Second

INTERIM REPORT

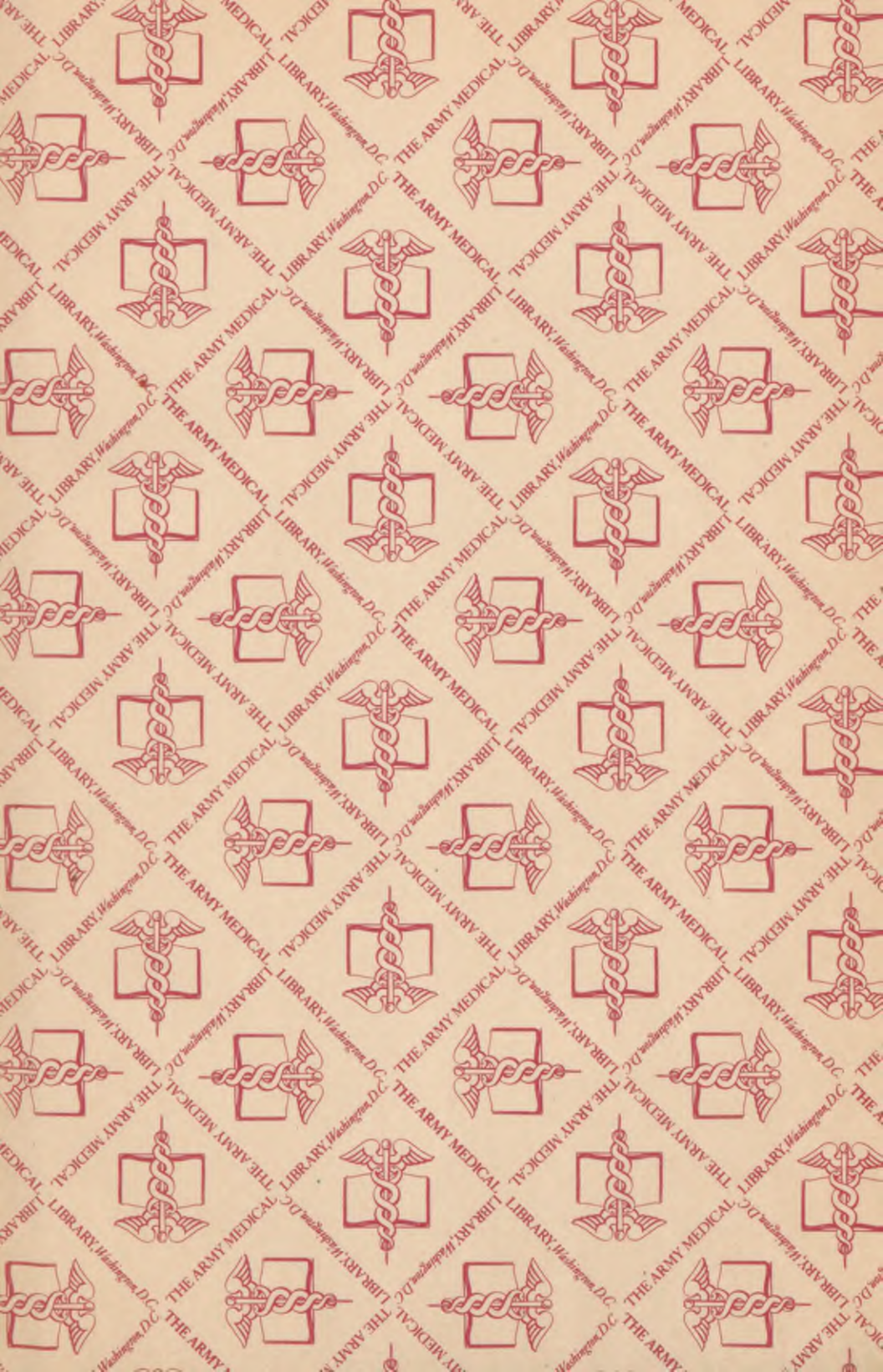
CONCERNING CARE OF THE CHRONICALLY ILL IN ILLINOIS

JUNE 1947

DWIGHT H. GREEN
Governor

THE COMMISSION ON THE CARE OF CHRONICALLY ILL PERSONS

ESTABLISHED BY ACT OF THE
SIXTY-FOURTH GENERAL
ASSEMBLY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JUNE 1947

DWIGHT H. GREEN
Governor

THE COMMISSION ON THE CARE OF
CHRONICALLY ILL PERSONS

Established by Act of the Forty-fourth
General Assembly

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INTERIM REPORT

CONCERNING CARE OF THE CHRONICALLY ILL IN ILLINOIS
JUNE 1947

DWIGHT H. GREEN
Governor

Illinois

THE COMMISSION ON THE CARE OF CHRONICALLY ILL PERSONS

Established by Act of the Sixty-fourth General Assembly

TEXT OF ACT CREATING THE COMMISSION ON THE CARE OF CHRONICALLY ILL PERSONS

(Senate Bill 436, Sixty-fourth General Assembly, Approved July 18, 1945)

An Act creating a commission to investigate the need of developing facilities for the care and treatment of persons who are chronically ill, defining the powers and duties of the commission, and making an appropriation therefor.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. There is created a commission, to be known as the Commission on the Care of Chronically Ill Persons, consisting of three members of the Senate to be appointed by the President thereof upon the advice of its Executive Committee, three members of the House of Representatives to be appointed by the Speaker thereof, the Director of the Department of Public Welfare, the Director of the Department of Public Health, and the Public Aid Director of the Illinois Public Aid Commission. The Commission shall select a chairman, secretary and such other officers as it deems advisable from among its members, and may employ such assistants as may be required for the performance of its duties hereunder. The members of the Commission shall receive no compensation but shall be reimbursed for actual expenses incurred in the discharge of their duties.

Section 2. The Commission shall make a thorough investigation and study of the hospitalization and other care and treatment facilities available in this State for persons who are chronically ill, the adequacy of such facilities, the need of developing additional facilities for such purpose, the desirability of enacting enabling or corrective legislation to increase or improve such facilities, and all matters germane thereto. The investigation and study shall embrace both governmental and private facilities and needs and shall relate to all chronically ill persons. The Commission may study and consider the matter of making State contributions for hospitalization and medical needs of chronically ill persons who are destitute and unable to meet such costs.

The Commission shall submit a report to the Sixty-fifth General

Assembly of the results of its research, together with such recommendations for legislative consideration and action as it determines to be necessary or desirable.

Section 3. In the conduct of any investigation hereunder the Commission may subpoena witnesses and compel the production of records, books, papers and other data, but no subpoena shall be issued except under the signature of the Chairman of the Commission.

Section 4. The sum of $20,000, or so much thereof as may be necessary, is appropriated to the Commission herein created for all ordinary and contingent expenses incident to the administration of this Act.

