"A SOCIAL SURVEY OF PERSONS OVER SIXTY LIVING IN INSTITUTIONS IN GREATER CAPE TOWN"

by

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PART ONE

Chapter 1 : Research method

Chapter 2 : Description of homes visited.

CHAPTER 1

Use of directories, results of a questionnaire sent to doctors and personal enquiries ended in the discovery of sixty-three addresses at which people over sixty were living, not in their own homes or as free or paying guests with relatives.

Seventy-eight personal letters were sent to doctors throughout the area of Greater Cape Town, and a sixty-five per cent return was obtained. The majority of the addresses were discovered by this means, particularly in the group described in the thesis under the heading "private homes," and valuable guidance was obtained regarding the nursing homes which specialise in aged patients, or are willing to accept such patients on a semi-permanent basis.

An advertisement inserted in a Cape Town newspaper, seeking accommodation for an aged lady, brought to light several new addresses.

From the final total of sixty-three units, six were excluded on geographical grounds. The group of students working during the year on independent pieces of sociological research, under the direction of Professor Batson, agreed to limit the area of their investigation to the geographical area understood to be included in the term "Greater Cape Town." Of these six units, one was a private household, two described themselves as "nursing homes," and three as convalescent homes.

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eans only) and they therefore form an important group of this age who are not living in their own homes or with relatives, and might therefore form the basis of a separate investigation at a later date. Hospital patients form approximately one third of the total number of cases discovered.

From the fifty-three units then remaining, one privately run nursing home was excluded because it accepted mental cases only, and its inclusion could have introduced a bias into the investigation, as far as the mental condition of the sample is concerned.

Also excluded was a block of flats built and administered by a utility company, because it was felt th at it was more properly included under "residential" than under "institutional" provisions. These flats are described, together with other housing provisions for the aged in Cape Town, in an appendix to the thesis.

Fifty-one homes then remained of the original total of sixty-three, and these were divided into three groups under the following headings :-

(1) Philanthropic homes
(2) Nursing homes
(3) Private homes

The term "philanthropic home" was applied to homes of various sizes, including those charging fees and those which provide board and lodging entirely free. This group was then further sub.- divided into homes owned or administered by religious organisations, and those owned or administered by companies and trusts.

The criterion for inclusion in this group was whether the home was run by one or more persons as a business enterprise, or not.

This group includes homes providing for between twenty and more than one hundred and fifty residents, so the division into sub-groups is more of sociological interest than strictly necessary for the purpose of

The term "private home" is applied to all units accommodating persons over sixty for a fee, providing that such persons are not related to the owner. Twenty such units were included in the final list, accounting for a total of one hundred and eighty-one persons. Of this figure, two cases were excluded on geographical grounds, leaving a total of one hundred and seventy-nine persons in private homes for the aged.

Nursing homes caring for patients over sixty numbered twelve (excluding those debarred on geographical grounds) and accounted for sixty-two cases at the time of enquiry. Of these twelve, one denied that aged patients were accepted at all, but as the name of the home occurred several times in the questionnaires returned by doctors, the figure of sixty-two cases should be taken as the minimum accommodated in these twelve homes.

Research method

The objects of the investigation were :-

(1) To discover as many addresses as possible where persons over sixty were living, except where they were living in their homes or with relatives.

(2) To investigate certain aspects of the physical, mental and sociological condition of these people, by means of a random sample.

It was not considered necessary for the purpose of this investigation, therefore, to visit each address.

Excluding the five hundred and fifty cases estimated to be living permanently or semi-permanently in hospitals, the group described as "philanthropic homes" accounted for approximately seventy-eight per cent of persons over sixty known to be living in homes for the aged and nursing homes. It was felt, therefore, that each of the homes in this group should be visited, and a random sample of cases investigated in each.

The remaining cases, those living in private homes for the aged and in nursing homes, comprised twenty-two per cent of the total cases discovered, excluding those in hospitals.

It was necessary to choose by random sample those of the twenty private homes and of the twelve nursing homes, which would be included in the survey. This was done by applying to a list of each group figures from a random sample table; eight units for investigation were taken from each group finally classified as "private homes" and "nursing homes."

This procedure gave a total of twenty-four homes to be visited, accounting between them for eight hundred and forty-one cases.

One philanthropic home was impossible to include in the statistical analysis, due to incomplete information being available, but it is described separately in an appendix. Of the twenty-three homes remaining, co-operation could not be obtained from two private homes, and one home originally listed in the "private home" category was reclassified under "nursing homes."

The statistical analysis covers five private homes, nine nursing homes, and eight philanthropic homes. Two private homes which refused information for Schedule B (concerning residents) gave information for Schedule A, which refers to the home itself.

Of the nine nursing homes investigated, two stated that they had no patients over sixty years of age at the time of the enquiry, although it was their practice to accept such cases. The final number of nursing homes included in the statistical analysis is therefore seven.

The final sample was made up as follows :-

Residents in private homes visited	: 45	
Sample taken	:	31
Residents in nursing homes visited	: 72	
Sample taken	:	53
Residents in philanthropic homes	:740	
Sample taken		91
		857:175

The actual number of cases in respect of which Schedule B was filled in therefore amount to 20.4% of the total number of cases living in all the homes visited.

Choosing sample of residents

Having chosen by statistical random sample those homes to be visited, the problem arose of choice of cases in each home in respect of which Schedule B would be used.

The homes varied in size from those accommodating one person to those having more than one hundred and fifty residents.

It was therefore decided that Schedule B would be filled in for each resident in homes accommodating ten persons or less, since the filling in of Schedule B for one case involved answering thirty-eight questions.

Where more than ten residents were living, a sample of ten cases would be taken by random sample from registers, alphabetical indeces, room charts, or whatever proved to be the most convenient method when the home was visited.

Where the number of residents exceeded one hundred, and if the necessary co-operation could be obtained, a one in ten sample would be taken.

Throughout the survey, great difficulty was encountered in inducing superintendents and matrons to co-operate in choosing the cases to be investigated by true random methods. Even where the importance of choosing cases "at random" was appreciated, interviewees wished to use "rule of thumb" methods. There was a constant desire on their part to make exceptions in the sample to include particularly interesting cases from a medical or social point of view, or to include the oldest inhabitant, or one with a picturesque personality.

In spite of these difficulties, cases were chosen by true random methods from each home accommodating more than ten residents. This was done by dividing the number of cases to be investigated into the actual number of residents, and using the resulting figure as the interval between the cases chosen.

No direct refusal of information was experienced, although a number of interviewees expressed suspicion, wariness, and stated that they were unable to understand the purpose of the investigation.

As the enquiry proceeded, it was found that emphasis on the sociological aspect of the work, as distinct from the social welfare aspect, produced quicker favourable reactions. It was also found more profitable to begin with a request for Schedule B information (concerning residents), leaving Schedule A to complete the picture.

The investigator was impressed throughout the enquiry by the facility with which persons in possession of most intimate medical and social information regarding others can be induced to communicate their knowledge; they do so, further, with only the most cursory enquiry into the investigator's credentials, her aim in obtaining the information, and the actual use to which it would be put. This attitude was connected with extreme caution in giving information for Schedule A, even although the details on this form are of a general nature, and many of the questions were actually filled in from the investigator's own observations, as the interview proceeded.

All philanthropic homes gave the information required for Schedule A, but in one case the completion of Schedules B was impossible due to lack of records.

Generally speaking, superintendents and matrons of philanthropic homes were the most co-operative of the three groups, and the records kept were adequate to complement personal knowledge of residents.

Those in charge of nursing homes were also very co-operative, but in this group there was a noticeable paucity of knowledge regarding non-medical facts concerning the patients.

Superintendents and matrons of private homes were perhaps less willing to give information than the other two groups, but in some cases this was no doubt due to the fact that municipal regulations were being infringed. All were assured that information given would be entirely anonymous in the final report, for both Schedule A and Schedule B.

Schedules used

The object of the investigation was to discover hitherto unknown facts about homes for the aged in Cape Town, and about residents in the homes. To carry out this purpose, two separate schedules were prepared; Schedule A referred to the home and its facilities and services, and Schedule B to the individual resident.

Since no scientific survey had been undertaken in this field before, it was decided to make the scope of the enquiry broad, rather than detailed on specific aspects of the subject.

Further, since the investigator intends to continue her research on the problems of old age in Cape Town, as much information as conveniently possible was obtained, in order to save time and expense in the future.

At the beginning of the survey, the information on Schedule A was intended for use in estimating the degree to which a home furnished the needs of residents, as represented by the random sample chosen for Schedules B, and of the suitability of the type of home for those living there. It was later decided to use the information recorded on Schedules A as a basis for a description of the homes visited, and this forms a separate chapter of the thesis.

In compiling Schedule A, extensive use was made of a number of books on the problems of old age, and on old age homes and their administration, all of which are listed in the bibliography. The investigator noted the points especially emphasised by a number of British and American authorities, and used these as the basis for Schedule A.

Schedule B presented a more difficult problem, because the facts which it was desired to bring forward were neither entirely medical nor entirely sociological in nature, but a combination of both. The survey is the result of a special interest in the relationship between environment and the ageing process, which involves information concerning the physical, mental and sociological condition of subjects included in the

Analysis of A Schedules

The recording and evaluation of the information required therefore involved medical and psychiatric facts, to deal with which the investigator was not specially trained. It was essential, therefore, that the information be unquestionably accurate.

It has been found by other investigators into the problems of old age that, as age advances, the individual becomes suspicious of the unfamiliar, less receptive to new ideas, and is in the majority of cases either unable or unwilling, without repeated and lengthy interviews, to give the information required. It was the experience of the investigators in both the medical and social surveys of Wolverhampton, undertaken for the Nuffield Foundation, that five interviews per day was the maximum possible with old people in their homes.

In this enquiry, the problem was intensified by the fact that the old people were living in homes for the aged, nursing homes and institutions, and access to them therefore depended in the first place, on the degree to which superintendents and matrons were willing to co-operate, and secondly, on the attitudes of the old people themselves. Even where those in charge were willing to allow personal interviews, and to assist with them where necessary, the interviews would have to be arranged on days and at times convenient to the home, and not to the interviewer.

It was therefore decided that the easiest and most accurate method of obtaining the information was not by personal interview with each case, but by interview with the matron or superintendent, who, it was found, could always fill in from personal knowledge what was not recorded in files or registers. Where the home was so large that all the personal details could not possibly be known and remembered by the matron or superintendent, the assistance of secretaries, nursing sisters and other personnel was enlisted.

As the enquiry proceeded, and the investigator learned how large a proportion of the cases were unable, because of mental deterioration, to answer the questions reliably, the wisdom of this course became more and more apparent.

A first draft of Schedules A and B was used as a pilot survey on twenty cases, and was revised in the light of this experience to the form used for the remaining one hundred and fifty-five cases. The information from the first twenty cases was transferred to the finally approved form.

Definitions

Definition of the term "old age" has so many pitfalls that it was decided to avoid its use in the title of the thesis, which refers to men and women over the age of sixty, and not to "aged persons."

themselves as "nursing homes." Such homes were therefore included in the group "nursing homes" and not in the group "private homes."

For the purpose of choosing the sample, "private homes" were further divided into four groups :-

(a) twenty residents and more

(b) between ten and nineteen residents

(c) between four and nine residents

(d) less than four residents

Only one home was discovered in the "private home" group which accommodated more than twenty residents.

Four homes are known to accommodate between ten and nineteen residents.

Nine homes are known to provide for between four and nine residents.

Only two homes were discovered accommodating less than four aged persons, and one of these, consisting of the head of the household, herself over sixty, and two boarders, was outside the geographical area with which the survey is concerned. The other, where one aged woman was cared for by two retired nurses, was visited and is included in the report.

The fact that only two homes in sub-division "d" of the category "private homes" were discovered, further proves the difficulty of tracing this type of home, which the investigator believes to be the most numerous of the four types of private home.

Chapter Two

Description of Homes Visited

Size

1. The one private home accommodating more than twenty residents provides for forty-nine persons of both sexes.

The four homes in sub-division (d), catering for between ten and nineteen persons, are all administered by the owners, and provide accommodation for fifteen, sixteen, eighteen and eighteen persons respectively. One is for aged women only, and the other three for both sexes.

In sub-division (c), nine homes were discovered providing accommodation for four, seven, four, four, six, six and five persons respectively. All are administered by the owners.

The two homes in sub-division (d) have already been described.

2. Of the nine philanthropic homes investigated, four are owned and administered by religious organisations; one was established by a private bequest and is now administered by a church. One is supported by contributions and bequests and is administered by a committee, although it is intended primarily for persons of a particular religious faith; two were established by private bequests and are controlled by boards of management; and one is controlled and owned by a utility company.

Philanthropic homes varied in size from accommodation for nineteen persons to more than one hundred and fifty.

Four homes were for women only; two were for men only; three accommodated both sexes, one of which accepted married couples.

3. Of the six nursing homes visited, two specialised in the care of aged patients, and two had the greatest proportion of patients over sixty; the remaining two also accommodated other age groups without preference.

The size of the nursing homes varied from ten to forty beds.

Registration

All nine philanthropic homes are registered as old age homes with the Cape Town municipality.

All six nursing homes included in the sample are registered as nursing homes.

Three of the six private homes for the aged are registered as such.

Buildings and Equipment

Of the nine philanthropic homes, seven were built especially for the purpose of homes for the aged; one is a converted private house; and one makes provision for aged persons in the same building as other classes of those in need.

Eight of the philanthropic homes have more than one storey, and five have lifts installed.

Four of them have lifts large enough to take a wheelchair, and two of these are large enough to take a bed or stretcher.

Of the three homes of more than one storey which do not have lifts, only one has stairs which can be easily and safely negotiated by persons suffering from any degree of disability of sight or locomotion.

Five homes have wheelchair ramps at the entrance, but enquiry showed that non-European employees are used for carrying wheelchairs in and out of doors in all homes, and in the case of those having no lift, up and down stairs.

Eight of the nine philanthropic homes have gardens, in most cases of considerable size. In all cases residents may work in the gardens if they wish to do so, and in seven homes were stated to do so, although in very small numbers.

All six private homes which gave information for Schedule A were houses intended for private residential occupation, and in four cases were of considerable age. In all cases only very minor conversions had been made to make the house suitable for use as a home for aged persons.

Three houses had more than one storey, and none had a lift. All three have stairs which could be negotiated without undue difficulty by persons having slight degrees of disability of sight and locomotion. In all three cases, non-European employees were used to assist in helping residents into the garden.

All six homes had gardens, and five would allow residents to work in the garden if they wished, but in no case was any resident reported to do so.

Of the six nursing homes from which samples were taken, one refused information for Schedule A, although B Schedules were filled in in respect of patients.

Only two of the six nursing homes were built especially for the purpose, the remaining four being residential premises of considerable age. Only one of these four had carried out major conversion, and three minor conversions.

