and their relatives, the official stance of the industry is first to deny the existence of a problem, and second to blame any documented abuses on government red tape. When the Attorney General of California recently issued a report charging an $8-million "bilking" of MediCal by doctors, pharmacies, hospitals, and nursing homes, spokesmen for these groups called the accusation "unfounded." "Only a small minority" always seems to be the culprit. Yet the state, which pays an average of $140,000 a year to each home under MediCal, claims that *most* of these homes are guilty of double billing, over-servicing, padding, or all three.

The Department of Health, Education, and Welfare has promised a nationwide review of Medicare and Medicaid as a result of the California scandal. This review could well be the opportunity for a look into the social and medical aspects of our old-age institutions as well as their financial meanderings.

Hopefully legislators and government agencies will examine the obvious alternatives to institutional care of the aged. In the parallel field of the mentally handicapped, "de-institutionalization" has already begun. Three-fourths of the population of the village of Botton, England, consist of mentally handicapped adults who have achieved a degree of isolation consistent with their malady but have, at the same time, avoided the hospital atmosphere and psychological imprisonment of an institution. At recent conferences in the United States, specialists in this field have called for an end to the "bounty" that government agencies confer on institutions for each handicapped inmate, thereby frustrating any other form of care.

Among the alternatives to institutional care of the aged are two general courses of action: greater stress on rehabilitation, and assistance to the aged as persons rather than as patients. Rehabilitation, socially and psychologically as well as physically, will have to be made as profitable as "terminal care" for any chance of success on a large scale. Medicare, with its higher medical standards and limitation to short-term care, is a step in this direction. Unfortunately, its impetus has been all but smothered in the far broader and less selective provisions of Medicaid.

Perhaps the most direct method of encouraging rehabilitation is simply to offer Medicare and Medicaid benefits to the person rather than to the institution that claims him as a patient. Payments could be made to the family for medical treatments under the supervision of their doctor and for nursing care when no adult relatives are at home. If this seems a less efficient method than mass-care in an institution, consider the success of Homemakers, Inc. This profit-minded operation now has franchises in some fifteen major cities, offering in-home nursing or attendant care at well under the cost of a nursing or rest home. Similar services are offered in some metropolitan areas by non-profit groups.

The point is that Medicare provides only for emergency in-home care, and Medicaid offers a maximum of four hours a day. Far too many old people who desperately require some sort of personal care therefore find themselves caught in a trap between the regulations of federal and state programs—simply because these programs are built on institutional requirements other than the variety of personal needs. HEW officials are now

—Fujihira (Magnum)

**"The rapid industrialization of America has stripped our aged of the responsibilities they [formerly] possessed. . . . Unproductive, they soon feel unwanted."**

exploring an "intermediate" form of Medicare that would recognize more general medical needs of old people other than post-hospital recuperation. Given our commitment to institutions, this at least offers a measure of relief for the present.

Amendments to Medicaid, to become effective in 1969, indicate that Congress is not unaware of the drawbacks of the present system. Although state agencies must still police the program, benefits are to be broadened beyond institutional care, and higher standards will be required—such as disclosure of ownership of nursing homes, accounting for drugs, and a level of health services similar to that of Medicare. By December 31, 1969, national fire safety regulations will go into effect for Medicaid facilities.

STRICT enforcement of Medicaid provisions at the state level will have to come before the stranglehold of substandard institutions can be broken. Nursing home associations must realize that such enforcement and such exposés as the Attorney General's report in California can only help them, not hurt them. The need for good nursing homes will remain for a long time to come in a competitive, profit-motivated society. At the same time, the more basic need for a just, human, and respectful treatment of 20,000,000 aged Americans cannot remain unfulfilled.

Charles Boucher, senior medical officer in the British Ministry of Health, says: "our philosophy is that old people want to remain at home, in their own houses, surrounded by their own possessions, their own memories. We don't mind whether it is a good home, a bad home, a tiny home. That's where we believe they should be . . . where they feel secure, where they've got confidence. It's tempting to think that it's a matter of institutions and that sort of thing. I think it is rather like condemming old cars to the scrap heap."

# THE SECRET OF NANCY DREW—Pushing Forty and Going Strong

"I'm afraid the worst has happened," Nancy said, but 30,000,000 pre-teeny-boppers have loved every Victorian moment.

By ARTHUR PRAGER

A FEW karmas ago, circumstance compelled me to raise a small daughter, without benefit of wife and mother, in the insecure atmosphere of a large hotel. Emily was ten, and because of my busy schedule, she had to spend a great deal of time alone, inventing her own amusements. One evening I observed her curled up in a ball on the sofa, shoes off, face unusually serious and preoccupied. Interrogated, she answered in a manner so vague, so ruminative, that if I had been a husband of ten years instead of a father I would have been certain she had taken a lover. She had discovered Nancy Drew.