COMMISSION ON THE CARE OF CHRONICALLY ILL PERSONS

MEMBERS

SENATOR T. MAC DOWNING, *Chairman*
Macomb

SENATOR HUGH M. LUCKEY
Potomac

SENATOR ALBERT L. SCHWARTZ
Chicago

REPRESENTATIVE WILLIAM ROBISON
Carlinville

REPRESENTATIVE ADAM S. MIODUSKI
Chicago

REPRESENTATIVE DAN DINNEEN
Decatur

ROLAND R. CROSS, M.D.
Director, Department of Public Health

RAYMOND M. HILLIARD, *Secretary*
Public Aid Director, Illinois Public Aid Commission

CASSIUS POUST
Director, Department of Public Welfare
(Represented by Paul Hletko, M.D., Chief Medical Officer,
Medical Care and Treatment Division, Department of Public Welfare)

STAFF

PEARL BIERMAN

MARY-CLAIRE JOHNSON

NORMAN T. PAULSON

ROBERT ROSENBLUTH

In Memoriam

Senator Hugh M. Luckey, a member of the Commission on the Care of Chronically Ill Persons, died on December 29, 1946. He had participated actively in the work of the Commission and his passing interrrupted the valuable contributions he was making to assist in a solution of the important problem of chronic illness. The sad news came as a profound shock to his associates.

Senator Luckey was born near Potomac, Illinois, on November 2, 1873. He attended the Potomac grade and high schools. For more than 50 years he actively engaged in farming. He was a member of the Vermilion County Board of Supervisors and served as its chairman. In 1922 he was elected a member of the Illinois General Assembly and served seven terms in the State House of Representatives. In 1942 he was elected State Senator to fill a vacancy and in 1944 he was elected Senator for a full term. He was a member of the Potomac Methodist Church, Danville Consistory, and the Modern Woodmen of America.

On January 13, 1947, the State Senate adopted a resolution stating, in part, as follows:

> "His career, both public and private, was marked by selfless and devoted efforts in behalf of those he served. The devotion to his family and his kindness and his concern for their welfare gained him added respect from all who knew him."

The Commission on the Care of Chronically Ill Persons extends its sincere sympathy to Senator Luckey's widow and family and expresses deep sorrow at their bereavement.

CONSULTANTS TO THE COMMISSION

On Research in Chronic Illness and Geriatrics

Andrew C. Ivy, M.D., Chicago, Vice President, University of Illinois, in charge of Schools of Medicine, Dentistry, and Pharmacy

On Medical Supervision and Care in Institutions for the Chronically Ill

Robert S. Berghoff, M.D., Chicago

Harold M. Camp, M.D., Monmouth

Everett P. Coleman, M.D., Canton

Harlan A. English, M.D., Danville

Malcolm T. MacEachern, M.D., Chicago

John P. O'Neil, M.D., Chicago

Walter D. Stevenson, M.D., Quincy

On Hospitalization

The Reverend John W. Barrett, Chicago

Stuart K. Hummel, Joliet

C. S. Woods, M.D., Peoria

On Minimum Standards for the Care of the Chronically Ill

Malcolm T. MacEachern, M.D., Chicago, Chairman

Hugo Hullerman, M.D., Chicago

Everett W. Jones, Chicago

Leo M. Lyons, Chicago

Miss Edna Nicholson, Chicago

On Nursing

Mrs. Madeline Roessler, R.N., Chicago, Chairman

Miss Helen Frederick, R.N., Joliet

Miss Margery MacLachlan, R.N., Chicago

Miss Lorna May, R.N., Chicago

Central Service for the Chronically Ill of Chicago

William F. Petersen, M.D., Chairman, Administrative Committee

Miss Edna Nicholson, Director

TO THE SENATE AND HOUSE OF REPRESENTATIVES
SIXTY-FIFTH GENERAL ASSEMBLY
STATE OF ILLINOIS

The Commission on the Care of Chronically Ill Persons, created by the Sixty-fourth General Assembly to carry on in a broader field the investigations of the Committee to Investigate Chronic Diseases Among Indigents, has the honor of presenting for your consideration the accompanying report of its activities and findings and its recommendations with respect to needed remedial action by the General Assembly and the people of Illinois.

This Commission has found that the problem is even more extensive and serious than estimated in 1945 by the predecessor Committee to Investigate Chronic Diseases Among Indigents. The predecessor committee estimated that there were in the State as a whole 90,200 chronic invalids, that is, persons who had become so handicapped by chronic disease or permanent impairment that they required care by others. This Commission has found that a more probable figure, exclusive of the tuberculous and persons with nervous or mental ailments, is 117,679. In any case there are not less than 107,000. Of these, a minimum of 35,000 need care outside their own homes. There is a deficiency of 23,479 institutional beds for this latter group of patients.

Home nursing and housekeeping services for the many thousands of chronic invalids who can be cared for in their own homes are practically nonexistent. Nursing services have been established in only 23 communities in the State and these do not have sufficient facilities to serve all chronic invalids in the community who are in need of such services.

Beyond any question chronic illness is the major health and welfare problem now confronting the State and local governments in Illinois, private philanthropic agencies, the medical and nursing professions, and all citizens interested in the general welfare. The problem can be met only by a two-pronged attack: (1) Provision of decent and adequate facilities for the care, treatment, and possible rehabilitation of those now afflicted with chronic disease; and (2) a concerted and co-ordinated program of research into the causes of chronic illness in order that the incidence of chronic disease may be reduced or eliminated and methods of treatment improved. From the long-range view only the latter will provide an ultimate solution.

Much has been done during the present biennium by State and

local officials, private agencies, and interested citizens in beginning an attack on this problem. Of particular value have been:

1. The State-local co-operative plan for converting the former county "poorhouses" into adequately staffed and equipped nursing homes for the infirm and chronically ill.
2. The Illinois Hospital Survey of existing medical and nursing facilities.
3. The program for licensing private nursing homes.
4. The development of infirmary facilities in private not-for-profit homes for the aged.
5. The health survey in the Chicago-Cook County area and the survey of chronic disease in Sangamon County.
6. The development of interest in geriatrics and gerontology on the part of physicians.
7. The interest displayed by the medical and nursing profession in standards of care in institutions for the chronically ill.
8. Finally, but perhaps of major importance, the genuine interest and concern on the part of the general citizenry that facilities for care be of the highest type, that the best professional services be available to all those afflicted without any stigma or discrimination because of poverty, and that institutional care be provided close to home where the patient and the care given him may be seen by relatives and friends. Only an alert citizenry can keep present and future institutional facilities for the chronically ill from deteriorating into substandard facilities such as the former county "poorhouses" and some of the present-day nursing homes and hospitals for the mentally ill.

Obviously, the steps so far taken constitute only a beginning. Continuous study of the problem on the part of the State of Illinois is vital if planning is to be co-ordinated and the total program directed so as to achieve the goal of adequate care of the afflicted and ultimately, through modern research, the conquest of chronic disease itself.