Four of the six nursing homes have more than one storey, but none has a lift. Of the fifty-three persons living in nursing homes, a total of thirteen were bedridden, and thirty-three suffered from a disability of locomotion (including the thirteen bedridden); twenty-four needed supervision and assistance with dressing. These figures indicate that almost half the cases investigated in nursing homes, while not bedridden, needed special facilities for moving from one place to another, and especially up and down stairs.

Of the total number of infirm persons in nursing homes, seventy-seven per cent spent some time in rooms other than bedrooms and in the grounds. (If the home had an open stoep, this was counted as part of the grounds). The remaining twenty-three per cent spent no time in other rooms than bedrooms, or in the grounds.

Sixty per cent of the patients classified as "sick" spent some time in both other rooms and grounds, while the remaining forty per cent spent no time at all outside their rooms.

Of the bedridden cases, ninety-six per cent spent no time in rooms other than bedrooms, while one hundred per cent never went out into the grounds or on the stoep. If it is remembered that the bedridden cases are a distinct category from those classified as sick and bedridden because of that sickness, it is seen that a large proportion of patients in nursing homes who could leave their rooms for some part of the time do not in fact do so; presumably this is because staff and facilities to assist them to do so are lacking, in spite of the emphasis placed in modern treatment of bedridden cases among the aged on getting the patient out of bed as much as possible.

All nursing homes had gardens, but in only one was one resident reported to work there; all stated that they would permit patients able and willing to do so to work in the garden, but the fact that so few do so is largely accounted for by the figures relating to disabilities in this group. Less than five per cent of all cases investigated in nursing homes had neither a physical disability nor mental deterioration due to age, and seventy-one per cent had a disability of locomotion. Sixty-nine per cent had a disability of sight, while forty-nine per cent needed regular and constant nursing care.

Equipment

Although the four terms used to describe furniture and equipment are subjective in nature, the investigator herself had a clear idea of what was implied in each term, and since all visits were made by one person, the information has value for comparative purposes.

Among philanthropic homes, five were classed as "superior"; two as "comfortable"; one as "homely"; and one as "institutional."

Of the six private homes for the aged, none was in the "superior" group; three were included under the heading "comfortable"; one was described as "homely"; and one as "institutional."

The rating of nursing homes was more difficult, as broadly speaking, the facilities required were of a different nature in this type of home. The same standards of comfort and cleanliness were applied, paying due regard to this point, with the result that of the six nursing homes visited, two were classed as "superior"; three were included under "homely" and one under "comfortable."

It must be emphasised that this rating refers only to furniture and equipment provided and its maintenance, and not to whether or not what was provided was suitable or sufficient for the actual needs of the residents, in the opinion of the investigator.

The term "institutional" does not refer to size of the establishment or to attitude of the staff, but only to the type and amount of furniture

Sex distribution

The philanthropic homes provided between them accommodation for two hundred and twenty males and five hundred and ten females. In one home only is there accommodation available for married couples, and there five couples are living at present.

In private homes visited, accommodation existed for seven men and forty-nine women at the time of enquiry.

In nursing homes, twenty-two residents were men and forty-three women, but no nursing home expressed any sex preference at all.

Two philanthropic homes take men only, four take women only, and three take both men and women, entry being obtained on criteria not including sex.

Of the six private homes, none took men only or wished to do so; three took women only, from choice, and three took residents of both sexes.

More accommodation is therefore available for women than for men in both philanthropic and private homes investigated. Where there is no objection to taking men, a larger proportion of the residents were still women.

As no nursing home expressed any preference for male or female patients, it may be assumed that accommodation was available equally for both sexes in the nursing homes visited.

All the philanthropic homes discovered after three months from the starting date of the enquiry were visited, and therefore the accommodation provided by this group can be stated with a high

degree of accuracy. It will be seen that the number of females living in this type of home is more than twice the number of males.

Of the three philanthropic homes accepting both sexes, one divides accommodation equally between the sexes and the other two decide admissions on individual merit, irrespective of the sex of the applicant.

The question remains of how much accommodation exists for each sex in private homes. As this type of home is run solely for personal profit, it seems unlikely that the sex of applicants is more important than their ability to pay a high fee, and although the homes included in the sample proved to have eighty-seven per cent of their accommodation occupied by women, the sample was small and no reliable conclusion can be drawn regarding the position in all private homes in Cape Town.

One private home expressed a preference for married couples, but stated that they were unable to find such applicants.

In looking for the reason why more provision is made in philanthropic homes for women than for men, the following points must be taken into account :-

(1) The fact that women live longer than men, and therefore there are more elderly widows and spinsters needing accommodation.

(2) The chance factor occurring in bequests and trusts, by which means most of the philanthropic homes were originally started.

Of the five philanthropic homes started by bequests, one was established by a man for aged men; two by women, for women; one by a man, for women; and one by a married couple, this being the only philanthropic home where married couples can live together.

Other grounds for preference

(1) Religion

Of the eight philanthropic homes included in the statistical analysis, one which was controlled by a church expressed no religious preference; five stated that they were definitely non-denominational; one excluded Catholics; and one provides for Jews only.

(2) Nationality

Three homes showed a predominantly English-speaking population, and one a markedly Afrikaans population, although no bias on the grounds of nationality or language were admitted by superintendents as influencing the admission policies. One home, established by a bequest from an English woman, preferred applicants born in England, but did not exclude others.

No bias could be discerned in the remaining homes.

The four homes showing bias in favour of English or Afrikaans residents could not have done so wholly accidentally, as innumerable small reflections of the differences in the way of living of the two groups were discernible when the homes were visited.

(3) Class

Two homes in the philanthropic group were described by their superintendents as catering for "ladies of the higher classes," and one which provides for both sexes has as the express object of its foundation the establishment of a home for "aged gentlefolk in reduced circumstances."

In the remaining five homes, no bias based on class could be traced.

(4) Financial circumstances

Six philanthropic homes charge fees to all residents. Two charge no fee at all, and one charges only those able to pay.

All homes, both entirely free and fee-charging, require that applicants have an income not exceeding a certain figure, but in practice it appears that there is considerable evasion of this rule, and superintendents complain that of all the inaccuracies they discover in application forms, misrepresentation of income is the most common.

Of the six homes charging fees, four charge a flat rate to all residents, while two vary the fee according to individual incomes.

The highest fee charged in a philanthropic home was £10 per month, and the lowest, £4 per month.

In one philanthropic home, widows of military pensioners are accommodated free of charge, and in one private home, retired nurses were charged a reduced rate.

In nursing homes, ability to pay the fees charged was generally the criterion for acceptance, providing the applicant's mental condition was not too severely impaired. Nursing homes were encountered which accepted patients retired from the government service whose fees, paid by a government department, were less than those normally charged, and also reductions were found where patients assisted with book-keeping or other duties.

Conditions of entry

All philanthropic homes, with one exception, have certain conditions which must be fulfilled before an applicant is accepted.

In private homes, all degrees of physical infirmity were acceptable, and only those cases where constant skilled nursing is necessary, or where the applicant's mental condition is severely impaired, are apparently refused.

Both private homes and nursing homes refuse to accept applicants whose mental condition is such that serious inconvenience to other residents would be caused, or whose behaviour is completely uncontrollable except by constant supervision.

Applicants suffering from any degree of mental deterioration have little chance of being accepted into philanthropic homes. This does not mean that residents in philanthropic homes investigated are not suffering from mental deterioration, because all such homes continue to accommodate residents whose mental faculty becomes impaired after entry, unless

The conditions of entry imposed by philanthropic homes included the following :-

(1) Production of testimonials of moral character from a reliable person of professional status.
(2) A medical certificate of freedom from infectious or chronic disease, stating that the applicant is able to care for himself in both the physical and mental meaning of the term.
(3) A guarantee, where fees are charged, that the applicant is able to pay the fees.
(4) A guarantee of funeral expenses in the case of death while resident in the home.
(5) Varying conditions regarding maximum and minimum age.
(6) Certain family and domestic situations must exist.
(7) The financial situation of the applicant must be within certain limits.

Of the eight philanthropic homes investigated, seven had regulations of varying rigidity regarding age, and seven required a medical certificate. Seven took into account the financial position of the applicant, and six required testimonials regarding his moral character.

Six considered the family and domestic situation, although in the sense that absence of family favoured the applicant, rather than possession of relatives being a factor against admission.

One home only required a written guarantee of funeral expenses.

One home stated that the only criterion applied was "need," and this included family and domestic situation as well as financial position.

Six homes took into consideration five of the factors referred to above; one considered three; and one, only two.

No one factor was found to be common to every philanthropic home's policy of selection, but character, production of a medical certificate, ahe, and financial position were the most commonly found criteria for entry.

Age limits varied between sixty and eighty years, but this rule is perhaps the least rigid of all operative factors in selection.

Two homes stated that they would accept applicants under sixty, if the need were great, and one would accept those over eighty if there were no particular physical or mental disability. Five of the eight homes stated that they had no upper age limit, and that acceptance of applicants in the seventies and eighties depended on their physical and mental condition.

The proportions of residents between the ages of sixty and eighty found in the three types of home are analysed in the following table :-

Age group	Philanthropic	Nursing	Private	Total	%
60 - 64	7	4	0	11	6
65 - 69	12	3	4	19	11
70 - 74	18	14	6	38	22
75 - 79	25	14	6	45	25
80 & over	29	14	14	57	32
Unclassified	0	4	3	7	4
Total	91	53	33	177	100

The category "eighty and over" included one male aged ninety-four and three females of ninety years, in philanthropic homes; one male of ninety and three females of ninety-one, ninety-one and ninety-two respectively, in nursing homes; and one male of ninety-two and one female of ninety-two, in private homes.

It will be seen that the category "eighty and over" accounts for the largest number of cases in the three types of home taken together, the group "seventy-five to seventy-nine" coming second. The proportion of each category in each type of home increases steadily until the age of eighty, and the fact that the number in philanthropic homes in the younger age groups increases both numerically and proportionately at a higher rate than in private homes may partly be accounted for by the fact that residence in philanthropic homes, which are generally of a high standard in Cape Town, is considered to be the next most desirable thing to an independent life, and the importance of being accepted into such a home while still in possession of physical and mental health is widely realised. On the other hand, residence in private homes is usually sought only when acceptance into a philanthropic home cannot be obtained, for some reason, and is a last resource.

Degree of security obtained by residents

The most commonly found reason for moving into all three types of home, with the exception of those entering nursing homes who did so because of the need for skilled nursing, were "domestic difficulties" and "wish for security."

Under the term "domestic difficulties" are included such factors as family friction, unsuitable family housing conditions, family in a financial position which does not permit the support of an aged relative, and death of a relative with whom applicant had been living. It was also applied in those cases where the applicant had been living alone, but was either unable or unwilling to continue doing so. The term is intended to give some idea of the proportion of residents investigated who need not have entered a home for the aged at all if certain services had been available to them and their families. The nature of these services as provided in other countries is discussed in the final chapter of the thesis.

The term "wish for security" overlaps to a considerable extent with the term "domestic difficulties" for in both types of domestic difficulty referred to in the previous paragraph, i.e. those experienced by ageing persons living with relatives, and those experienced by such persons living alone, a lack of security is involved. Those without relatives, or with no close relatives, probably suffer from anxiety about their future more than those who have families, but it would seem that the need for

event of a long illness, mental deterioration, or permanent infirmity is a very real and constant one to every ageing person.

In determining how far the homes visited fulfil this fundamental need of the aged person for security, it is necessary to analyse two factors :-

(1) Whether, after once being admitted, a resident has a home for the rest of his or her life.

(2) Whether the home has facilities for the care of residents during a long illness, or if removal to a hospital or nursing home for a long period, or until death, would be necessary.

Five philanthropic homes stated that their residents had a home for life, except for cases of severe senile dementia which were certifiable and for which admittance to a mental hospital could be obtained.

All but one of the nursing homes said that they could care for patients until recovery or death, whatever the circumstances.

Three of the six private homes said that, once having accepted a resident, they would care for him until death.

In the case of all three types of home, however, information obtained at other points during interviews indicated that <u>in no home is security of residence absolutely certain</u>.

The figures obtained from a home which accommodates more than one hundred and fifty aged women show that during one year, 0.7% of the residents left the home voluntarily, and 4%

For long illnesses, i.e. those lasting more than twenty-eight consecutive days, five philanthropic homes said they could care for residents in such circumstances; five of the six nursing homes and three of the six private homes said the same.

The position is represented in the following table :-

Type of home	Facilities for Short illness	Facilities for Long illness	Both
Philanthropic	9	5	5
Nursing homes	6	5	5
Private homes	5	3	3
Total	20	13	13

(Total number of homes visited - 21)

Therapy for the disabled

Table showing degree of disability in residents in the three types of home

Disability	Philanthropic	Private	Nursing
Sight	65%	60%	69%
Hearing	19%	50%	36%
Locomotion	10%	33%	70%
Hands	8%	18%	28%

The tables showing degree of disability and disease present in those resident in nursing homes show that this type of home has the largest proportion of residents suffering from disability of locomotion. The figures for disability of sight show no large difference from the other two types of home.

The figure for disability of the hands is significantly higher in private homes than in philanthropic homes, and considerably higher still in nursing homes.

It is clear that, in view of modern geriatric findings concerning the degree of rehabilitation possible in patients suffering from disabilities of movement, there must be a proportion of residents in each type of home included in the survey who could benefit by therapeutic efforts to improve their power of movement in both hands and legs.

Although the figures for disability of locomotion and of hands are highest in the nursing home group, it is doubtful whether this group is, in fact, the one where the most benefit could be obtained by therapy especially directed to relief of disabilities of hands and legs. In a large proportion of the cases of residents in nursing homes, disability of locomotion is the result of weakness directly resulting from a particular disease, and in the case of cardiac patients, it is the result of restrictions placed on the patient by the disease, rather than from actual inability to walk normally.

Nevertheless, the relation between disability of locomotion and of hands showed that in nursing homes 24.4% of the residents suffer from both disabilities, indicating the presence of such disabling conditions as rheumatism, arthritis, and paraplegia, for which special therapeutic measures can do much.

In philanthropic homes, where residents are generally expected to be able to care for themselves, at least on entry, 10% suffer from disability of locomotion. It was not possible to discover whether the disability was caused by infirmity, by conditions of the muscles and joints, or by foot ailments to which chiropody could be applied. However, in view of Dr. Sheldon's conclusion regarding the random sample of old people living in their homes in Wolverhampton, which he studied, that pain in the feet is a very important cause of disability of locomotion in old people, it is probable that provision of a chiropody service in the homes would assist a considerable proportion of those suffering from this type of disability.

Disability of sight was the most common single disability found, and was also present in the majority of cases where more than one disability occurred in the same person.

In all homes except one philanthropic home for men, the majority of those needing spectacles had them.

Of the total number of cases in the sample, six had sight in one eye only, four were described as "blind," three were totally blind, and one had vision so defective that it was unsafe for her to leave the home alone.

In all homes except one philanthropic home for men, the majority of those who needed dentures had them.