In a local bookstore, mixed in among out-of-date Little Golden Books and the misadventures of improbable animals, my daughter had found a row of blue-jacketed volumes, each bearing in a printed medallion the intrepid girl detective's seductively *nice* face. Emily bought *The Secret of the Old Clock*, identified as the first in the series by the small numeral (1), and promising countless hours of pure happiness ahead. By the time she was ready for *The Hidden Staircase* (2), she was hooked, like so many bored, lonely kids before her. "So many" means 30,000,000, reading Nancy's adventures in seventeen languages over a period of thirty-eight years.

My daughter is grown now, and oriented toward more sophisticated pleasures, but Nancy's magic still galvanizes the nine- to eleven-year-old set in the same wonderful way. The dauntless, bewitching girl detective is still happening, while other favorites dwindle and disappear. Bomba the Jungle Boy crumbles into dust. Tom Swift is replaced by Tom Swift, Jr., but Nancy is still a smash at the box office. In a world of gaudy exhibitionism, subteens find refuge in Nancy's enviable, secure, conservative world.

Nancy is written in East Orange, New Jersey, by "Carolyn Keene," who is really a grandmotherly lady named Harriet S. Adams, abetted by her partner Andrew Svenson and four anonymous ghost writers. This group also writes the "Tom Swift, Jr." series, the "Hardy Boys," the "Bobbsey Twins," and a number of others. Mrs. Adams has written forty-three Nancys, the latest of which will appear this year. The girl sleuth is the financial star of the list. Last year Nancy sold 1,500,000 copies compared to 1,000,000 for the Hardy Boys and a paltry 250,000 for the Bobbseys. Mrs. Adams's publisher, Grosset & Dunlap, is understandably reticent about how much actual cash Nancy has brought her creator, but simple arithmetic tells us that since 1930 she has probably netted her author considerably more than $1,000,000.

Augmenting this profit, Nancy came to the attention of Warner Brothers in 1938, and they decided to film her, with Bonita Granville in the title role. There were four films in all, beginning with *The Hidden Staircase*, loosely based on the book of the same name. The other three, dreamed up and "improved" by contract script writers, were *Nancy Drew, Detective* (1938); *Nancy Drew, Reporter* (1939); and *Nancy Drew, Trouble Shooter* (1939); after which the series petered out, having failed to achieve the popular following of, say, Andy Hardy or Charlie Chan. What Grosset & Dunlap calls "contract complications" have prevented Nancy from appearing as a TV series, although she would probably make a good one.

A GIRL usually gets her introduction to Nancy Drew from someone else: a gift or loan from some friend or relative. After initial exposure, she mounts a campaign of wheedling and cajoling until she has extracted the other forty or so from her parents. Advances are begged on allowances. Hints are dropped before birthdays and Christmas. Once a kid is hooked she has no scruples about infecting her friends and classmates, and Nancy reaches epidemic proportions in the fourth, fifth, and sixth grades. Strict reciprocal trade agreements are drawn up, and woe to anyone who tries to slip in a "Dana Girls" or a "Judy Bolton."

A parent who tries to fathom the secret of Nancy's success is doomed to failure, because, strictly speaking, Nancy is terribly square. Yet she appeals to subteeny-boppers today just as she did in the Thirties. Apparently there is a rock-ribbed streak of conservatism in the nine-to-eleven group. They will participate in outlandish fads for the sake of show, but they like things simple, basic, well organized. Just as the brashest smart aleck will still gulp down a massive lump of anguish when Amy, in *Little Women*, comes in out of the snow and says, "Beth, the baby's dead . . . ," the loudest little cynic will retire to her room, curl up among the psychedelic posters and "Legalize Pot" buttons, and devour some forty Nancy Drews in a row with deep concentration and heartfelt involvement.

PARENTAL permissiveness is thought to be a major factor in Nancy's longevity. Women of my generation passed their worn copies to their daughters fondly, and with (as Nancy would say) a suspicious moisture in their eyes. Mothers who have never read the series examine it and find it harmless if not downright wholesome. Parents who don't care one way or another tolerate Nancy because she keeps the children quiet and arouses in them an interest in books and reading. These reasons do little to explain Nancy's attraction. On the contrary, any one of them is sufficient to poison a little girl's mind against the series. Nancy appeals to her readers in spite of parental approval, not because of it.

The books have an odd, timeless quality. I looked for anachronisms in our 1930 first edition of *The Secret of the Old Clock*. Except for Nancy's roadster, with its running boards and rumble seat, there were none. Like the Land of Oz, Nancy Drew Country is in another time dimension, untouched by the outside world. The Depression came and went, followed by three wars, but they passed unnoticed in Midwestern, suburban River Heights, where Nancy and her chums and their well-to-do country-clubbing parents live. Teen-agers all have new cars there. They buy unlimited pretty clothes, and they summer at fashionable resorts. They give lovely parties. At the height of World War II Nancy went on a pleasure cruise to Buenos Aires, untroubled by U-boats in the sea-lanes. There was always plenty of gasoline for her convertible. Hungry kids, shattered by the announcement of bubble-gum ra-

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