The Commission wishes to express its appreciation and indebtedness to the many citizens and organizations who attended the hearings and, in particular, to the consultant committees of physicians, nurses, and hospital administrators who gave so freely of their busy professional time in providing the Commission with technical information and recommendations. The Commission also wishes to acknowledge

with sincere appreciation the assistance given by Dr. Henrietta Herbolsheimer and the staff of the Illinois Hospital Survey, the staff of the State Department of Public Health, the Illinois Public Aid Commission, and the physicians and health and welfare agencies of Sangamon County. Appreciation must also be expressed to the Chicago-Cook County Health Survey for permission to reprint in full their findings with respect to chronic illness in the Chicago-Cook County area.

Respectfully submitted,

COMMISSION ON THE CARE OF CHRONICALLY ILL PERSONS
By T. Mac Downing, Chairman

Springfield, Illinois
June 3, 1947

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I

RECOMMENDATIONS

Information assembled as a result of this Commission's studies, investigations, and consultations with interested citizens and competent authorities in the fields of medicine, nursing, and hospital administration has established beyond a doubt that the plight of Illinois citizens afflicted with chronic disease is the most pressing health and welfare problem now confronting this State.

The problem can be met constructively only by a *two-pronged attack*: (1) by providing adequate facilities and services for those who are now afflicted, using to the greatest possible extent already known and accepted methods of treating chronic disease; and (2) by research into the causes of chronic disease to the end that the incidence may be reduced and better means of treatment provided. From the long-range view the problem will ultimately be solved only through the second approach.

In the meantime Illinois is faced with doing something *now* in behalf of the estimated 118,000 citizens so seriously afflicted with chronic disease that they need care from others. In addition to these 118,000 there are numerous others afflicted with tuberculosis and those conditions requiring psychiatric treatment, commonly referred to as "nervous and mental," but not including neurological conditions such as muscular dystrophy, multiple sclerosis, cerebral palsy, and similar disorders. For the state as a whole there is a deficiency of 14,937 beds needed by persons with nervous and mental ailments and a deficiency of 3,113 beds for persons afflicted with tuberculosis. But the greatest need of all is for persons incapacitated by other types of chronic disease such as arthritis, cancer, heart conditions, and neurological disorders. The studies of this Commission show that there is a deficiency in beds for this group of chronic invalids ranging from 23,500 to a more probable figure of 31,600.

During the past biennium, as a result of interest stimulated by the predecessor Committee to Investigate Chronic Diseases Among Indigents, there has been wide activity and interest in getting something done to make additional beds available and to improve standards of

care and service provided for these afflicted people. Outstanding in terms of concrete action have been the program for converting the former county "poorhouses" into modern nursing homes for the infirm and chronically ill; the attention given by private philanthropic organizations toward utilizing homes for the aged as facilities for the infirm; and the program for State licensing of private nursing homes which has laid the groundwork for establishing better standards in all types of medical and related institutions.

The basic difficulty in long-time planning for the chronically ill, however, rests in the dilemma that the institutions which are apparently so sorely needed today—and these institutions are costly—may not be needed in future years when medical research strikes at the causes of incapacitating chronic diseases and succeeds in reducing or entirely eliminating it. Yet in facing this dilemma the State of Illinois cannot afford to wait out the results of research while those now afflicted suffer acutely and demand that something be done to help them in their plight. One need only quote from a letter written by a young woman of 30 to Miss Eleanor McClurkin of Aledo, herself crippled by arthritis and confined to a wheel chair for the past 24 years. This afflicted young woman stated her tragic plight in the following words:

> "My Mother may have to go for another operation this March or April and I have no place to go but to Oak Forest for three or four months until Mother is sufficiently recovered from her operation. My aunt is in poor health and is unable to care for me as she did last year.
>
> "I notice that you have studied about various homes where people with chronic diseases are taken care of. Oak Forest hasn't got treatment rooms where massages and electrical treatments[1] are administered to the patient in order to prevent the muscular structure of the patient becoming too weak from disuse of the muscles. If I go to Oak Forest and just lie in bed for a few months, my muscles will become too weak to walk as I'm doing now.
>
> "Eleanor, isn't there an institution in Illinois or even other states where I could go and where massages and exercises will be administered while I'm staying there? These treatments will prevent my muscles from becoming too weak from disuse. I can't afford to become too weak, or my Mother will have a bedridden patient to care for as long as I live.
>
> "Another thing is we can't afford to pay for my care. I don't

[1]Since this letter was written in 1946, Oak Forest has purchased considerable physiotherapy equipment.

know if we'll even manage a small sum to pay as long as I stay there.

"I heard through a friend that the Elgin State Hospital may have such facilities in taking care of chronically ill patients. Is this true?

"If you can help me, won't you do so immediately, Eleanor? My doctor will then try to make the necessary arrangements. My malady is Muscular Dystrophy."

The foregoing example can be matched from the files of physicians, hospitals, and health and welfare agencies throughout the State. Chronic disease is obviously this State's foremost health problem. This Commission therefore offers for the consideration of the Sixty-fifth General Assembly and the citizens of this State the following 10-point program:

1. *The State of Illinois should authorize immediately the establishment of a State Research Institute for the study of chronic disease and geriatrics to be operated by the University of Illinois College of Medicine in connection with the research hospitals attached to the University.*

   There should be developed between this Research Institute and hospitals throughout the State, public and private nursing homes, and homes for the aged serving the infirm and chronically ill a close relationship whereby the patients in these institutions may benefit by improved treatments developed at the Research Institute and whereby patients from these other institutions may be referred to the Research Institute for clinical study.

   It has been estimated that such a State Research Institute will require an initial appropriation of $2,500,000 for the purchase of land, erection of a building, and the acquisition of necessary equipment and that annual operating costs will approximate $950,000. On the basis of expenditures now being made for persons requiring public assistance because of chronic invalidism there is every indication that research and improved treatment will reduce these costs over a period of years and more than pay for itself.