Of those who had a disability of hearing (30.1% of the total sample) only 5.5% used a hearing aid, and 85% of those described as "partially deaf" used no aid. It was not possible to discover whether these cases could benefit by the use of hearing aids, but it seems probable that a proportion of them could.

Only three homes of the total visited stated that they had a rehabilitation programme for residents with disabilities, and all were of the philanthropic type. The facilities available included the services of a qualified masseur, chiropodist and diathermy expert, in the home.

Practice of preventive medicine

None of the homes visited can be stated to have a really effective policy of preventive medicine, as the term is understood in the light of the most recent geriatric progress.

However, the principles of dietetics, occupational therapy and regular preventive inspection to the age group over sixty were appreciated and put into practice as follows :-

	Philanthropic	Nursing	Private	Total
Dietetics	3	4	3	10
Occupational therapy	2	0	0	2
Preventive inspection	2	2	0	4
Total	7	6	3	16

Total number of homes visited, 9,6,6 = 21

It would seem that, except in the field of dietetics, philanthropic homes are giving the lead and have a more enlightened attitude and policy regarding the preventive and curative aspects of geriatrics than the other two types of home. In private homes, especially, is there room for much improvement.

Recreational facilities

The value of facilities for recreation for residents in old age homes has been demonstrated by experienced workers in this field.

People as they grow older become less inclined to seek out occupation for themselves; they become doubtful about their ability to participate in occupations well within their powers in fact, and, in common with other age groups, have only the haziest ideas of what they would like to do with their leisure time.

A recreational programme is not, however, only a means of passing the time pleasantly for residents in homes, but has a place in social medicine in giving that interest in life which is so essential to the prevention of mental deterioration, and is also invaluable in keeping residents as active as possible and so postponing physical infirmity.

Because of a certain mental inertia, which, combined with decreasing physical energy, makes the age group under consideration more in need of leadership in this field than other age groups,

it is essential that homes have an official policy concerning the recreational activities of residents, and an active programme putting the policy into practice.

It is, at the same time, important that old people should not be regimented into organised recreation, nor bullied into participating in activities which their own good sense tells them is beyond their powers. For this reason it is important that the superintendent of a home be a person with training in group leadership, as well as having extensive experience of the special psychological aspects of dealing with old people. In very large homes, the services of a qualified social worker with special training in group work with the elderly is the ideal, as yet unattained in any of the homes investigated.

The problem is complicated by the special difficulties, both physical and mental, with which old age is confronted, but it is not insoluble.

Five of the philanthropic homes stated that they had recreational programmes. The nursing homes were not expected to provide this type of service and none did so. None of the private homes visited provides any facilities for recreation at all.

The facilities provided by the philanthropic homes consist in library, cinema, concerts and film shows given by voluntary organisations, organised religious meetings, and very rarely, excursions into the country and to the theatre and cinema.

Several have indoor games of various kinds, but none provides any outdoor game such as bowls or croquet which require comparatively little expenditure of physical energy.

In both philanthropic and private homes, card games were reported to be a favourite pastime with both men and women.

In seven philanthropic homes visited, residents were allowed to help with gardening, and in three, a number of residents had their own plots which they could cultivate as they wished.

In one large home for women, individual gardens are intensively cultivated by twelve per cent of the residents, and the superintendent speaks highly of their beneficial effect on the physical health of the gardeners, as well as the pride and satisfaction they afford.

The women do all the necessary work themselves, even the heavier tasks, and there is an interesting difference in the amount of ingenuity used to make the most of the small area, and the difference in the layout of the plots and the flowers chosen is striking; there are rose gardens, rock gardens, cactus gardens, and some are just gardens, where anything that grows is welcome and lovingly tended.

It is obvious that where such schemes are operating, as residents pass from being merely elderly to advanced old age, even the lightest activities in a garden will not be suitable for the majority of them.

Contact with outside organisations

Three philanthropic homes either owned or controlled by churches reported regular visiting by church clubs; five philanthropic homes said that the Rotary Club visited them regularly to show films; two were receiving regular visits from Toc H; and two from the Western Province Charity Bioscope.

Not one of the nursing homes or private homes was visited by any voluntary organisation, except for the B.E.S.L. Women's Section, which visited two nursing homes once monthly. The visitors establish friendly contact with ex-service residents, distribute magazines and cigarettes, and will carry out any small task such as shopping or exchange of library books, which they are asked to do.

Of all homes visited, seveteen stated that ministers of religion visited members of their churches regularly. Four said that ministers of religion visit residents when requested to do so only. Contact with church representatives was therefore theoretically available to all residents in homes who desired it.

Period of residence

The philanthropic homes reported that they had residents who have lived there for periods from two to thirty-six years, as well as those who have entered the home during the last two years.

The shortest period spent by any resident in any one home at the time of enquiry was six months, and the longest four years, in respect of nursing homes.

In private homes the shortest period spent was thirteen months, and the longest, six years.

Rules

Most authorities on the administration of homes for the aged agree that there should be as few rules as possible, and then only those which are required for the smooth running of the home and the comfort of the residents as a group.

Of the philanthropic homes visited, none was found to have unreasonably restrictive rules. In the majority, the number and type of rules was such as may be found in any hotel, boarding house or other establishment where people live in groups.

In all philanthropic homes, visitors were allowed at any reasonable time. In two homes no alcohol may be taken into the home. In only one are residents not allowed to stay in bed when not ill, and this is a reflection of the home's policy of keeping residents active and occupied as much as possible.

Of the six private homes visited, only one admitted to a restriction of visitors to afternoons only, and did not allow residents to stay in bed when not ill. Again, the latter is a corollary

of the matron's policy of getting residents out of bed daily for as long as possible.

No unduly restrictive rules were found in any nursing home visited. In all nursing homes visiting was restricted to the usual visiting hours for nursing homes and cannot therefore be considered unreasonable.

Facilities for privacy

Seven of the nine philanthropic homes provide each resident with a private room, and in four cases the rooms are equipped as bed-sitting rooms. The other two homes in this group provide cubicles in dormitories.

Five nursing homes have private rooms, three have rooms with two beds, seven have rooms with three beds, and five have rooms containing up to six beds.

Six private homes have residents living in private rooms, four have rooms shared by two persons, and two have three people sharing one room. No private home visited had more than three persons sharing any one room.

Where more than one person lived in a room, facilities for storing personal effects could not be considered satisfactory.

Fees charged

1. Philanthropic homes

Two homes provided board and lodging entirely free, including free me ical attention. One further home was free to those unable to pay the fee.

The remainder charged fees as follows :-

£4 per month, including laundry; no variation
£5 " " "
£6/6/- " " "
£4/10/- to £7/10/- " depending on income
£9 to £10 per month " "
£5/10/- " " no variation

2. Nursing homes

12/6 to 25/- per day (£17/10/- to £35 per month)
25/- to 45/- " (£35 to £60 ")
20/- to 30/- " (£30 to £45 ")
21/- " (£30 per month, retired nurses £20 per month)
30/- to £2/12/6 " (£45 to £70 per month)
£30 per month, or less by arrangement

3. Private homes

£16 to £25 per month, including laundry
£9/10/- to £20 " "
£16/16/- " "
£26/5/- " "
£18/10/- to £23/10/- "
£9/10/- to £25 per month, "

It will be seen that nursing homes, as would be expected, charged the highest fees. Fees in this type of home varied according to whether a private room was occupied, and the amount of attention needed. Generally speaking, a high fee and a high standard of equipment and service were found together.

The highest fee charged by a philanthropic home was £10 per month, and in this home the lowest fee paid was £9 per month, meaning that unless a resident had some private income, he was dependent on others for personal expenses. In the remainder of the philanthropic homes, it was possible for an old age pensioner to live and have a reasonable amount of money left from the pension for personal use.

Since it was not possible to obtain information about the incomes of residents in nursing homes, no estimate could be made of the financial burden placed on residents or their relatives, or both, by the high fees charged there.

Although private homes exist which charge the amount of the old age pension only, this is done only where the resident has no other income at all, and therefore these people are left penniless when their fees are paid.

Fees in private homes were always found to be adjustable to applicants' incomes, except that no case was found of a private home charging less than the full amount of the old age pension, whereas the ceiling fee varied according to ability to pay.

No private home was discovered in the sample which charged more than £26/5/- per month.
No strong positive correlation existed between the fees charged and the quality of the service given. While there are shrewd owners of private homes who charge the highest fee they can obtain for very

inferior service, there were others who are providing excellent care and attention for a fee which must give them only a small margin of profit.

All private homes stated that where residents were accommodated for the amount of their pension only, it would be essential to have also several residents paying a much higher fee for the minimum attention. In other words, those able to pay high fees are subsidising those who cannot do so.

Waiting lists

Every philanthropic home in Cape Town has a long waiting list, and the estimated average time between filing an application and entry into the home varies from six months to three years.

There would seem to be no difficulty in obtaining accommodation in nursing homes for those aged patients who are able to pay the fees charged.

Private homes reported that they had no difficulty in obtaining the maximum number of residents they are able to accommodate, and although none keeps a waiting list, all stated that they were continually receiving applications which they could not accept.

PART TWO

Chapter Three

Definitions
Accuracy of information
Analysis of sample by age, sex and marital state.
Diseases and disabilities
Mental condition
Factors associated with mental impairment
Family situation and number of visits
Previous residence and reasons for moving

Chapter Four

Conclusions and recommendations
Types of homes required
Problems common to all homes for the aged
Categories for which homes should provide
Functions of homes in the survey
The problems involved in keeping the aged out of institutions

Chapter Three

One Schedule B was filled in for each case included in the sample taken from the homes visited. In order to secure co-operation of staff more easily and to ensure complete anonymity for all cases included in the survey, no space was included on the Schedule for the name or private address of any individual subject.

The investigator is satisfied that information given concerning the physical condition of the sample is substantially accurate. Some variation was found in the terms used to describe certain diseases, according to whether the informant had medical training or not, but all information was classified for the investigator by a medical practitioner.

There was no difficulty in obtaining an opinion on the mental state of the subject in any of the cases investigated. Where the subject had been stated by his medical attendant to be suffering from senile dementia, this was recorded on the schedule; in other cases, the symptoms were described under the heading "signs of mental deterioration."

Information concerning the previous life of the subject and his present sociological condition was more difficult to obtain. In too many cases, this information was completely unknown to staff, and in others, those in attendance on the subject had no knowledge, although the information

It proved impossible to obtain for purposes of statistical analysis information regarding the amount and source of income of the sample.

Only for those whose sole income is the old age pension was this possible. In philanthropic homes where an income ceiling is fixed, it can be stated that almost none of the residents had an income above this level; in private homes and nursing homes staff had no knowledge of residents' incomes.

It was explained to all superintendents and matrons that information concerning family status, nearest relative living, number of visits received, previous residence and reason for move, were intended to facilitate an estimation of the subject's social isolation, and were therefore to be used for sociological and not social welfare purposes.. Nevertheless, this information proved most difficult to obtain, and in one case the superintendent of a large philanthropic home declined to give the information, although she was in possession of it, on the ground that she did not see its relevance and that it was in any case of a too personal nature. Full information regarding the medical condition of the sample taken was obtained from this home.

Definition of terms

The use of the words "regular" and "intermittent" in connection with medical attention needs some clarification. The terms refer to medical attention both at the time of enquiry and during 1953,

and where a different answer applied, this was indicated on the schedule.

The term "regular" was used to denote treatment or supervision by a medical practitioner who understood that the patient was in his care continuously.

The term "intermittent" was used in those cases where an interval of more than one month elapsed between the occasions on which the physician was called in for a particular purpose.

The use of the terms "healthy, infirm, sick or bedridden" involved difficulty only in the distinction between the infirm and the sick. A degree of infirmity is implied in sickness, but in practice the use of the term "infirm" was confined to those who but for the infirmity would have been described as "healthy," and where infirmity was correlated with sickness, the subject was described as "sick."

The term "bedridden" applies to those who could not leave their beds for any purpose, but also to others who could not do so without actually being lifted by others, and who without such assistance would not be able to leave their beds at all. A number of those described as "bedridden" then do, in fact, spend some time in rooms other than their bedrooms.

It proved extremely difficult to decide whether certain diseases should be included under the category of "curable" or "incurable"; it was

decided, for instance, to classify cancer as a curable disease, unless the subject was in the last stage of the disease and in the opinion of the informant, would die from that cause. The medical practitioner who supervised the classification of this section of the information decided to include "stroke" under incurable diseases, since although recovery might be complete from one attack, in this age group the onset of further, and eventually fatal, attacks is probable.

It was impossible to obtain opinions about the expectation of life of those who were diseased, unless subjects were almost moribund already. As the survey proceeded, it was realised that even the medical practitioner in charge of the case could give only a guess on this point in the majority of cases, and it was therefore excluded from the remainder of the cases under enquiry.

The question relating to disability of sight referred to any disability of sight, however mild, although it was realised that in this age group to find no disability of sight at all would be very rare. "No disability of sight" was therefore taken to mean vision without spectacles which was satisfactory to the individual for all purposes.

The same criteria were taken for disabilities of hearing, locomotion, and disability of the hands. It was realised that some disabilities are so common that they may be considered normal for age, but the difficulty of defining what is "normal" and what is not for the purposes of enumeration was so great that

it was decided to include any degree of disability at all under these two questions, so that any interested person may allow for his own opinion of what is "normal" disability for the relevant age group, in applying the figures for any particular purpose.

Under the question relating to ability of the subject to leave the grounds alone, not only the ability to walk this distance was taken into account, but also eyesight, liability to vertigo, and pathological fear of walking alone, of falling, and of traffic were also considered.

Under question twenty-two relating to incontinence, any degree of incontinence at all was recorded affirmatively.

Table showing number and percentage of subjects in each age group under medical attention at the time of the enquiry

Age group	Philanthropic		Private		Nursing		Total	%age
	M.	F.	M.	F.	M.	F.		
60 - 64	2	5	0	0	2	2	11	100
65 - 69	2	2	0	3	1	2	10	50
70 - 74	1	6	1	2	4	11	25	65.4
75 - 79	3	8	1	5	2	5	24	52.2
80 & over	6	11	3	10	7	7	44	77.2
Total	14	32	5	20	16	27	114	

This table shows that at the time of enquiry, 65% of the total sample was under medical attention.

Of the total male sample, 66% were under medical attention at the time of enquiry; of the female sample, 63.7%. There was thus no significant

difference in the proportion of the sample of each sex which was under medical attention.

Comparison with the figures given by Dr. Sheldon for the random sample investigated by him in Wolverhampton shows that 24.5% of his male sample and 28.7% of his female sample were under medical attention at the time of enquiry. Allowing for the fact that residents in nursing homes would normally be in a worse physical condition than old persons living in their homes, the proportion of residents in nursing homes included in the present investigation would not appear to account for so large a difference, and it may therefore be concluded that the physical condition of residents in philanthropic and private homes investigated is appreciably worse than might be expected to exist in any aged urban population living at home.

The proportion of all males under medical treatment over the age of eighty is 100%, and of all females in the same age group, 68.3% were under medical attention at the time of enquiry. The amount of medical attention received by both males and females increased very considerably after the age of eighty, and the proportion of men is appreciably greater than women. In view of this result, it is interesting to note Dr. Sheldon's findings regarding old people living in their homes in Wolverhampton, that after the age of eighty the proportion of men receiving medical treatment falls abruptly, while the opposite occurs with women.

The size of the sample in the present survey prevents any conclusive finding on this point, but the results would seem to indicate that residents over eighty in old age homes are not as fit as those in the same age group living at home.

While all males in philanthropic homes over the age of eighty were under medical attention, the proportion of females in the same category was only 50%.

The following table gives details of the medical treatment being received by the whole sample, irrespective of sex :-

Age	Total number in sample	Number under treatment	Percentage of sample
60 - 64	11	11	100%
65 - 69	20	10	50%
70 - 74	39	25	64%
75 - 79	46	24	53%
80 & over	47	44	93%
Total	163	114	

Unclassifiable - 14 cases

It will be seen that the age group 60-64 was receiving more medical treatment than any other, including the most advanced ages. 6.2% of the whole sample came into this age group, and of all residents investigated in nursing homes, 7.5% were between sixty and sixty-four years old.

Common diseases

7.3% of the sample suffered from various cardiac complaints
6.45% suffered from arteriosclerosis
6.45% had arthritis in both forms
4.4% had hypertension
4.4% were described as having "had a stroke"
3.9% suffered from chronic bronchitis
3.3% had, or were recovering from, cancer
3.3% had Parkinson's disease
2.08% were diabetic

The above figures refer only to those conditions for which subjects were under medical treatment, and the actual incidence of such conditions as arteriosclerosis, hypertension, and chronic bronchitis would in all probability be much higher.

Of the 65% of the total sample under medical attention at the time of enquiry, 46% were suffering from a disease which was stated, and which was the cause of the medical attention.

41.7% of the residents in philanthropic homes were under medical attention because of actual disease, 49.5% of residents in nursing homes, and 51% of residents in private homes. There is thus an appreciable difference in the residents in the three types of home who have diseases for which medical attention is necessary.

Of the total number of residents in the three types of home, the following proportions were under medical attention at the time of enquiry :-

Philanthropic homes	:	50.5%
Nursing homes	:	81.1%
Private homes	:	75.7%

It would appear, therefore, that residents in philanthropic homes are healthier than those in private homes, where the physical condition of residents is very little better than that of residents in nursing homes.

6.7% of the residents in philanthropic homes were stated to be incontinent; 39% of residents in nursing homes; and 3.01% in private homes. It is not known to what extent the presence of some degree of incontinence is unfavourable to an applicant wishing to enter an old age home, but the fact that this question is included on application forms indicates its importance in selection. It is to be expected that the highest proportion of incontinent subjects would be found in nursing homes, where the highest proportion of diseased and infirm persons are living, and of course this type of home is best equipped to handle such cases.

The incontinent case is the one least wanted by any type of home, and the fact that this question is estimated by superintendents to be the next least truthfully answered after the one relating to income, indicates that incontinence may be an important contributory factor to the placing of aged relatives in homes.

It was impossible to discover how many of the incontinent cases were suffering from the condition when they entered the home, but in view of the long waiting lists in all homes, it is not likely that such cases would be chosen.

Medical attention during 1953

Age group	Philanthropic		Nursing		Private		Total	%
	No.	%age	No.	%age	No.	%age		
60 - 64	7	7.6	4	7.5	0	0	11	6.3
65 - 69	6	6.6	3	5.6	4	12	13	7.5
70 - 74	13	14.3	12	23	6	18	31	17.7
75 - 79	14	15.4	8	15	6	18	28	16.0
80 & over	24	26.4	15	28	14	42	53	30.3
Total	64	70.3	42	79.3	30	90.9	136	77.8

It is seen that 77.8% of the total sample had been under medical attention during 1953, against 65% at the time of enquiry. Comparison of these figures for the three types of home gives the following result :-

	1953	At enquiry
Philanthropic homes	70.33%	50.5%
Nursing homes	79.3 %	81.1%
Private homes	90.9%	76.0%

Of the one hundred and thirty-six subjects under medical attention during 1953, 35.3% received such attention regularly.

Disabilities

Disability of sight was common in all types of home, and was the most frequently encountered single disability. Generally speaking, females in all three types of home suffered more disabilities than males.

Table showing percentages of males and females in each type of home suffering from disabilities of sight, hearing, locomotion and hands

Disability	Philanthropic		Nursing		Private	
	M.	F.	M.	F.	M.	F.
Sight	51.8	71.1	63.2	73.5	57.1	73.1
Hearing	25.1	17.2	31.5	38.2	42.8	53.8
Locomotion	3.7	12.5	63.2	76.5	28.5	34.6
Hands	7.4	7.8	21.1	32.3	14.3	19.2

It is significant that only 63.2% of all males investigated in nursing homes, and 76.5% of all females, suffered a disability of locomotion. This fact will be referred to again in the discussion of how far old age homes and nursing homes overlap in function, in the final chapter of the thesis.

Hearing

Surprisingly few of the total number of cases in the survey were reported to be totally deaf (2.9% of the whole sample), but of those classified as partially deaf (28% of the total sample) only 17% were using hearing aids.

Disability of both sight and hearing was found in only 7.75% of the total sample.

Multiple disabilities

The following table shows the number of cases in the three types of home suffering from one, two, three and four disabilities :-

Age group	Private				Nursing				Philan-thropic				Total	%
	1	2	3	4	1	2	3	4	1	2	3	4		
60 - 64	0	0	0	0	1	2	0	1	4	0	0	0	8	72.7
65 - 69	3	2	0	1	1	1	1	0	5	1	0	0	15	75.0
70 - 74	4	2	0	0	2	5	6	0	10	3	0	0	32	82.0
75 - 79	1	3	2	0	2	1	5	0	15	3	1	0	33	71.7
80 & over	5	3	5	0	0	4	9	1	10	10	3	1	51	89.4
Total	13	10	7	1	6	13	21	2	44	17	4	1	139	79.4

The percentage of subjects in each age group suffering from some disability was highest, as would be expected, in the group "80 and over." It is perhaps more surprising that the lowest proportion of subjects with a disability is found in the group "75 - 79."

While 100% of the age group 60-64 was under medical attention at the time of enquiry, only 72.7% in this age group were reported as having one or more of the disabilities recorded.

79.4% of the total sample suffered from one or more of the disabilities investigated.

2.24% of the sample had all four disabilities listed.

Even in the age groups 75-79 and 80 and over, there are cases with only one disability, although it would be expected that from the age of seventy upwards, the number of disabilities suffered by subjects would increase.

Of all males in the sample aged eighty and over, 43.7% suffered from multiple disabilities; in each case three disabilities were recorded.

Of all females in the sample aged eighty and over, 29.3% suffered from multiple disabilities; 33% of those with multiple disabilities had two disabilities, 58.3% had three disabilities, and 8.3% had all four.

Connection between physical disabilities and mental condition

Investigations in this field have shown that there is a higher positive correlation between the sociological circumstances of aged persons and their mental condition, than between their physical and mental condition.

Since at least three of the four disabilities listed on Schedule B have a restrictive effect on social contacts and activities, particular attention was paid to the connection between physical disabilities and mental deterioration in the survey.

The following table shows the position found :-

PART ONE

Chapter One

Discovery and choice of units
Research method
Objects of the survey
The schedules used
Definitions of terms

Chapter Two

Description of the Homes visited :-

(a) Size
(b) Registration
(c) Buildings and equipment
(d) Sex distribution
(e) Bases for selection
(f) Conditions of entry
(g) Degree of security given
(h) Therapy for the disabled
(i) Practice of preventive medicine
(j) Recreational facilities
(k) Contact with outside organisations
(l) Period of residence
(m) Rules
(n) Facilities for privacy.
(o) Fees charged
(p) Waiting lists

	Philanthropic		Nursing		Private		Total
	M.	F.	M.	F.	M.	F.	
Physical disability only	55.5	66.5	52.6	41.1	43	61.5	57.7
Mental deterioration only	7.5	6.4	0	0	0	3.8	4.0
Both of the above	7.5	9.6	31.5	35.2	28.5	30.6	20.5

The proportion of subjects with both physical disabilities and mental deterioration was highest in nursing homes, where none of the subjects had neither one nor the other. No cases in nursing homes showed mental deterioration unaccompanied by any physical disability.

The highest proportion of cases having neither physical nor mental disability was found in philanthropic homes, and the proportion was appreciably higher for men than for women.

In the Wolverhampton survey carried out by Dr. Sheldon it was found that 88.7% of old people living in their homes could be classified as mentally normal. The fact that in the present survey 4% of the sample suffered from mental deterioration due to age only, and 20.5% of the sample suffered from a physical disability and from mental deterioration due to age, gives a figure of 75.5% of the sample who were described as mentally normal. In the light of this result it is interesting to note that Dr. Sheldon found that the general health of old people living in their homes was distinctly better than their physical health.

Those subjects suffering from mental deterioration due to age, but having no physical disability, comprise the smallest group, i.e. 4% of the total sample.

are needed for those suffering from mental deterioration; and the burden placed by this group on the staff of homes not intended originally to deal with such cases.

In this connection, information concerning the amount of supervision required is important, and is given in the following table :-

Attention needed	Philanthropic		Nursing		Private		Total
	M.	F.	M.	F.	M.	F.	
Constant nursing	0	3.1	52.6	47	0	3.8	16.2
Assistance with dressing	5.4	7.8	31.5	17.6	28.5	38.4	17.7
Constant supervision	10.8	12.5	15.7	26.4	28.5	26.9	18.8

35.4% of the total sample needed constant care in the form of nursing or supervision, and a total of 52.7% of the sample needed attention from staff, of all types. Only 47.3% of all subjects, therefore, were able to care for themselves both physically and mentally without individual attention from staff.

The proportion of subjects needing constant nursing care is of course weighted by the large number in nursing homes who are in this condition; the position in the other two types of home was that 2.2% of both sexes in philanthropic homes needed constant nursing, and 3.03% of both sexes in private homes.

The broad fact emerges that only 47.3% of the sample was capable of self care for all purposes. Of those living in philanthropic and private homes, who might be expected to be more capable of self-care than those living in nursing homes, a total of 34.6% of the total sample taken from these two types of home needed constant attention of some kind, leaving 65.4% capable of self-care for all purposes in philanthropic and private homes.

The capacity for self-care was approached from both the physical and mental standpoints; if a person was capable of self-care physically, but due to his mental condition needed continual supervision, he was recorded as not capable of self-care. By the same rule, a person mentally capable of self-care for all purposes, but needing constant assistance from others because of a physical handicap, was also recorded as not capable of self-care. The object of the question, as already indicated, was to give a broad idea of the need for staffing and other facilities.

The general impression throughout the survey was that residents in private homes are in a worse condition, both mentally and physically, than residents in philanthropic homes, is supported by the results of the question relating to self-care, which shows that 23.1% of all residents in philanthropic homes investigated needed constant attention of some kind, from nursing to help with dressing, whereas 66.6% of residents investigated in private homes needed such attention.

Psychological changes of old age

One superintendent of a lrge home who has twenty years' experience of dealing with the aged described them as being "selfish, cruel, and liars."

It is generally considered to be true that the traits possessed by an individual throughout life tend to become exaggerated in later years, and as much as selfishness, cruelty and untruthfulness are human characteristics, the quoted statement is no doubt true. Nevertheless, the principle cannot be expected to work negatively only, and it might reasonably be expected that both desirable and undesirable traits become stronger in old age.

If this is true, it becomes of prime importance that education for old age should begin early in life, in order that preparation may be made not only for the physical decline which is the inevitable lot of the majority of people, but also for the changing perspective of age, and for its different values and new sociological status.

In discussing this subject, it is interesting to note that opinion expressed by several superintendents that the mental deterioration of old age (including its severe form, senile dementia) is due to a lack of emotional balance in the personality, and not to events in the life history.

Conversely, two doctors with spychiatric training and six superintendents and matrons of old age homes whose opinions on this subject were requested, stated that they believed the life pattern to have the greater influence on mental

condition in old age, both as regards the presence of deterioration and the particular form it takes.

Authoritative opinion, whether of the heredity or environment school, agrees that much of the mental deterioration of old age is preventable by avoidance as far as possible of emotional shock and sudden violent environmental changes, and that loneliness and a sense of futility contribute very highly to mental decline in the elderly.

Factors associated with mental impairment

In a recent work on the problems of old age, geriatrician Dr. Trevor Howell stated that "happiness in the aged is more closely associated with psychological condition than physical health," and went on to point out that about one quarter of the hospital beds in Great Britain for old people are occupied by cases of mental disorder. +

Other studies have shown that mental disorder is the most common complaint of old age, accounting for a larger proportion of cases than cardiac complaints, cancer, or any other condition.

It is clear, therefore, that more understanding is necessary of the psychological process of ageing, and of what sociological factors are correlated with mental disorder in old age. Even where the mental condition has a physical basis, as in arteriosclerosis, there are important precipitating factors of a sociological nature.

+ "Our Advancing Years," by Trevor Howell, M.R.C.P.

which would bring a good deal of pleasure into their lives; and in those cases where financial assistance is needed from children, the resident can hardly avoid the feeling that he is a burden on children who are probably themselves in an unstable financial position.

In those cases where income was old age pension only, and where these were accepted by private homes, either no money at all or very little was left to residents for personal expenses. Bearing in mind that the cost per head of providing accommodation, with free medical treatment, at one of the best philanthropic homes was £24 per month, it is still very questionable whether board and lodging and nursing attention can be provided of an adequate standard for the amount of the pension. In several private homes, the full amount of the pension was accepted for board and lodging, and children or other relatives made themselves responsible for doctors' and chemists' accounts, as well as for the provision of clothing and other personal needs.

The survey shows up a great need for provision of philanthropic homes for both men and women who have no other source of income than their pension. In homes where no charge at all is made for accommodation, the resident in receipt of an old age pension is in a comfortable position, and even where a charge of four or five pounds is made, a reasonable balance is left to allow the resident to be independent of relatives and friends for items of personal expenditure.

The absence of money for personal expenses is an important factor contributing to social isolation, for without some money for club subscriptions, church collections, bus fare and similar items, social contacts for the physically and mentally fit are cut to the minimum of well-disposed friends and relatives. Here is an important cause of withdrawal into the life of the home, and its eventual corollary, physical and mental deterioration.

As already stated, 7.9% of the sample suffered disability of locomotion and mental deterioration of some degree, but as 43% of the cases were over eighty, where both kinds of disability would be expected to some extent, no reliable conclusion can be drawn from these figures regarding the effect of limitation of movement on mental condition.

Significant agreement was found among superintendents and matrons of all types of home regarding the important connection between activity and happiness for old people. Reference has been made elsewhere in the thesis to the extent to which this principle is put into practice in the homes visited.

Sociological factors influencing mental impairment

Both Sheldon and Rowntree in their surveys of old people in their homes found happiness and efficiency dependent on the nearness of relatives

to a very large extent, and this applied even to those who were able to lead an independent life alone.