2. *Immediate attention should be given by State and local governments working together and by public and private agencies working together, with the active participation of all citizens interested in health and welfare problems, to ways and means of meeting the present acute need for additional beds for chronic invalids who cannot be cared for in their own homes.*

   All planning for additional facilities, however, should be inte-

grated with the Illinois Hospital Survey and Plan and addressed to needs as therein revealed through careful study. It cannot be too strongly urged that integrated planning is essential if facilities are to be established where they are most needed and if those which are established are to be of the high standard necessary if costly waste is to be avoided. Information derived through this Commission's studies has indicated that the needed additional beds might be provided through several methods, it being understood that all such additional facilities would undertake to meet the minimum standards recommended by the technical committees consultant to this Commission. Additional beds may be provided through several sources:

a. *Through the addition of chronic care wings or adjunct buildings to general hospitals both public and voluntary (not-for-profit).* This will free beds in the general hospital for acute cases yet will provide chronic care in convenient access to a general hospital to which the patient may be transferred when in need of active medical care. Studies indicate that, in general, wings or adjuncts with not more than 20 per cent of the capacity of the general hospital will be assured of sufficient occupants, both private pay patients and patients coming from the public assistance rolls, to justify the cost of erecting the facility.

b. *Through extension of the program for converting county homes into public nursing homes for the infirm and chronically ill.* All counties having county homes suitable for conversion and of sufficient size to permit economical operation should undertake to convert county institutions into county homes for the infirm and chronically ill under the terms of legislation enacted by the Sixty-fourth General Assembly. About one third of the counties having convertible plants have already acted or plan to act under this enabling legislation, but the county boards in other counties appear to be hesitant because of the initial financial outlay and because of unwarranted fears that the State plans to assume control of the institution. This Commission joins with its predecessor Committee to Investigate Chronic Diseases Among Indigents in emphasizing that facilities for the chronically ill are best located in the local communities near the friends and relatives of the patient and that they are best operated under local control with appropriate State supervision to provide guidance as to standards and services. To date, the counties which do not have suitable plants for conversion have not explored fully the possibility of erecting or purchasing a suitable building or of developing a joint county home for the infirm and chronically ill as is permitted by the en-

abling legislation. This Commission strongly urges that the counties give consideration to this plan as preferable to the alternative of having the State erect a state-financed and state-controlled nursing home in areas where need is not met by local officials.

c. *Through extension of infirmary facilities in private nonprofit homes for the aged.* Private homes for the aged should be encouraged to carry forward plans begun during the present biennium to adapt their facilities so that an increasing percentage of chronic invalids may receive care in such homes. When endowments or other moneys become available for the erection of new facilities for private homes for the aged, it is urged that these be primarily for chronic invalids and the infirm, preferably located in connection with or convenient to a general hospital.

d. *Through the establishment of additional private nursing homes of high standard.* Additional nursing homes operated for profit should be encouraged in communities where need does not warrant the establishment of larger public or private not-for-profit nursing homes, but such private nursing homes, through the continuation of the State licensing procedure, should be encouraged to develop standards above the minimum now required and operators should be aided in developing understanding of the particular needs of chronically ill patients. Plans should be undertaken at once to establish regular medical supervision for these homes and to arrange for a close relationship with a general hospital in the community in which they are located.

3. *The State should enact legislation which will enable the State and local communities to share in federal funds made available for grants-in-aid under the Federal Hospital Survey and Construction Act (Public Law 725).*

The Illinois Hospital Survey and Plan carried out by the Department of Public Health with the assistance of an Advisory Council on Hospitals appointed by Governor Dwight H. Green has laid the groundwork for the State to participate in these federal benefits. The plan for participation will have been completed once enabling State legislation has been enacted. Such legislation will aid the State in expanding its hospital facilities in a co-ordinated manner and in providing facilities in those areas of the State where such facilities are now lacking.

4. *The development of provisions for rehabilitation, both for persons in hospitals or nursing institutions and in their own homes, is of utmost importance if the hopelessness of the remaining years of life of*

chronic invalids is to be ameliorated and as many as possible retrained so that they may be restored to usefulness, both for their own good and for the good of society.

A rehabilitation program, in addition to providing the best corrective medical care, should include occupational and recreational therapy, vocational retraining, and social services which will help the afflicted person understand his condition and help his family and friends co-operate with him in his effort to regain a useful role in life consistent with his incapacities. Indications are that through an adequate program of rehabilitation dependency among chronic invalids can be reduced by as much as 20 per cent. Intensified effort should therefore be made to institute a program of rehabilitation in all institutions caring for chronic invalids and ways and means should be developed for extending such programs to the greater number of chronic invalids who are cared for in private homes. Since many institutions are too small to permit the employment of full-time specialists in these lines, plans might be developed for several institutions to share the services of specialists. There is also here great opportunity for utilizing the services of volunteer individuals and groups such as were established during the war for service hospitals and camps. Extensive planning in this regard should be developed during the course of the next biennium.

5. *The State should enact legislation providing for a uniform system of licensing all hospitals and related medical institutions, both public and private.*

Such a uniform licensing provision is not only necessary as a means of establishing minimum standards for the protection of the patient, but it is also necessary as part of an integrated system of hospitals and nursing institutions.

6. *The costs of custodial care in an institution could be reduced and the needs of many chronically ill persons met more suitably if provision were made in each and every county of the State for visiting nurse and housekeeping services.*

At present such services are provided in only 23 communities. Such services should be provided on the principle that those who can pay for the services will do so and those who cannot pay will be aided through public assistance funds to meet such payments. The development of a system of visiting nursing and housekeeping services, however, must await further study of the needs within each community, existing facilities, and the development of the best plan of division of field as between public and private agencies which

are providing or which might provide the service. Such study should be pursued intensively during the next biennium.

7. *Housing authorities should give attention to developing apartments and accommodations for the aged as part of the normal community which will comprise the housing project.*

It has been suggested that approximately 10 per cent of the units located on the ground floor might be assigned to ambulant chronic invalids, other factors permitting. This should particularly be the case in housing units located near a general hospital.

8. *A register of available facilities which provide care and service at or above minimum standards should be developed in each county so that persons afflicted with chronic illness and the members of their families may be guided to the best care available in terms of the particular patient's needs.*

Such a register should be made available to all persons in the community, rich and poor alike, and might well be established by councils of social agencies or other organizations of health and welfare groups. In some areas it may be feasible also to establish a register of seriously invalided persons through the co-operation of physicians and health and welfare agencies as an aid in planning the facilities and services required to meet community needs.

9. *No person afflicted with chronic disease should be denied the care he needs because he is poor or because what resources he has are not sufficient to meet the usually heavy costs of chronic illness.*

The State of Illinois from the beginning of its history has recognized public responsibility for helping pay the costs of medical care for all persons who cannot pay such costs in whole or in part. In recent years, with the development of the State's health and welfare programs, this principle of public responsibility has been further refined to include the principle that there shall be no stigma attached to persons who must receive public help because of illness or other cause; that such persons should have access to the same facilities as private pay patients and receive the same quality of care; and that they should be free to choose, as any other citizen, the physician and institution which will give them the care needed by their condition. At present persons otherwise needy and qualifying for one of the four major types of assistance (Old Age Pension, Blind Assistance, Aid to Dependent Children, and General Relief) are assured of complete medical care whenever they become ill whether from acute or chronic disease. The Illinois laws also provide for meeting at public cost through General Relief funds and State supplementation the medical needs of the border line income group

known as the medically indigent. It may be assumed that the preponderance of medical indigency in the low income group not otherwise in need of public assistance is caused by chronic disease.