For the purpose of the present investigation, it was decided to include marital state, family situation and number of visits received as a simple means of measuring degree of social isolation.

The assessment of loneliness is almost impossible to achieve objectively, particularly when the subject himself is not interviewed personally. The term "loneliness" is in itself a vague one, as it may imply either physical isolation, or mental distress, or both, and it has different meanings for different people.

It was realised at the time of enquiry that a subject may be very active both inside and outside the home, receiving regular and frequent visits, and still suffer deeply from spiritual desolation. Because it is accepted that effective social contacts do minimise the effects of even this type of loneliness, the amount and frequency of such contacts may be used in measuring the condition generally described as "loneliness," and without the use of psychiatric or intensive social work techniques, is the only measurement which can be conveniently used.

Connection between marital state and mental condition

Marital state	Normal	Some impairment	Senile dementia	Whole sample
Married	61.01	27.7	11.1	10.3
Widowed	73.9	14.7	11.3	65.7
Divorced	100.0	0	0	1.1
Never married	66.6	16.6	11.8	24.0

The number of persons in the sample who were divorced or separated was too small for any conclusions to be drawn for this group.

Among the married, widowed and never married, the proportions suffering from senile dementia are strikingly similar. Although the highest proportion suffering from some mental impairment occurs in the married group, the size of the sample of married subjects was again not large enough to give conclusive results.

Of the widowed group, however, which comprised 65% of the total sample, 73.9% were classified as mentally normal, and among those who were never married, which group totalled 24% of the sample, 66.6% were mentally normal. This would seem to indicate that in the subjects investigated, neither widowhood nor being unmarried has any strong positive correlation with mental impairment in old age.

Connection between family situation and mental condition

Nearest relative	Some mental impairment	Senile dementia
Spouse	10%	8%
Child	24%	17%
Brother, sister	4%	14%
Nephew, niece	4%	14%
Other relative	27%	14%
No relatives	14%	28%
Unclassifiable	17%	5%
Total	100	100

Of those suffering from some mental impairment, the proportions whose nearest relative was a child and whose nearest relative was a distant one, were largest.

The group suffering from senile dementia showed a distinctly higher proportion of those having no relatives than any other category. This group is seen to be more than twice as large as the proportion of mentally impaired having no relatives, strongly suggesting that lack of family contacts is positively correlated in these cases with severe mental deterioration, although this conclusion may be modified by the presence in the sample of a large proportion of subjects over eighty who had senile dementia; this age group would be expected to have the fewest family contacts, since a spouse as well as brothers, sisters and other relatives are frequently outlived by this age. It is, of course, impossible to assess how many of the subjects described as suffering from "some mental

Connection between visits received and mental condition

This information was unobtainable for 9.7% of the total sample, and percentage calculations are made on the 90.3% of the sample for whom the information was recorded.

10.1% of the cases classifiable were mentally normal and receiving no visits.

0.6% of the cases classifiable were suffering some mental impairment and receiving no visits.

3.8% were senile, and receiving no visits.

14.5% of the total number of cases classifiable were receiving no visits at all.

62.02% of the cases classifiable were mentally normal and receiving visits. The proportions of those in the two groups showing mental impairment and receiving visits were 13.9%, and in the senile group 9.5% of the total number of cases classifiable.

Of all the cases classifiable who were not receiving visits at all, 10.1% belonged in the normal category; .6% to those showing some mental impairment; and 3.9% to those classified as demented.

It cannot therefore be concluded that attention or neglect from relatives contributes significantly to mental deterioration in the subjects investigated, but it must be borne in mind that the receiving of visits does not in itself indicate a good relationship between the subject and his visitors. No doubt many visit from a sense of duty only; others are representatives of churches and voluntary organisations and have no direct personal interest in

the case; nor can the ulterior motive be ruled out, as according to the accounts all superintendents give neglectful relatives frequently become very actively on the scene after death has occurred.

The most valuable fact which emerges from enquiry on this point is that almost 15% of the total number of cases investigated in all types of home never receive a vist at all.

Those receiving "occasional visits" amounted to 7.5% of the total sample.

Therefore, the percentage of the whole sample which can be stated to be in a satisfactory position as far as the receiving of visits is concerned amounts to only 77.8%.

Connection between family situation and number of visits

Of the total number of cases classifiable on this point, those having no relatives and receiving no visits constitute 10% of the total.

3.7% of the classifiable cases had no relatives, but receive visits from other sources.

5% of the classifiable cases had relatives who did not visit them at all.

70% of the classifiable cases were receiving visits from a spouse, child, or other relative.

Previous residence and reasons for moving

Table showing previous residence of males and females in all types of home

Previous residence	Philanthropic		Nursing		Private		Total
	M.	F.	M.	F.	M.	F.	
Alone	26	16	0	12	14	8	13%
Family	59	41	32	44	43	54	46%
Friends	4	6	10	21	0	4	5%
Hotel	0	0	16	9	29	4	5%
Lodgings	0	0	0	3	14	8	2%
Other institutions	7	6	11	0	0	22	8%
Unclassifiable	4	31	31	11	0	0	21%
Total	100	100	100	100	100	100	100

Of residents of both sexes in philanthropic homes, 18.6% had lived alone previous to entering the home; 7.5% of both sexes in nursing homes had done so; and 9.1% in private homes.

45.7% of the total sample had lived with relatives. 46.1% of residents of both sexes in philanthropic homes had done so; 3.9% in nursing homes; and 51.5% in private homes.

5.1% of the total sample classifiable had lived with friends. 5.5% of residents in philanthropic homes lived previously with friends; 5.6% of residents of both sexes in nursing homes; and in private homes, 3.03%.

5.1% of the total sample had lived in hotels. None of the residents in philanthropic homes had moved there from an hotel; in nursing homes, 11.3% of residents of both sexes investigated had done so; and 9.09% of those in private homes.

2.2% of the total sample had lived in lodgings. No residents in philanthropic homes had done so; in nursing homes, 1.8%; and in private homes, 9.09%.

8% of the total sample had lived previously in another institution of some kind.

20.9% of the whole sample was unclassifiable, due to information either being refused or not known.

The largest proportion of residents investigated in all the homes visited had lived previously with relatives - a total of 45.7% of the whole sample. The smallest proportion who had lived with relatives was found in nursing homes; the most frequent previous residence for this group was either an hotel or alone in own home.

The percentage in philanthropic homes who had lived alone was greater than the same percentage for the whole sample, bearing out the general impression that most applicants enter philanthropic homes because of a wish for the security which such homes offer in varying degrees. The fact that 46.1% of residents in philanthropic homes and 51.5% in private homes had lived with relatives indicates that absence of family ties is <u>not</u> the primary cause of entry into these two types of home. Domestic difficulties and the wish for security were given by superintendents as the main reasons for application, and this would seem to be confirmed by the above figures.

17% of all cases investigated in nursing homes had no relatives, whereas 24% of all cases in philanthropic homes had none, and 21.2% in private homes. A greater proportion of those living in nursing homes had relatives than in the other two

groups, therefore, but a smaller proportion had lived with relatives than in the other two groups.

Although due to the large proportion of unclassifiable cases on this point, the above figures cannot be taken as representing the position accurately, the fact emerges that by far the largest proportion of subjects in the whole sample lived previously with relatives, and shows a twofold need :-

(1) For skilled family case work where domestic friction is the cause of an aged member of the family proposing to enter a home

(2) For homes which provide accommodation for aged persons irrespective of their family situation, where the cases who cannot be dealt with successfully by case work can live.

The factors which tend to make it impossible for children to accommodate their aged relatives, or which make them unwilling to do so, will be discussed in the final chapter of the thesis; the above figures confirm their existence and their importance in the solution of residential and institutional provision for the aged.

Reasons for moving into a home

44.5% of the total sample moved into a home because of domestic difficulties. This term was used in a wide sense, to cover not only friction with family, but also physical infirmity or mental incapacity to live alone, as well as financial

difficulty in doing so when both physically and mentally capable. It is seen therefore that the term embraces several factors which are in themselves quite different, but which have in common the result that the applicant sought entry into a home because of some domestic factor whose effect could have been avoided.

The means by which these effects could be avoided include higher pensions; family case work; and provision of various forms of assistance to old people living in their homes, such as are in existence in Great Britain and other countries, of both statutory and voluntary origin. Regular domestic help, "meals on wheels," shopping and laundry services, and regular visiting by volunteers are the means by which many old people are able to go on living an independent life in their homes for much longer than would otherwise be possible.

Table showing percentages of males and females in each type of home, and reason for moving

Reason for moving	Philanthropic		Nursing		Private		Total.
	M.	F.	M.	F.	M.	F.	
Domestic difficulties	63	66	0	18	43	38	44%
Nursing needed	4	2	58	29	43	11	17%
Supervision needed	7	9	26	38	14	23	19%
Infirmity	18	17	16	12	0	8	14%
From other home	8	6	0	3	0	15	6%

16.5% of the total sample entered a home because nursing was needed, and the same percentage because of a need for supervision. The latter group comprise the cases where mental deterioration is developing.

14.2% entered a home because of general infirmity which made the leading of an independent life difficult or impossible for them.

6.2% of the total sample came to the home in which they were living at the time of the investigation from another home or institution (including hospitals), and of this number, more than half lived in philanthropic homes, and the majority of the remainder in private homes. This seems to indicate that there is some movement going on constantly between the homes, but the proportion who moved into philanthropic homes came from a similar institution which had closed, leaving the private homes as being the group in which the most voluntary movement takes place. In spite of the shortage of accommodation provided by private homes, the fact that this movement goes on may mean that private homes are often not satisfactory to residents.

64.8% of the total residents investigated in philanthropic homes moved there because of domestic difficulties; 11.3% of residents in nursing homes gave the same reason; and 39.4% in private homes.

In the paragraph referring to previous residence it was stated that 46.1% of the residents investigated in philanthropic homes had lived with

relatives, and the fact that a total of 64.8% of the total residents investigated in philanthropic homes moved there because of domestic difficulties, indicates that almost one-fifth of this group had domestic difficulties of a different nature from family friction.

2.2% of residents investigated in philanthropic homes moved there because some nursing was needed, and this small proportion is probably accounted for by the fact that this type of home is not usually willing to accept cases which need regular nursing.

39.6% of residents investigated in nursing homes entered the home because nursing was needed, and this is a strikingly low figure, in view of the type of service nursing homes are normally expected to provide. The inference must be that the remaining 60.4% entered a nursing home because of domestic difficulties, infirmity, or the need for supervision because of mental deterioration. In fact, therefore, the nursing homes investigated are playing the role of private homes for the aged to a very considerable extent. In mitigation of this conclusion, it must be remembered that four of the nine nursing homes in the survey do accept other patients than those in the age group over sixty.

In private homes, 18.2% of the residents investigated entered the home because they needed nursing care, putting private homes midway between philanthropic and nursing homes on this point. Here again, the fact that private homes should not

provide regular nursing service unless registered as nursing homes, shows that the functions of the nursing home and the private home overlap.

18.8% of the total sample entered a home because of the need for supervision as the result of mental deterioration. The degrees of mental deterioration varied from slight intermittent confusion to the typical clinical picture of senile dementia, and without more detailed psychiatric investigation a better classification than the one employed was not possible.

8.7% of the total number of residents investigated in philanthropic homes entered because they needed supervision; 33.9% in nursing homes did so; and 21.2% in private homes.

Having regard to the general policies of selection in philanthropic homes, it is to be expected that the smallest number entering the home because of need for supervision would be in this group.

The figures for nursing homes and private homes show that 73.5% of residents investigated in nursing homes entered either for nursing or supervision; and 39.3% in private homes entered for one of these two reasons. A reverse proportion is found in each case in the two types of home, slightly higher percentage entering nursing homes for nursing than entered private homes for this reason, and a slightly higher percentage entering private homes because of need for supervision than entered nursing homes for this reason. In both cases, however, the difference was small.

Chapter Four

The information obtained on the physical and mental state of persons over sixty years living in the three types of home in the survey is, of course, not representative of old people living alone or with relatives. While in many cases people not living in old age homes are in a better condition than those who are, there must also be many cases of aged relatives living with their families whose condition is far worse than that encountered in old age homes. The shortage of homes for the aged, and the fees charged, must result in aged relatives being cared for in many homes where they impose a great burden on other members of the household. There is also the probability that in many cases family affection and solidarity is so strong that such a burden is voluntarily carried; in the survey of old people in their homes in Wolverhampton, Dr. Sheldon found that this situation existed very frequently.

A comparison of the physical and mental condition of people over sixty living in their own homes or with relatives with the same age group in various types of homes for the aged would only be possible if a random sample of the population over sixty were to be investigated.

Valuable information about the former group has already been published by the Nuffield Foundation, * which carried out a survey of men over sixty-five and

* "Old People" and "Social Medicine of Old Age", Report of the Nuffield Committee, Oxford University Press, 1948

women over sixty living in their homes, by means of a random sample taken from the ration book records of Wolverhampton. The results may, therefore, be fairly applied to any urban population of a similar type anywhere in the western world.

Each country has, however, its own methods of providing institutional accommodation for its ageing population, and within each area both the type of provision made and its adequacy may be expected to vary. Therefore, surveys made of homes for aged persons and their residents, while always of general interest to those studying this field, have an especial individual value locally in the attempt to solve the problems an increasingly high proportion of aged persons brings to the community.

An additional peculiarity in South Africa is the difference between the racial groups, both in the estimated present need and in the provision actually made.

While the survey was confined to Europeans over the age of sixty, this was done for convenience in research, and not to demonstrate any differences in the ageing process between this and other racial groups in this country. The facts concerning the life span of the different racial groups, however, and the official statistics on the causes of death, indicate that under the social organisation now prevailing, vital statistics prove a difference in need, as well as the difference in actual provision which is known to exist.

For the area of Greater Cape Town - and this is the only area with which the survey is immediately concerned - the fact that both the urbanised African and the Coloured have a shorter life span than the European leads to the conclusion that, for the present, the white group has a greater need for residential provision for the aged.

As improvement continues in the economic status of the non-European groups, combined with better housing, diet, and medical facilities, it can be expected that their life span will become equal to that of the white group at present, and therefore their need for accommodation for their aged will be the same. Whether any allowance should be made for differences in family customs, and if so how far such customs may be expected to remain stable, is a subject for further research.

At present there is no home for aged Coloured or African persons in Cape Town, other than chronic sick and mental hospitals, and even these are quite inadequate to the needs of the two sections as a whole. No private home for the aged or nursing home was encountered which provided for the needs of non-Europeans.

The conclusion must be that those members of non-European groups who survive to an advanced age are either cared for by relatives or friends, or are left alone to fend for themselves.

The discriminatory pension provisions made for the non-European aged, as well as family customs of a different kind, make research on the aged non-European particularly interesting to the sociologist, and a

Although the term "home for the aged" and others similar are used throughout the thesis, the survey has left the impression that such terms are better avoided. Apart from difficulty of definition, because of the great individual variation found in the conditions, attitudes and capabilities of persons in the group usually described as "aged," the use of such terms must have an adverse psychological effect, continually bringing before the "aged" person a mental picture of a negative kind.

It is usual to find only in advanced age a pride in chronological age; in the sixties and seventies, even when the number of years is admitted freely, there is a strong repugnance to being classified as "aged."

In other civilisations where a different attitude towards youth and age is found, the situation would be different; in modern western society, where a premium on youth exists, and where activities considered until comparatively recently to be the prerogative of the young are practised (with varying degrees of success) by persons who qualify for the description "elderly", terms emphasising chronological age are best avoided. Particularly should they be avoided in the names of homes, clubs, and special services for the aged. Such names as "old people's home," "over-sixty club," and others in very common use are the antithesis of modern ideas of what old age should and could be. The use of these terms could be detrimental to the

aim is to promote a new appreciation of the role of the aged in the community, and whose emphasis on the positive aspects of age is to some degree nullified by the mental impressions the mature person at present associates with them.

Compulsory registration

Throughout the survey the question of compulsory registration of all types of homes for the aged has been brought to the investigator's notice, both by doctors, nurses and social workers, and by the owners and managers of the homes themselves.

The difficulty of definition is important in solving this problem, for while the regulations are such that a large number of homes are able to evade them, there is little point in discussing whether all homes for the aged should, in theory, be registered compulsorily.

In Great Britain, the Rowntree Committee favoured statutory inspection of all voluntary homes, but was unable to find a definition of "voluntary home" that would make inspection administratively possible.

At present, all homes providing regular skilled nursing service to residents must be registered as nursing homes, employing a certain minimum of qualified staff and conforming to structural specifications.

The present legal definition of "boarding house" is "any place where six or more persons, other than the owner's family, live and pay rent."

It follows that, since there is no legal definition of "home for the aged," homes providing accommodation for six or more persons as described above must fall into the category of either "nursing home" or "boarding house."

All nursing homes investigated in the survey were registered as such, but many clearly provided services which homes for the aged could reasonably be expected to provide. On the other hand, many private homes for the aged are, in fact, providing regular skilled nursing service to residents, but are not registered as nursing homes.

The question is a complicated one, and while the registration and inspection of private homes for the aged is theoretically very desirable, the effect in practice of the present regulations would be to prevent the operation of a certain type of home which is filling an urgent need, in caring for residents who are for the most part neither entirely well nor sick, but deviate constantly, as aged people tend to do, between the two conditions. A nursing home is clearly not the most suitable residential provision for these cases. There is also another group for whom the small private home provides, and this comprises those who, while needing the regular skilled nursing care to be obtained in a nursing home, are unable to pay the fees charged in such a home. Most of these cases may be described as chronic or long-term sick, and it is possible to care for them adequately in a

small private home, if there is in attendance a person with practical nursing experience and a sensible attitude towards old age. In these cases, of course, the residents are entirely dependent on the efficiency and sense of responsibility of the person in whose charge they are placed, and while this type of home could be a very satisfactory solution for these cases, the reverse applies and they could also be exceedingly miserable.

There would appear to be no administrative machinery at present by means of which private homes for the aged accommodating less than six persons can be traced or controlled. The number of such homes discovered during the survey would indicate that a large number of this description do exist, and that the service they provide varies from ordinary residential accommodation for physically and mentally well persons, to supervision for mental cases and nursing for chronic sick.

If all types of home for the aged are to be brought within administrative control, therefore, it would be necessary to create a new category to include those at present able to evade classification into either "nursing home" or "boarding house."

The difficulty is enhanced by the division of control, boarding houses being under the control of the municipality, and nursing homes under the provincial administration. A number of homes are voluntarily registered with the City Health Department, and these are inspected by officers of

provides some safeguard to both owner and resident, the general feeling on the part of owners contacted during the survey was that it is not wanted by them.

The survey has revealed that a number of unregistered private homes for the aged exist, where provision for residents of varying degrees of physical and mental capability is made, at varying costs and with vastly varying efficiency.

The Johannesburg City Council recently recommended to the Transvaal Commission on Local Government that homes for the aged by compulsorily licensed.

Adequacy of present provisions

An interesting and important question on which the survey attempted to throw light was how far the provisions already existing in Cape Town, in all types of homes for the aged, are adequate to the need; also how far the functions of the various types of home are overlapping, and how far the facilities provided by each type of home are blocked in their most economic and satisfactory use by this overlapping.

Firstly, the total amount of provision made for aged Europeans in Cape Town is very inadequate, and this applies to all types of need.

The most elementary classification of need is a fourfold one :-

(1) Hospitalisation for the chronic sick
(2) Hospitalisation for mental cases
(3) Residential provision for the physically and mentally fit
(4) Residential provision for cases needing some nursing or regular assistance, or supervision of those with early symptoms of mental deterioration.

Hospitalisation for the chronic sick and for mental cases is very difficult in Cape Town for all age groups, for those unable to pay private nursing home fees, and all that is known about these two problems already applies also to the age group with which the survey is concerned.

Residential provision for the physically and mentally fit does exist, although in much smaller quantity than is necessary to meet the demand. The quality of the existing provisions is high, however; a brief description of two schemes providing different types of residential accommodation for this group is given in Appendix Five and Appendix Six.

The fourth group for which provision is necessary consists, broadly speaking, in the type of case which is ideally catered for by homes for the aged of various kinds, and into this group fall the great majority of cases investigated in the survey.

In Cape Town, seven of the nine philanthropic homes visited were originally intended to provide residential accommodation for physically and mentally fit aged persons, but in fact, due to the peculiar problems associated with residential and institutional provision for the aged compared with any other age group, all homes provide nursing and supervisory services too. Where generous sick bay provision has been made in the original plans, this does not cause undue difficulty to the staff, but where this is not the case, the care of residents needing nursing and supervision presents a very real problem and interferes with the normal activities of both superintendent and staff.

In the planning of homes for the aged, it must be remembered that the condition of the average resident must be expected to deteriorate during his period of residence, and therefore these homes have the special problem of providing facilities for both the fit and the unfit, under the same roof and administrative control. In deciding how far this can be done, an important factor is the degree of security which the home wishes to provide, and undertakes to provide, to each resident. The strong desire for security which is a characteristic of advanced age, if not of all ages, makes desirable as much security of residence as can be reasonably provided. It is believed by authorities on mental health in old age that changes of environment cause emotional shock and are frequently the precipitating cause of mental breakdown; the problem is therefore how much security of residence can be provided at an economic cost.

Types of homes required

The conclusion reached at the close of the survey was that all types of residential and institutional provision for the aged in Cape Town are inadequate to the need, but that the facilities already existing could be used more economically and satisfactorily to residents if greater variation in the types of home existed.

Throughout the investigation the clear fact emerged that central planning and control of homes

for the aged of all types is essential, and that such planning must be based on scientific knowledge and not on isolated philanthropic actions.

The investigator does not wish to minimise the role played at present by philanthropic and private homes; the former especially have a high standard of building, equipment and ideals of service, and are in almost all cases entirely satisfactory from the residents' point of view. Without exception, the philanthropic homes for the aged in Cape Town originated in private donations and bequests or in voluntary effort, and in this field, as in so many others, voluntary organisation has led the way.

The point to be made is that with the increase in the proportion of the population in the age group over sixty, and in view of the demographic forecast that this may be expected not only to continue, but to do so at an accelerated rate in the immediate future, the problem of provision for the community's aged is one of such magnitude and urgency that it can be handled efficiently only by some kind of central authority, which has not only knowledge of the need, but also power to control available resources in future planning.

This authority may be statutory or voluntary in nature; in either case, the best results can always be obtained only by the closest co-operation between government and voluntary social services. This is appreciated by the government of Great Britain, which distributed a special circular to local authorities on the need to work with voluntary organisations already

established in the field, in considering and carrying out their plans for the aged of their communities.

The fact that this survey was concerned with the aged in institutions does not imply that the problems of age were seen as capable of solution by institutionalisation. Also, in assessing a community's needs in such provision for its aged members, the problem should not be magnified by consideration of proportional increase in population in this age group, only. The greater part of the problems of age are connected with independent living outside institutions, and not only do the majority of the aged wish to live in such a way, but also the majority are able to do so, or would be able to do so given certain forms of assistance.

The social survey of old people both in their homes and in institutions carried out by a committee under the chairmanship of Dr. B. Seebohm Rowntree, came to the conclusion that probably more than 95% of old people in England lived in private dwellings. The committee also considered that a considerable number of these people were unfit on physical or mental grounds to live either alone or in normal family life with relatives or others.

Institutional provision in the areas investigated by the Rowntree Committee is therefore estimated to be required for not less than 5% of the aged population, and it is likely that a similar figure will apply to any urban western community. *

* "Old People," Report of Nuffield Committee, Oxford University Press, 1948.

It is impossible to assess a ceiling figure, but an estimate of 25% is probably safe, in the light of various investigations on the condition of old people living outside institutions. This estimate is based on the ideal of homes for all categories of need, and not on that proportion whose physical and mental condition necessitates some kind of regular care above the ability of the average family to provide.

An interesting difference in attitude towards old age homes from that described in the report of the Rowntree Committee was noted during the survey. During contacts officially associated with the survey and also in informal association occurring as the result of working on research connected with old age, no fear or dislike of entering a home of the philanthropic type was encountered.

The Rowntree Committee concluded that the very common fear and dislike of entering a home, which they found throughout their survey, was a corollary of the statutory provision for the aged poor made in Great Britain in the last century. This form of provision, known as "the workhouse," carried a social stigma as well as a reputation for unpleasant, frugal, and even harsh, living. It was only as the result of the use of "workhouses" as emergency hospitals during the last war that conditions in them improved, and today, although the buildings have in many cases been converted and the standard of the institutions as such have been altered almost out of recognition, the phenomenon

of cultural lag exists with regard to the attitudes of the public towards them.

With the provision of more small homes by local authorities in Great Britain for the accommodation of their own aged population in need, this attitude may be expected to change; at present, it results in great hardships being endured by both old people themselves and by their relatives, rather than enter a government institution.

Since provision of institutions for the aged has been until very recently entirely the province of voluntary social service in South Africa, and because of the high standard of such institutions, to which reference has already been made, fear of entering them or of social stigma attached to doing so, hardly exists. The fact that misrepresentation of income is the most commonly found inaccuracy on application forms for entry to philanthropic homes indicates that those who could probably afford the fees of a private home or nursing home, actually prefer to enter a philanthropic home.

The same difficulty in tracing small private homes was encountered by the Rowntree Committee as impeded the present survey. The Committee concluded, however, that the provision of private homes for the aged in Great Britain was far short of the demand, and it is considered that the same situation exists in Cape Town.

The Rowntree Committee expressed the opinion that a good deal of exploitation of old people in small private homes occurred because "an aged person seeks what he or she imagines will be the greater

The Rowntree Committee suggests the following categories of aged persons who need provision in homes and institutions :-

(1) Healthy aged, except those who can satisfactorily run their own home.

(2) Those needing some assistance and supervision, but not regular nursing.

(3) The long-term sick.

(4) Senile and demented persons.

A fifth category, "those lacking normal power to get on with others," is also described; it is possibly doubtful, however, whether the best course in dealing with this small group is communal living in isolation from other more normal personalities, but it is also impossible to assess the degree of success which could be obtained by using psychiatric and social work techniques in dealing with this type of case.

Groups (3) and (4) would be provided for by special institutions of a medical nature, leaving groups (1) and (2) in need of accommodation in homes.

There is another category, the slightly senile, who would appear to come within the scope of group (2) above, but in cases of true senility the best solution is probably a nursing home, for those able to afford the fees. The fact that 33.9% of the residents in nursing homes investigated in this survey entered because of the need for supervision, shows that nursing homes are playing an important role in the care of this category of aged person in Cape Town.

Problems common to all homes for the aged

Whatever the category of aged person for which they are intended to provide, all homes for the aged have certain problems in common.

The problems of size and situation are the first to be solved. The Rowntree Committee recommended a maximum of twenty residents as ideal, but stated that optimum size for economic running is probably between thirty and thirty-five residents. Where a high degree of personal liberty is wanted and permitted, homes may accommodate up to two hundred residents very successfully. Two homes of this latter type in Cape Town provide for more than one hundred residents each, and appear to be successful from the point of view of both administration and residents.

Observations made during the survey do not indicate that a pleasant, even intimate, atmosphere cannot exist in a large home; the presence or absence of such an atmosphere depends on the planning and equipment of the home but to a possibly greater extent on the attitudes of the superintendent and staff. During the survey, small homes were encountered which were much more institutional in type than those accommodating more than one hundred residents.

For philanthropic homes, the optimum size was considered by Cape Town superintendents to be about fifty residents, but those homes where more than one hundred are living expressed the opinion that this is not too high a figure either for

convenience in administration, or for personal contact with residents and the provision of an intimate atmosphere.

For private homes, where the making of a profit is an essential factor to be considered, there was general agreement that less than six residents is not an economic proposition, unless they are completely independent of nursing care and supervision.

The optimum number will vary with the extent to which owners are prepared to employ non-European labour, and on the quality of the employees of any racial group for which they are prepared to pay. The fact that most of the private homes traced fell into the category accommodating between four and nine residents, and that only one home provided for more than twenty, suggests that within the limits of private enterprise a maximum of twenty is the general rule.

The second problem of homes for the aged, that of situation, is a more difficult one to solve. Very often choice of a site is restricted by financial considerations, or a particular piece of land is donated for the purpose, or restrictions exist in a bequest.

Where none of these factors is the ruling one, homes for the aged should be situated in a setting as similar to the one from which prospective residents are expected to come as is possible; homes accessible to the centre of a city are wanted by urban dwellers;

homes in rural or agricultural communities by those accustomed to such an environment; and suburban homes by lifelong dwellers on the outskirts of cities. The unhappiness caused by uprooting of old people from their familiar type of environment was the subject of comment on numerous occasions by the staff of all types of home.

The opinion was also offered that it is the type of environment which counts more than the specific details of environment. Those who held this view said that they considered that although old people are likely to suffer more from a radical change in environment than other age groups, they adapt themselves quickly to minor changes, as long as their physical needs are satisfied. If this is correct, an aged person moving from his own family to a home, suffers less if the home accords with the type of environment to which he has been accustomed.

The general opinion of superintendents and matrons was that there is a strong case for regional zoning of old age homes, if only from the practical consideration of difficulty and expense encountered by relatives and friends in visiting; whatever the effect of absence of visits on residents in homes, there can be no doubt that regular visiting is more satisfactory both to the resident and to his family.

Several cases were described by a superintendent of a philanthropic home of men and women who had lived all their lives in remote country districts, and who had suffered first bewilderment and fear, and then

complete withdrawal from all activities both outside and inside the home, after experiencing a violent change in environment.