The State and local program for care of the medically indigent is at present defective in two respects despite the broad coverage intended by the governing law: 1) Adequate moneys for aid to the medically indigent have not been set aside in every area of the State, particularly in local governmental units which are not receiving State grants-in-aid for General Relief; and 2) the present statute makes an exception for medically indigent persons living in the City of Chicago or the Incorporated Town of Cicero. These persons must look to the County of Cook rather than to the General Relief agencies in these communities. Furthermore, the County of Cook gives them no choice of care, requiring that they go either to the Cook County Hospital or accept the services of the Cook County physician. Elsewhere in the State a medically indigent person goes to the General Relief agency which provides for his care by the hospital and physician of his choice.

It is urged that these faults in the present structure for payment of costs through public assistance be studied to the end that uniform provision may be made for the care of the medically indigent including the chronically ill.

10. *To bring to a successful conclusion the activity which has developed during the past few years in mobilizing the community to develop sound future plans for the care of the chronically ill, it is necessary that the State of Illinois, through representative members of its General Assembly in co-operation with citizens and persons competent in the field, continue to study the problem of chronic illness and direct all efforts toward a co-ordinated and well-thought-out plan.*

There should therefore be created a successor commission to continue the State's responsibilities especially in the following fields:

a. To study and make recommendations concerning the proper relationships which should be developed between the various types of public and private facilities and the State Research Institute.

b. To develop and make recommendations concerning a suitable plan for the extension of home nursing and housekeeping services including the proper relationship of these services to institutional care for the chronically ill.

c. To consider the desirability and feasibility of State grants-in-aid for construction expenses for county nursing homes and other not-for-profit nursing institutions not qualifying as "hospitals"

and therefore not eligible for federal-state grants-in-aid under the Federal Hospital Survey and Construction Act.

d. To carry out additional first-hand studies of the extent of chronic invalidism and the need for beds for the purpose of seeing that need is met but that unnecessary and costly facilities are not projected should developments in research and other types of services indicate that they are not needed.

e. To analyze State-local relationships and public-private relationships in joint undertakings for service to the chronically ill for the purpose of clarifying fields of responsibility and preventing duplication and overlapping. It should be emphasized that sound planning for the chronically ill is the joint responsibility of all levels of government and it is the joint responsibility of public and private philanthropy. Only through clear understanding of these relationships and full co-operation can there be developed a co-ordinated and efficient plan.

II

OUTSTANDING FACTS CONCERNING CHRONICALLY ILL PERSONS IN ILLINOIS

Number and Age of Persons with Chronic Disease as of 1947[1]

It is estimated that there are 1,483,000 persons in the State, 18.8 per cent of the total population, who have some kind of chronic disease or permanent impairment. Of these, 18,700 are children under five years of age; 273,000 are persons 65 years of age or over; and 1,191,300 are persons between the ages of five and 65. The age groups presenting the greatest numbers with chronic disease are 35-44 years, 263,000 persons; 45-54 years, 288,300 persons; and 55-64 years, 236,100 persons. Thus it will be seen that chronic illness is not a problem of the aged alone. *It strikes most devastatingly in the middle years when persons should be at their prime in terms of contribution to the economic and social welfare.*

Number of Chronic Invalids[2]

It is estimated that there are in Illinois from 107,000 to 118,000 chronic invalids exclusive of the tuberculous and persons with nervous or mental ailments; the latter number is the more probable figure. The chronic invalid, as distinguished from the total and larger group of persons afflicted with chronic disease or permanent impairment, is one whose condition is so handicapping that he requires care from others.

Dependency

Chronic invalidism is the greatest single causative factor (other than great economic depressions) in forcing people onto public assistance rolls. Assuming that the situation in Sangamon County in Janu-

[1]The information summarized here is set out in more detail later in this report together with explanation of source material and methods used in assembling the data in support of these conclusions.

[2]Definition of chronic or long-term illness or invalidism: The acute or short-term illness is one which, when recovery is completed after a relatively short period of time, does not result in change of normal adjustments and ways of living which prevailed for the individual before the onset of the disease. The chronic or long-term illness, in contrast to the acute, requires an adjustment of the manner of living for the individual for the remainder of his life or for a very long period after the chronic disease attacks. A chronic invalid is a patient whose chronic illness is of such severity that his condition requires at least the availability of others when need arises; occasional or seasonal care from others is generally needed; and from such minimum degree of affliction the need for care progresses to the point where constant attention needs to be available either from others in the patient's own home by supplementation to home care by visiting housekeeper or visiting nurse service, and in most advanced stages by care in special nursing homes or institutions.

ary 1947 was typical for the State as a whole, 23.2 per cent of all public assistance recipients (Old Age Pension, Blind Assistance, Aid to Dependent Children, and General Relief) are chronic invalids. Of the aged, 35.6 per cent are chronic invalids requiring care from others; of the blind, 63.6 per cent; of dependent children and the adults caring for them, 5.6 per cent; and of recipients of General Relief, 13.8 per cent.

Other Social Problems

There are serious social problems in addition to the economic and physical care problems caused by chronic invalidism. Children may have to forego employment to look after chronically invalided parents (or the reverse), leading often to the loss of their own careers or interfering seriously with the supervision of their own children. In addition, chronic invalidism often leads to physical or emotional impairment of those who have to care for the invalided person in the home. There is a "chain-reaction" effect to chronic invalidism, affecting many others besides the actual invalid.

Need for Research

While the whole field of geriatrics (diseases of the aged) and of gerontology (the aging process) represents the least known and most neglected areas of medical and sociological science, there is a present awareness of the problem and its great significance. It has been estimated that, given needed support, medical research could reduce by 20 per cent the number who would otherwise develop into chronic invalids and could greatly ameliorate or improve the condition of many others.

There is no matter of greater significance than the stimulation of such research. A proposal of such a project has been made to this Commission by Dr. Andrew C. Ivy. This proposal has the complete endorsement of this Commission and is set out as its first recommendation for future action by the General Assembly and the people of Illinois.

Possibilities of Rehabilitation

It is estimated that at least 20 per cent of sufferers from chronic invalidism may, by a program of rehabilitation, be restored to a reasonably normal and self-sustaining regime of life. Most of the remaining sufferers can have the hopelessness of their remaining years greatly altered by adequate programs, understanding, constructive guidance, and help.

Attitudes

Public and individual attitudes toward chronic invalidism need thorough revision. There seems too often an unwarranted sense of

shame, tending to concealment of the presence of a chronic invalid in the home. This concealment, particularly as to a senile parent or a palsied child, minimizes the known extent of the problem and hinders community planning for meeting the problem.

This attitude, in part, is intensified by the fact that there is a great dearth of adequate facilities outside the home, either public or private, where care for the chronic invalid might be secured, particularly at a reasonable cost. This intensifies the feeling that anyone who even considers having the invalid cared for outside the home (even if only inadequate care can be given in the home) is "unnatural" or "heartless."

Need for Beds

Of the 118,000 chronic invalids, a minimum of 35,000 need care outside their own homes. To meet this need there are only 11,521 beds available, or a deficiency of 23,479 beds. In addition, there is a deficiency of 3,113 beds for the 7,708 tuberculous requiring care outside their own homes, while the deficiency is 14,937 beds for the 37,741 chronic invalids requiring psychiatric care because of nervous or mental conditions.

Type of Care Required by Chronic Invalids

Of the chronic invalids, slightly over one third can be cared for adequately in their own homes with occasional help from other members of their household.

One third of the chronic invalids can be cared for adequately in their own homes, provided outside assistance, such as visiting nurse or visiting housekeeping service, is available.

But approximately 30 per cent of the chronic invalids require more care than their own homes can provide and need special facilities such as care in public or private nursing homes, in general hospitals or in special chronic disease hospitals.

Types of Facilities Needed

There is need for a great increase in facilities for chronic invalids, particularly in public and private nursing homes and in special institutions, the latter preferably connected with large general hospitals.

Creation of adequate and satisfactory special facilities for chronic invalids will not only help meet their needs but will most economically serve the need for more adequate facilities for the acutely ill in general hospitals. It has been estimated that as much as 20 per cent of patient-days in general hospitals would be made available for acute cases were there adequate provision for care elsewhere for chronic invalids.

Standards in Existing Institutions

Every effort must be made to raise standards of nursing homes

and of existing public institutions caring for chronic invalids. Much progress has been made in Illinois along these lines, but much still remains to be done.

Chronic Invalidism in the General Population

Chronic invalidism is not by any means confined either to public assistance recipients or to those 65 and over. While the proportion of chronic invalidism in the assistance group is much greater, the number of chronic invalids *not* on assistance rolls exceeds that in the recipient group. Analysis of the group of chronic invalids, that is, those who require help from others, shows that between 8 per cent and 12 per cent develop into chronic invalids because of lack of treatment or care, particularly in the earlier stages of the disease.

III

THE PRINCIPAL CHRONIC DISEASES

Various listings and classifications of chronic disease are given by different authorities. Based on the Sangamon County Survey (see Section XI of the Appendix), out of 3,296 cases of chronic diseases listed[1] by the doctors of that county, the principal chronic diseases are as follows:

Disease	No. of Cases	Per Cent
TOTAL	3,296	100.0
Hypertension	587	17.8
Heart disease	520	15.8
Arteriosclerosis	295	9.0
Rheumatism and arthritis	275	8.3
Chest conditions other than tuberculosis	264	8.0
Fractures	187	5.7
Physical senility	169	5.1
Asthma	160	4.9
Urological conditions	129	3.9
Cancer	108	3.3
Diabetes	106	3.2
Nephritis	96	2.9
Orthopedic and crippling conditions other than fractures	93	2.8
Neurological conditions	73	2.2
Mental senility	58	1.7
Epilepsy	56	1.7
Blood dyscrasia	55	1.7
Mental disease and defects other than senility (noncommittable)	42	1.3
Other conditions	23	0.7

[1]Tuberculosis is not listed in this group because there are special laws and special facilities provided for sufferers from this disease. (See special section on this subject in the very excellent report of the Illinois Hospital Survey.) For the same reason committable mental defect and mental disease were not included since the State maintains special state institutions for such patients.

The National Health Survey, in 1938, found that if all causes of invalidism were counted including tuberculosis and nervous or mental diseases or defects tuberculosis would account for 5.3 per cent and nervous or mental diseases for 18.2 per cent of an over-all total.

In the *Interim Report* of the predecessor Committee (1945) the same findings with minor variations are reported.

If the classification were based on severity of invalidism, some modification would have to be made. Likewise, modification would have to be made if classification were based on knowledge of causes and preventability of progressive disability provided early diagnosis and proper care were given. Thus, the American Cancer Society states that one out of every eight deaths is caused by cancer, which numerically occurred in only 108 of the 3,296 cases of chronic disease reported in the Sangamon County Survey.

In general, the findings reported in the table above correspond to accepted findings elsewhere as to the relative numerical importance of causes of chronic invalidism with diseases of the heart and circulatory system and rheumatism leading all other causes.

IV

MOST IMPORTANT NEXT STEP: RESEARCH IN CHRONIC DISEASE AND GERIATRICS

The outstanding finding of this Commission is that the State of Illinois should take steps immediately to establish a research institute for the study of chronic disease and geriatrics.

As the Commission proceeded to work with its consultant committees representing the medical and nursing profession and hospital administrators, as it heard testimony at the hearings conducted in various points in the State, and as it evaluated statistics concerning present facilities, it reached the inescapable conclusion that the major attack on this problem must be immediate attention to decreasing the incidence of chronic illness.[1]

As this conclusion emerged early in the deliberations of the Commission, Dr. Andrew C. Ivy, Vice President of the University of Illinois in charge of the Schools of Medicine, Dentistry, and Pharmacy was asked to submit a concrete proposal. This proposal is set out in detail in Section IV of the Appendix.

Dr. Ivy points out the great importance of sound planning for the care of the chronically ill with facilities and services to meet the existing emergency need and research in those diseases which cause chronic illness and premature aging to stem the increasing incidence of chronic illness. He recommends, therefore, a research institute for the study of chronic illness and geriatrics, established as a part of the University

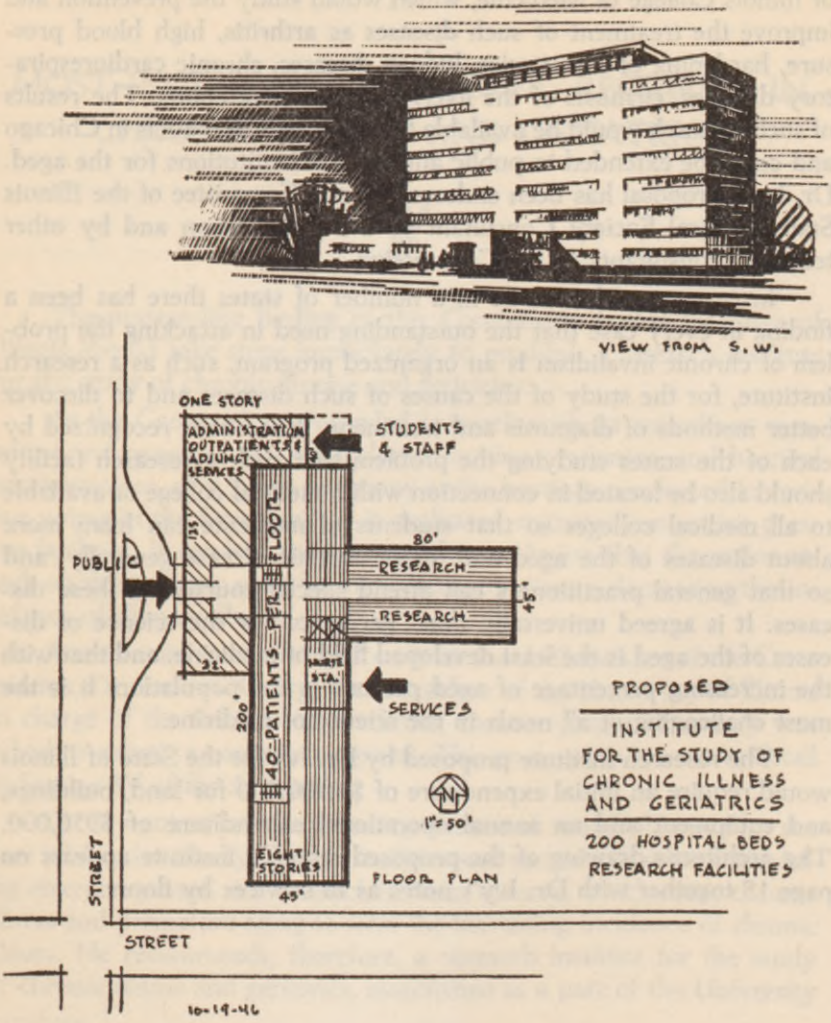
[1]Henrietta Herbolsheimer, M.D., Director of Study, Illinois Hospital Survey, commented in a letter to the Commission on May 22, 1947 that while research will lessen the incidence of chronic disease, full use of known methods of therapy will also do so. To quote in part from her letter:

> "Many of the conditions commonly listed in tabulations on chronic diseases include conditions for which considerable amelioration can be accomplished at the present time with facts now well in hand. In asking so much of medical research, the rehabilitation factor seems lost. From the Federal Congress on down to the smallest sociological group the atom bomb has catalyzed widespread use of the word 'research' so that the term has almost become a platitude and stripped of its real meanings. Real and fundamental medical research is an inspired activity the end results of which as they apply to man have passed through numerous and time-consuming studies by laboratory scientists. This takes years, decades or centuries. If the case load of the chronically ill is as significant medically, socially, and economically as the figures indicate, emphasis should be placed on the practicability of using known facts to ameliorate the present circumstances."

of Illinois College of Medicine, which would study the prevention and improve the treatment of such diseases as arthritis, high blood pressure, hardening of the arteries, kidney diseases, chronic cardiorespiratory diseases, cirrhosis of the liver, and ulcerative colitis. The results of such research would be available to other medical schools in Chicago and could be extended to public and private institutions for the aged. Dr. Ivy's proposal has been endorsed by the Committee of the Illinois State Medical Society Consultant to the Commission and by other technical consultants to the Commission.

In current studies made in a number of states there has been a finding in every case that the outstanding need in attacking the problem of chronic invalidism is an organized program, such as a research institute, for the study of the causes of such diseases and to discover better methods of diagnosis and treatment. It has been recognized by each of the states studying the problem that such a research facility should also be located in connection with a medical college or available to all medical colleges so that students of medicine can learn more about diseases of the aged and about chronic disease generally, and so that general practitioners can attend special courses on these diseases. It is agreed universally that "geriatrics" or the science of diseases of the aged is the least developed field of medicine, and that with the increasing percentage of aged persons in the population, it is the most challenging of all needs in the science of medicine.

The research institute proposed by Dr. Ivy for the State of Illinois would require an initial expenditure of $2,500,000 for land, buildings, and equipment and an annual operational expenditure of $950,000. The architect's drawing of the proposed research institute appears on page 18 together with Dr. Ivy's notes as to services by floors.



Schedule of Services by Floors

Basement—Service Rooms; Mechanical Equipment Space; Storage; Staff Food Service; Locker Rooms.

First Floor—Administrative Offices; Outpatient Services; Radiology; Physical Therapy, Occupational Therapy; Conference Rooms; Special Diet Kitchen; Social Service.

Second to Sixth Floors (5 floors)—40 Beds each; Nursing Services; Food Service; Research Laboratories; Offices; Service Rooms.

Seventh and Eighth Floors—Long-term Studies on Animals.

V

ACTIVITIES OF THE COMMISSION

The Commission on the Care of Chronically Ill Persons was created by Senate Bill 436. This Bill was introduced in the Sixty-fourth General Assembly by Senator Arthur J. Bidwill of River Forest and Senator T. Mac Downing of Macomb and signed by Governor Dwight H. Green on July 18, 1945.

In accordance with the creating Act (see page i for complete text), the Commission consisted of three members of the Senate, three members of the House, the Director of the Department of Public Welfare, the Director of the Department of Public Health, and the Public Aid Director of the Illinois Public Aid Commission. The Commission was created to continue in a broader field the studies begun during the preceding two years by the Committee to Investigate Chronic Diseases Among Indigents. It was empowered to investigate and study both governmental and private facilities and needs as they relate to all chronically ill persons, not only the indigent, and to examine the adequacy of existing facilities, the need of developing additional facilities, and the desirability of enacting enabling or corrective legislation to increase or improve facilities.

Organization

The Commission held its organization meeting in Chicago on March 20, 1946. Senator Downing was elected Chairman and Raymond M. Hilliard, Public Aid Director of the Illinois Public Aid Commission, was elected Secretary.

The Commission was promised an auspicious start because of the wide public interest in the problem which had been aroused by the *Interim Report* of its predecessor committee, which was submitted to the Sixty-fourth General Assembly on June 7, 1945. Subsequent to the submission of the *Interim Report* the Sixty-fourth General Assembly passed bills carrying out several of the major recommendations of the Committee. These included the Rennick-Laughlin Bills enabling county boards to convert the former "poorhouses" into county nursing homes for the infirm and chronically ill; the Gibbs Bill providing for the licensing of private nursing homes by the Department of Public Health;

and the Peters-Ryan Bill providing for the construction of five State tuberculosis sanatoria.

During the period between the adjournment of the Sixty-fourth General Assembly and the organization meeting of the Commission on the Care of Chronically Ill Persons in March 1946, state and local agencies responsible for the county home conversion program and the nursing home licensing program had these activities well under way. In addition, the Governor had appointed an Advisory Council to the State Department of Public Health to assist that Department in conducting a state-wide survey of hospital and health facilities, in which survey it was planned to assemble data concerning available facilities for the chronically ill as well as the acutely ill.

Field of Investigation as Recommended by Predecessor Committee

In planning its investigations and studies the Commission had the advantage of conclusions reached by the predecessor Committee to Investigate Chronic Diseases Among Indigents. The most significant of these conclusions, as set out in the *Interim Report*, are quoted here because of their continuing significance and because they provide the background for the detailed activities of the present Commission.