Whatever the type of community in which an old age home is situated, the home should not be isolated from the mainstream of community life. This point was effectively made in a plea for central placing of homes for the aged made by Mr. Aneurin Bevan in the British Parliament, when he reminded members that old people do not want to look only on processions of funerals of their friends, but also on processions of perambulators.

However, although the aged have a strong interest in the community life of which they are, or should be, a part, this factor should not be carried as far as to provide accommodation for the aged and other groups in the same building, unless the accommodation is of the ordinary residential kind; experiments in providing self-contained flats for aged persons on the ground floor of a block, and for single persons of other age groups and married couples without children on the other floors, appear to work successfully.

Where a home is built for the purpose, the most modern ideas on institutional planning can be utilised, and financial resources are the only restriction. Too often, however, an antiquated large house must be adapted, and the nature of the conversion depends on the house itself, the money available, and the type of home it is intended to establish.

Broadly speaking, there should be efficient means of heating and lighting; if no lift is to be installed, the staircase should be easily negotiable by persons with varying degrees of infirmity; no irregular surfaces or highly polished floors should be allowed; and all equipment, such as bathrails, corridor rails, and beds of a height to enable the occupant to get in and out easily, should be designed to assist residents to be as independent and as safe as possible.

The problem of obtaining suitable staff appears to be a universal one for all types of institution. Perhaps it is on the attitude and efficiency of staff that the success or failure of an institution, from the residents' point of view, depends more than on any other factor.

Apart from quality of staff, the correct numerical ratio between staff and residents is important for the economic running of the home, as well as for the residents' comfort. The Rowntree Committee recommends one staff to seven or eight residents for an institution accommodating between four and five hundred healthy old people. Clearly the ratio will vary with the size of the home and the type of resident accommodated, and no rigid rule can be laid down.

In private homes and nursing homes, the personality of the superintendent or matron is the operative factor in the quality of the service provided. Although some owners of small private

homes encountered in the survey were clearly persons of high ethical standards, with a sense of vocation towards their work, there are others to whom the running of the home is purely commercial in nature and whose interest in and contact with residents is confined to the presenting of their monthly accounts.

In nursing homes, the survey found a generally sympathetic and intelligent attitude towards the problems of aged patients, which would be expected of the nursing profession as a whole. There were instances, however, of matrons and staff of nursing homes having an attitude which can only be described as "negative"; their function appeared to them to be confined to making their aged patients as comfortable as possible until merciful death supervened, and it is unlikely that this attitude does not influence the patients' own attitude to themselves and their condition. This statement is made in full appreciation of the fact that there are many such cases being cared for in nursing homes, and that nothing of a medical nature can be done for them which is not being done.

The work of Dr. Wilson at St. John's Hospital, Battersea, and of Dr. Marjorie Warren and others has shown the importance of both medical and social factors in senile dementia, incontinence, and physical immobility. More training for nurses in geriatrics but also in psychology and sociology will have an important influence on the nursing of aged patients, as on all relationships between medical personnel and patients where the latter subjects are part of the students' curriculum.

Status of superintendents

In philanthropic homes in Cape Town, the majority of superintendents and matrons have nursing experience, varying from fully qualified state registered nurses to those with St. John's and similar certificates.

Where both a superintendent and a matron are employed, the latter always has nursing experience. In four of the homes visited, the quality of the nursing staff was easily in excess of actual need.

Where the functions of superintendent and matron were combined in one person, the possession of nursing experience was the most frequently found common factor. Special training in institutional management, dietetics, psychiatry or social work is either not considered necessary by management boards of philanthropic institutions in Cape Town as a whole, or suitably qualified persons are not available. Here again, no criticism is intended of superintendents and matrons who, as already stated, have a high general standard of work; a number of them have familiarised themselves with the techniques referred to above, as far as is possible without specialised training. The point to be made is that the administration of homes for the aged is generally considered to be a function for which those with nursing experience are particularly fitted, and while there is no doubt that practical nursing experience is essential for the superintendent or matron of a home for the aged,

it is questionable whether fully qualified nurses are the most suitable professional group for the work, and also whether their particular skill is not actually unnecessary.

Now that the importance of psychological and sociological factors in the physical and mental condition of the aged is appreciated, and if the central problem in the administration of a home is the adaptation of a group of people with very different personalities and life histories to a communal way of life probably entirely new to most of them, it would seem that the qualified social worker is the most suitable among the professional groups to occupy a position of authority in a home for the aged.

A course of specialised post-graduate training in psychiatry, practical nursing, dietetics and institutional management would make the employment of individual specialists in these fields unnecessary, and would enable small homes to offer higher salaries to suitably qualified personnel. In large homes where qualified nursing and housekeeping staff can be kept, it is still essential for the superintendent to have knowledge of all these fields.

Although at present a number of highly qualified persons are working as superintendents and matrons of homes for the aged for very inadequate salaries, these are the ones who feel themselves dedicated to the work, and their number

is only too small. To attract sufficient professional men and women into this field, higher salaries and status than at present accorded, must be introduced.

In Great Britain, the National Old People's Welfare Committee was responsible for the introduction in 1950 of a six months' training course for wardens and matrons of old people's homes. The course had the support of the Ministries of Health and Education, and comprised the following :-

(1) Eight weeks' theoretical training, including lectures on sociology, legislation, household management, home nursing, first aid, and the psychological effects of ageing.

(2) Eight weeks' practical training in the geriatric unit of a hospital.

(3) Eight weeks' practical training in an old people's home.

There is no other recognised training in Britain for this type of work.

The National Old People's Welfare Committee also organises short "refresher" courses for wardens and matrons who are already in charge of homes.

In South Africa, there is no specialised course of training for case or group work with the aged.

The Department of Social Science in the University of Cape Town includes lectures on the sociological problems of old age and on legislation affecting the aged, in the course leading to the degree of Bachelor of Social Science, and the Diploma in Social Work.

Categories for which homes provide

The ideal provision of homes for the aged takes cognisance not only of the physical and mental condition of residents and the different type of provision required on these grounds, but also takes into account the following sociological factors :-

(a) That there is a quantitative difference in the provision needed for the two sexes, resulting from the longer life span of women; also that there is a need for homes providing for males only, for females only, and for both sexes.

(b) That aged persons, like all self-respecting members of the community, wish to be independent of "charity" as far as possible. Therefore, homes providing for those who can pay the entire economic cost of their support are needed, as well as homes charging a smaller fee which may be subsidised by government grant or by voluntary organisations.

(c) That in advanced age, as at all other times in the life cycle, people are happier in the proximity of others of a similar educational and cultural standing to themselves. In old age, where one of the greatest problems is loneliness, the cultural heterogeneity of residents in a home is not the ideal, and provision for such differences is as important as for differences in physical and mental fitness.

Equipment and fittings

General standards of comfort may be applied to the fitting of old age homes, and although the ideal of a private bed-sitting room for each resident is not always possible to achieve, the greatest possible amount of privacy should be the aim. It is also essential to the residents' happiness that provision for keeping personal possessions should be adequate, and it is helpful if small articles of

furniture, pictures and similar articles be allowed in use. In the Cape Town homes which provide a bed-sitting room for each resident, the rooms are as different as the personalities of the occupants, and much satisfaction must be obtained from the expression of individuality which residents can achieve.

The Cottage System

Several superintendents spoke with favour of the cottage system as providing a higher degree of comfort for residents, and enabling staff to have more personal contact with them. The system is, however, only suitable for residents in the sixties and seventies, generally speaking, since as age advances and infirmity increases there are important advantages in having all residents under one roof.

Whether the best solution is entirely separate homes for those in the broad categories of under seventy and over seventy, or whether a combination of the two types of provision under the same supervisory attention is better seems to be a matter of opinion.

It seems inevitable that in homes where security of residence until death is given, such homes must eventually become chronic sick hospitals, for only a small proportion of residents enjoy good health and capacity for self-care until their final illness, and rarely is that illness of short duration. However fit residents are when they enter a home, it must be realised in planning the home's facilities that their condition may be expected to deteriorate, either

physically or mentally, or both. This is the central problem in the provision of old age homes, and makes the execution of policies regarding this type of home unique and more difficult than provision for other groups of the population needing institutional care. The point is emphasised because the effects of failure to pay attention to it are visible in more than one home in Cape Town, and causes difficulties and extra work which could have been avoided. The practice of one large home in keeping one or two corridors reserved for residents who need unskilled nursing attention is to be commended.

If residents are to have security of residence until death, the provision of facilities to deal with extensive and long-term illness and infirmity is essential, and such facilities add very considerably to the cost of both equipping and running the home.

The provision of both the cottage type of accommodation and the institutional type under the same management has the advantage that residents can be moved into the main buildings as they become too infirm or too sick to continue living the more independent type of life in the cottages, thus getting the advantage of nursing care and supervision without violent changes into unfamiliar surroundings.

In the cottages, residents have the further advantage that they can lead there a life most resembling that of a private household; with modern methods of transporting food, the provision of meals to the cottages does not present any problem.

It should not be used, however, as an argument in favour of an ostrich attitude and to encourage selfishness and indifference; rather can it be used to stimulate attitudes of co-operation and service, especially among the group who are in the best position both to sympathise and assist - those who are themselves already needing to make adaptations to both the positive and negative aspects of their maturer years.

Running costs

A philanthropic home making provision for more than one hundred residents was able to give exact figures of running cost, which amounted to £24 per head, per month.

This home was in the category described as "superior" in regard to furniture and equipment, charged no fees, and provided excellent regular, free medical attention and supervision.

Although it was not possible to obtain exact figures concerning running costs from any private home, a very reasonable idea of the running costs of such homes, and of the profit to be made, can be obtained from the information given concerning the inclusive cost per resident in a home where a very high standard indeed is maintained. For comparative purposes, due allowance should be made for the advantages enjoyed by homes large enough to purchase food in large quantities at wholesale prices.

Residents' activities

The report of the Rowntree Committee refers to a statement made by the superintendent of a London Public Assistance Institution, that loneliness in institutions is largely caused by inability to join in the recreational occupations of ordinary life, and a reluctance to do so. *

It is generally agreed by those with experience of the aged in institutions that the provision of occupation is important in keeping residents physically and mentally fit.

This point was particularly stressed by three superintendents of philanthropic homes in Cape Town. One uses the various skills and experience of residents to assist in the actual running of the home, in the garden, in maintenance of electrical equipment, assistance with nursing, and secretarial duties. In one nursing home, a resident who is bedridden has the entire responsibility for the book-keeping, record keeping and correspondence, in return for which he is charged a much reduced fee. One philanthropic home pays small salaries to men who assist in various ways with the running of the home, and a total of twenty residents are employed in doorkeeping, cleaning, book-keeping and other tasks.

It is clear that this system considerably reduces the running expenses and staff problems of a home, but what is more valuable, it gives residents an interest in life and in the home which it would be difficult for them to obtain in any other way.

* "Old People," Report of the Nuffield Committee,

While recreation is important for residents in old age homes, as for any other group in the community, the fact remains that a game is but a game, and the pleasure and satisfaction to be gained from it cannot compare with that obtained from work done which is of value to the community, whether such work is paid or unpaid. Throughout life, the work done by an individual and its worth to society is an important factor in his status, both in his own eyes and in the opinion of the group.

The truth of this was discovered by a group of elderly men and women in the United States, who met regularly to listen to a series of lectures on the ageing process, and at the end of the course formed a club which they called "Senior Citizens' Recreational Group." After a while the club extended its activities to include various forms of service to the community, and changed its name to "Senior Community Club," signifying that the members wished to do service in and for the community.

To the inumerable list of human instincts listed by psychologists might well be added the instinct to serve, and this human characteristic can be developed and used among old people to help in solving the problems the elderly present in the modern community.

Residents needing hospital treatment

Superintendents of all three types of home complained that they were unable to get residents to hospital as often as was desirable for examination and treatment. Part of the difficulty was the

expense of ambulances and taxis, and part was the time taken at the hospital. Most of the residents had to be accompanied by a member of the staff, and in the smaller homes this disrupted the routine of the home for the entire day.

The matron of a nursing home reported that she was occasionally able to get an ambulance at a reduced rate to take a patient to hospital for treatment, and there is no doubt that some arrangement of this kind to take effect automatically for residents of old age homes would be very desirable.

In many private homes and nursing homes, residents are paying high fees, apart from doctors' and chemists' accounts, and they cannot afford frequent trips to hospital; they therefore economise on this most necessary aspect of their welfare.

In hospitals where there is no special geriatric unit, there also seems to be a need for some arrangement with outpatients departments so that the requirements of old people may be met with as short a period of waiting as possible. The fact that patients accompanied by a matron or nurse have to wait so long for attention means that others in this age group not so accompanied must have probably greater difficulty, and this would seem to militate against the best possible use of outpatient facilities by old people living in private households, as well as by those in homes and institutions.

In no case was any special arrangement between an old age home and a hospital found to enable residents to obtain priority treatment.

In view of modern advances in the treatment of the elderly sick and disabled, it seems essential that for the benefit of these new methods to be applied to those needing them, there should be some administrative concession made to elderly patients, despite general difficulties of overcrowding and understaffing which exist in most hospitals at present.

Reasons for placement of aged relatives in homes

Five of the nine philanthropic homes stated that they considered family conditions in the modern community the main reason for the placing in homes of aged relatives.

Four matrons of nursing homes and four superintendents of private homes agreed with this opinion.

One may conclude from this that it is not only the fact that both sexes live longer today than ever before in our civilisation, or the fact that women outlive men, which underlies the urgent need for special attention to the residential needs of the aged. Analysis of the sample shows that 65.75% were widows or widowers, and that of the total cases, approximately 22.6% had no relatives at all.

The answer to this problem lies not only in demographic statistics, but also in the size of the modern family, the housing considered desirable and actually provided, the high cost of living, and perhaps most of all, the prevailing attitude toward the aged.

In any modern western community, it is considered ideal for each married couple to have a house of their own immediately after marriage, and if, for any reason, an aged parent or other relative has to live with them, it is considered a hardship to be borne as well as possible, and to be ended at the earliest opportunity.

The presence in the home of a third person, particularly an aged relative, is considered to be actually prejudicial to the chance of success in the marriage, even being listed by some authorities in the field of marriage guidance as a contributory cause of divorce.

The peculiar fact exists, however, that it is precisely in those countries of the western world where this ideal of housing is practised as far as possible that the highest divorce rates are found; where the patriarchal type of family is still found, the divorce rate is lower. Under this type of family organisation there would therefore seem to be greater security in marriage and for the aged.

Even where children wish to have an aged relative living with them, the prevailing housing norms make such an arrangement often inconvenient and trying for both the family and the aged relative.

The functions which the aged may fulfil in primitive society carry not only social value but also considerable power and influence; in the modern world both law and custom combine to prevent the aged from filling most of these roles. *

* "The Role of the Aged in Primitive Society," Leo W. Simmons,

How far children wish to and attempt to evade their obligations to their aged parents is a contentious question. The following table shows the position found during the survey regarding visits received from spouse or children, whichever was the nearer relative :-

	Philanthropic homes	Nursing homes	Private homes
No visits	1.1%	1.49%	3%
Occasional	3.29%	0%	0%
Regular	23.18%	9.45%	18.2%
Frequent	6.6%	0%	9.01%

The table shows that of those residents whose nearest relative was a spouse or child, although only a very small proportion in each type of home received no visits at all, the number receiving regular visits was in each case only 23.18%, 9.45% and 18.2% respectively. Those receiving frequent visits, i.e. one or more each week, formed only 6.6%, 0% and 9.01% of the totals in each type of home.

These figures do not indicate a very highly developed sense of obligation on the part of the children whose aged parents were included in the survey.

It was impossible to arrive at any conclusion about the number of children who contribute to their parents' maintenance in homes, as statistics regarding amount and source of incomes were incomplete.

Unless the attitude of the public to the question of the natural and desirable place for aged persons to live is influenced very considerably in the near future,

the provision of such forms of assistance to the aged outside institutions which are discussed in a later paragraph, cannot be used to best advantage.

Functions of homes in the survey

The superintendent of a philanthropic home providing accommodation for more than one hundred aged persons stated that the home is, in fact, a chronic sick hospital.

The average age of residents in this home is seventy-nine years, and forty per cent of the total number of residents are in the eighties and nineties. Approximately fifty per cent are incontinent to some degree.

This home has a well-equipped sick bay and employs trained nurses. It has an average of two deaths per week.

It is clear from these facts that there is considerable justification for the superintendent's description.

A home for ladies, which was classified in the "superior" category, accommodating more than one hundred residents, gave the following figures relating to the health of residents for the year 1953 to 1954 :-

Under general medical care	50
" continuous medical supervision	59
" general supervision	7

In this home, an average of 7.3 patients per day were nursed in the sick bay in one year, and 4.7 in their own rooms.

The sick bay in this home has twleve beds, and a qualified medical practitioner is in attendance; in addition, two corridors have rooms reserved for semi-invalids who require constant attention.

The medical officer of this home estimated that 20% of the residents were under continuous medical attention during the year.

Since 65% of the total cases in the sample were under medical attention at the time of enquiry, the health of the residents in this home is decidedly above the average found. It is a philanthropic home intended to provide residential accommodation for residents in a condition of good physical and mental fitness.

The fact that there were only nineteen deaths in the home during the year also shows that the residents are in a better physical condition than in the first home described, and this has a definite connection with the selection policies of the two homes.

The two philanthropic homes described show great variation if examined in the light of the question of how far old age homes in Cape Town are actually functioning in part as chronic sick hospitals. The former is probably functioning as such to a greater extent than any other philanthropic home visited, while the latter probably takes a middle position.

In the case of five philanthropic homes, they are certainly functioning partly as chronic sick hospitals; in the case of the other four, this description could not be fairly applied.

It was not possible to obtain statistics from private homes to demonstrate this point, but on the basis of observations made during visits and on information given by owners, it is reasonable to infer that a worse position exists, comparatively, in private homes than is described above for philanthropic homes.

This question is intimately connected with the extent to which the functions of the different types of home overlap.

The conclusion reached at the close of the survey was that the facilities in homes for the aged which are intended for persons who are physically healthy for their age, are in fact taken up to a considerable degree by those who should be classified as "chronic sick," and provided for separately.

The term "chronic sick" is a very broad one, and covers a number of different conditions, for which the same type of providion is not necessarily the ideal.

A gift from the people of South Africa made possible the establishment of a co-ordinated medical service for old people, based on co-operation between the geriatric unit of a hospital, and a residential home run in close association with the geriatric unit. The hospital provided long-stay annexes for those under medical supervision, and the home cared for those patients who were too infirm to live alone or to be cared for in their homes. This scheme, which was originated by the National Corporation for the Care of Old People, is based on the most modern geriatric principles, but lack of

hospital accommodation and staff to carry out schemes similar to the one described above means that the care of the long-term sick will probably remain the responsibility of homes and institutions where old people are already residing, for many years to come.

It is arguable whether expensively equipped homes should be inhabited by persons who are unable to make full use of their facilities for a large proportion of the time they are residing there, but if full security of residence is to be given, the answer would seem to be larger sick bays to accommodate those needing regular nursing as well as for emergencies, so that private bed-sitting rooms can be released to those able to make best use of them.

The fact that all homes have long waiting lists indicates that there are people who need the type of accommodation which the homes were originally intended to provide, and which at present is taken up to a large degree by those who really need chronic sick accommodation.

If it is true that philanthropic and private homes are caring for a number of residents who should be in hospitals and nursing homes, how far is it true that nursing homes have a proportion of residents who are more suitable for philanthropic or private homes?

The fact that in nursing homes, 49% of residents investigated were there because of domestic difficulty or infirmity, or both, bears out the conclusion that nursing homes are acting as old age homes. Likewise, the fact that only 42.4% of those residents investigated

living in private homes fall into the categories for which private homes for the aged would normally be expected to cater, shows that these homes are blocked in carrying out their expected role by functioning, either by necessity or choice, as nursing homes and mental homes.

It is true that the majority of private homes are willing to accept residents who need varying degrees of nursing care, if they are able to pay the fees demanded, and these residents are in many cases not ill enough to need nursing home care. Nevertheless, there must be a number of residents in private homes who do need nursing home care, but are unable to afford the fees, which are usually higher than those charged in a small private home.

Although private homes do serve an important purpose in providing care for these cases, which is probably unobtainable elsewhere, the fact that a proportion of residents in nursing homes do not need nursing home care means that there is a group able to pay well for some supervision and slight nursing, but who are unable to obtain such care in a private home for the aged. Although such cases are probably welcomed in nursing homes, because they are semi-permanent and comparatively easily cared for, not only is a nursing home environment not suitable for this type of case, but also it is a waste of nursing home facilities.

Since there is a great shortage of what may be termed "residential accommodation" for aged persons who are physically and mentally well, and who, either

because of domestic difficulties or a degree of infirmity, need such accommodation, it is unfortunate that homes intended to provide for this group are cluttered with cases clearly belonging elsewhere.

In discussion of this point, however, it must be pointed out that the description of all homes given by superintendents was accepted for purposes of classification. There were several homes classified in the two categories of "nursing home" and "private home" whose correct classification according to function was exceedingly doubtful, and in several cases, so-called "private homes" were clearly functioning as nursing homes.

The survey has demonstrated that there is an urgent need for more accommodation of all types, and that present facilities are not always used for the purpose for which they are best suited.

Particularly does this inadequacy of present provisions apply to the "lower income groups", who, when old age is reached, have either the old age pension only, or an income very little above that amount.

Perhaps the most difficult category of aged person for whom provision has to be made is that where mental deterioration is present, but where the description "senile dementia" cannot be applied. Where these cases are not suitable for care in the homes of relatives a difficult problem exists, as they are frequently sensible of their surroundings and capable of some degree of self-care.

must be solved. These are, the provision of adequate and suitable independent residential accommodation, and the provision of various types of assistance to enable those aged who are able and wish to do so, to live in their own homes or with their families.

It is not within the province of the thesis to discuss the housing needs of the aged, but the recommendations of the Rowntree Committee on this point may be referred to :-

> (1) The total proportion of the aged living alone (including married couples) does not exceed about 3½% of the population.
>
> (2) Whereas the average number of persons per household in the population is about 4, the average number of old people per small house probably does not exceed 1.5. Therefore the number of dwellings needed to house the aged is higher than 3½% of all dwellings.
>
> (3) The Committee therefore suggests that an average 5% of all houses in any community should be such as are best suited to the special needs of old people. This figure is a national estimate, however, and each local government area has its own particular needs, according to such factors as the predominant type of employment and family pattern.
>
> (4) The exact proportion of houses to be built for old people in any area can only be ascertained by a survey of the locality, and local authorities are recommended to carry out such surveys before deciding on building plans.

The report of the Rowntree Committee gives a detailed description of the types of housing suitable for the needs of old people. *

* "Old People," Report of the Nuffield Committee, Oxford University Press, 1948

Domiciliary services

An investigation undertaken in Birmingham, England, discovered that of admissions to a hospital for the chronic sick, one quarter were suitable for the district nurse's care, "home helps" and supervision by a general practitioner. The majority of these cases entered the hospital because of lack of relatives. Another quarter of the cases needed only simple nursing, and one-tenth needed accommodation in a mental hospital. *

This survey indicates the need for domiciliary services for the aged, including the following :-

(1) An adequate district nursing service, which not only assists relatives in caring for aged patients, but also conserves hospital space.

(2) A centrally organised system of "home helps," controlled either by the municipality or by a voluntary organisation. While the need for actual domestic workers is not as great in this country as elsewhere, due to the extensive use of cheap non-European labour, the service could be more in the nature of relief to people who are caring for aged relatives in their homes.

(3) Shopping and laundry services to those living alone. The provision of hot meals delivered to old people by special vans is reported to be valuable in preventing the malnutrition which is a common symptom among old people, carried out by voluntary organisations in Great Britain.

(4) Clubs for those in the age group over sixty may be usefully employed to provide a home visiting service to the bedfast or housebound.

Although these services may be provided by several different sources, their use is best directed by the social worker, who is able because of her specialised training to solve many of the problems besetting old age, both of the practical kind which

the type of service described in the previous paragraph can deal with, and of the more complicated kind concerning family and social relationships.

Where an aged relative is living with a family, the role of the social worker in interpreting the mutual difficulties encountered and eredicating those which are amenable to treatment, is of great value.

The pioneer work of Lillien Martin in America, which led to the establishment of the Old Age Counselling Centre in San Francisco in 1929, laid the foundations of modern case work with the aged.

The theory is based on the belief that mental decline in the elderly can be retarded, sometimes even reversed, and the technique used was to analyse the problems of the individual and then to re-educate him in participation in the community life. The method is intensive case work, and combined therapeutic treatment of physical disabilities with psychiatric analysis and sociological adjustment.

At the San Francisco Counselling Centre the most frequently found problems of clients were boredom, loneliness, frustration and social failure. These are the problems for the solution of which modern case work has the most to offer.

Old age in the modern community, with its still increasing expectation of life, combined with the custom of compulsory retirement common to many occupations, leaves the physically and mentally fit person over sixty-five in a position where these very problems make their appearance. The custom of compulsory retirement is based on a hypothesis that

chronological age coincides with physical and intellectual efficiency. The falseness of this popular view has been proved by scientific investigations, among which the work of Dr. Charlotte Buhler in Vienna on the ur typical curves of output is outstanding. Compulsory retirement leads to changed social status, reduced income, and to physical and mental decline.

The scientific investigation of the elderly in employment, both of the survey and experimental type, is among the most promising fields of research on the problems of old age at present being carried out.

The needs of the old do not vary strikingly from those of the rest of the community, but as a group they may suffer from the disadvantage of being unable, for various reasons, to satisfy these needs without assistance from outside sources.

In providing this assistance, the sociologist and the social worker have vital, leading roles to play.

All residents over sixty are receiving an old age, military or disability pension.

The physical condition of the aged residents was stated to be generally good. One is partially blind, four have only one leg and one has both legs amputated. Two residents are confined to their rooms permanently, one because of infirmity due to age and inability to climb the stairs, and one is infirm and blind. One of these two cases is incapable of self-care for any purpose.

Approximately half the residents in the age group under consideration were stated to be suffering from some degree of mental deterioration, and this estimate included three epileptics.

Three residents are totally deaf, and a number are partially deaf, including several who could benefit by the use of hearing aids.

About one quarter of the residents who need glasses are unable to get them because of transport difficulties.

Practically all have no relatives, and <u>not one receives visits at all</u>.

Residents who can go out are encouraged to do so as much as possible, but outings for groups are arranged very seldom because of lack of transport. A bioscope show is given by the Toc H once weekly, but apart from this no organisation visits the home to provide recreation and entertainment, and shortage of funds prevents any recreational programme from being carried out by the staff. Religious services are held regularly, and ministers of other religions visit the home, both regularly and when specially asked to do so.

Although this home was not intended to function as a permanent residence for aged men, it is seen that it does so, in fact, to a considerable degree. The home is intended to provide residential accommodation for homeless men in the working age groups, and temporary accommodation for others in social difficulties. The superintendent stated that he is continually turning away applicants of the former type because the home is full, and as the home's facilities and the experience of the superintendent and matron are intended to serve this particular social need, and their methods of social rehabilitation are aimed at eventual complete adjustment to living in the larger community, the presence of a number of permanent aged residents impedes this work, itself of vital social importance, and makes this home an illustration of the comments on page 118 of the thesis.

Appendix Five

Residential provisions for elderly tenants in a Cape Town housing scheme

The scheme provides residential accommodation for Europeans of the lower income groups, and is situated a few miles outside Cape Town.

The provision for aged tenants comprises sixty-four cottages for elderly couples and thirty-four flatlets for single women drawing an old age pension.

The cottages are semi-detached; the flatlets are in blocks of four, five and six, and both cottages and flats are scattered throughout the township.

Both cottages and flatlets are allocated to new and old tenants, but where the circumstances of the latter change so as to make an allocation necessary, they are given preference.

The cottages contain a living room, kitchen, bathroom and lavatory, and one bedroom; they have a shed in the yard for storage. The flatlets consist of a living room and bedroom combined, and a kitchenette; bathrooms, lavatories and storerooms are communally used.

Heating of water is done in the flatlets by means of electrically operated hot water cylinders, but the cottages do not have these.

All tenants may have small gardens if they wish, and it is reported that all tenants have at some time cultivated a garden, with some excellent results.

The tenants are visited regularly by social workers, who arrange for visits from the district nurse where necessary. Although no "home helps" are employed, the social workers often make arrangements informally with neighbours, relatives and servants to do what is necessary.

No special club facilities are organised, but social evenings for elderly tenants are arranged regularly.

It is reported that tenants make the fullest use of all facilities provided at present.

The most frequently found problems among this group of tenants are <u>infirmity and loneliness</u>.

The waiting list for this type of accommodation contains the names of forty-three couples wanting cottages, and one hundred and fourteen women needing flatlets. The selection committee does not take age into consideration as a primary factor, but works to the broad policy that the accommodation is intended for elderly people who are physically and mentally capable of making proper use of it.

In answer to a question regarding the improvements which would be made if resources permitted, the administrative staff said they would provide running water in the cottages; enlist the services of "home helps" on the basis that they could be called when required; and employ a full-time nurse.

Residential accommodation in a block of flats

This scheme provides residential accommodation for Europeans of the "genteel poor" class who are pensioners, with an income not exceeding £30 per month.

There are one hundred and ten flats, which are divided equally between single persons, married couples and couples with children.

Single bedroom flats are let at £4/17/6 per month, plus six shillings for electric stove; double bedroom flats at £5/12/6 per month plus six shillings for stove; and two bedroomed flats £7/12/6 per month plus six shillings for stove.

There is no heating system other than electric points, and water is heated by electric cylinders.

No cleaning services are provided, and there are no communal facilities; a small restaurant and grocery shop which operated were closed as the tenants did not make much use of them.

No problems have arisen among tenants which have required the attention of the social work personnel.

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