NATURE OF CHRONIC DISEASE

"Chronic disease has been described by The Surgeon General of the United States Public Health Service as 'the nation's number 1 health problem.' The full effect of the change in the nature of diseases causing death is only beginning to be evident. It is apparent that this change will require increased attention by the medical profession and by hospital management which have in the past given major emphasis to acute illnesses. It is also apparent that chronic disease carries with it serious social and economic implications. These will require immediate and careful study, in order that a public policy may be formulated which will keep to a minimum the economic and social losses attendant upon prolonged illness."[1]

EXTENT OF CHRONIC ILLNESS

"All . . . . factors . . . . point to the increasing seriousness of the problem of chronic illness. They indicate that chronic invalidism is not confined to the aged or to any one group alone; nor is it confined to the indigent. While the problem of chronic illness bears more heavily on the poor than on others, it is important to keep in mind the fact that the indigent chronically ill constitute only one part of a very large

[1] *Interim Report of the Committee to Investigate Chronic Diseases Among Indigents*, Springfield, Illinois, June 1945, p. 5.

group of invalids in Illinois, all of whom are urgently in need of more and better facilities for care."[1]

Possibilities for Additional Facilities

". . . . facilities currently available in Illinois for care of the chronically ill would indicate that future study should be directed toward the following possibilities for establishing additional facilities for the chronically ill and for co-ordinating all types of facilities so as to assure adequate care and service to all residents of the State of Illinois who are afflicted with chronic disease or permanent impairment:

1. "The possibility of setting aside more beds in general hospitals for patients who are chronically ill, or of establishing infirmary facilities in connection with general hospitals.
2. "The possibility of converting County Homes which can be so converted into homes for the infirm and chronically ill, with proper regard to construction, sanitation, and general hygiene so as to safeguard the health, safety, and comfort of the patients.
3. "The possibility of establishing additional tuberculosis sanatoria, with attention to their proper distribution so as to provide ready access to tubercular patients in all parts of the state.
4. "The possibility of establishing additional infirmary facilities in private institutions for the aged.
5. "The possibility of establishing additional private nursing homes and homes for convalescent care, under competent management and with proper standards, licensed, and supervised by a state agency or by local governments in conformity with state standards.
6. "The possibility of establishing additional home nursing and housekeeping services."[2]

Fundamental Questions To Be Considered

"Dr. (Herman L.) Kretschmer has ably summarized the fundamental questions which must be considered in developing a sound public policy. Dr. Kretschmer says:

" 'Before any sound program can be instituted, careful and serious consideration must be given to the fundamental questions, as:

1. " 'The relative distribution of responsibility which should be maintained by voluntary, philanthropic and proprietary services for establishing and operating the necessary homes and hospitals.
2. " 'The responsibility which should be assumed by the government for the indigent.

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[1] *Interim Report*, p. 9.
[2] Ibid., p. 18.

3. " 'The desirable size and location of the facilities to be established.
4. " 'The extent to which beds are needed in hospitals or treatment centers as distinguished from homes for patients who cannot hope to profit from treatment and need only continued personal care and nursing attention.
5. " 'The most satisfactory method of financing care for patients unable to pay the costs of care, in whole or in part.
6. " 'The most effective means of maintaining adequate standards of care in institutions serving these patients, i.e., through licensing laws, periodic inspection by state or local authorities, and so on.

" 'Whether there are to be special institutions for the chronically ill, i.e., chronic disease hospitals separate and apart from those serving acutely ill patients, or whether they are to be separate wings or additions to these hospitals. Much discussion must be given to this question'."[1]

Method of Conducting Investigations

The problems, as outlined by the predecessor Committee, made it obvious that the work of the present Commission must necessarily focus on five main lines of inquiry.

1. Assembly of information (through persons competent in the technical and professional fields involved) concerning the medical, hospitalization, and nursing needs of chronically ill persons and the standards which should be required of persons and agencies giving care to such persons.
2. Evaluation of existing facilities, as these had developed or not developed subsequent to the appraisal made by the predecessor Committee.
3. Utilization of data assembled by the state-wide Illinois Hospital Survey and by local surveys as a means of providing a current and accurate estimate of available facilities and gaps in these facilities, and, if necessary, the execution of additional surveys to provide a comprehensive current picture of the problem.
4. Consultation with persons in various sections of the State who are interested in the problem of chronic illness to determine from their reports what the problem is locally and what plan for meeting the problem is recommended by persons who know conditions in their own communities.
5. Determination, on the basis of the information assembled, of what is today's problem and what action should be taken in terms of enabling or corrective legislation and in terms of endorsing or correcting existing programs.

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[1] *Interim Report*, p. 27.

Appointment of Consultant Committees

Since the formulation of sound standards of care and of recommendations concerning methods of providing such care required the professional knowledge of physicians, nurses, and hospital administrators, the Commission asked the Illinois State Medical Society, the Illinois Hospital Association, and the Illinois State Nurses' Association to designate persons to serve as consultants to the Commission in considering these many technical aspects. The members of these consultant committees and of other groups who served the Commission at its request are given on page v. A meeting of all of the technical consultant committees was held in Chicago on September 7, 1946 and separate meetings with individual committees in November and December 1946 and in March 1947.

Public Hearings

Public hearings were held in Urbana on May 8, 1946; in Danville on May 9, 1946; in Carbondale on August 7, 1946; in Springfield on October 10, 1946; and in Rockford on February 14, 1947. In addition, a special meeting was held in Chicago on July 11, 1946 with representatives of medical schools in the Chicago community, hospital administrators, and representatives of homes for the aged.

Inspection of County Institutions

The Commission visited the county homes for the infirm and chronically ill in Champaign, Vermilion, Jackson, and Winnebago Counties. In addition, the Commission sent a small subcommittee to California to inspect county institutions there which had gained nationwide repute for excellence in care and research. This subcommittee also met with state and local officials in California and representatives of the California medical schools who have been concerned with the problem of the chronically ill and who had been developing a program which it was felt might provide constructive suggestions for future planning in Illinois.

Surveys

The Commission arranged for access to the findings of the Illinois Hospital Survey which was carried out by the State Department of Public Health, and the Chicago-Cook County Health Survey which was carried out by the United States Public Health Service. Permission has been given to reproduce in this report pertinent findings from these surveys (see Sections IX and X of the Appendix).

In order to provide a first-hand study of the extent of chronic diseases and other long-term illnesses in a typical downstate county the

Commission arranged with the Sangamon County Medical Society, local public officials, private and public health agencies, and the State Department of Public Health to undertake such a survey. The survey was carried out by Robert Rosenbluth of the Public Aid Commission with the co-operation of these Sangamon County agencies. A detailed report of this survey is made in Section XI of the Appendix.

Mr. Rosenbluth also assembled for the Commission information concerning activities in other states.

VI

SUMMARY OF ILLINOIS DEVELOPMENTS DURING THE 1945-1947 BIENNIUM

Illinois Hospital Survey

On July 23, 1945 Governor Dwight H. Green appointed an Advisory Council on Hospitals to assist the Illinois Department of Public Health in making a state-wide study of hospital facilities in Illinois for the purpose of developing a plan for postwar improvement and extension of these facilities. It was contemplated that the plan would embrace both governmental and nongovernmental institutions and agencies, on both state and local levels, and would qualify Illinois for participation in any federal benefits which it was anticipated would become available to the States for the development of hospital facilities.[1] Robert S. Berghoff, M.D., Chicago, President of the Illinois State Medical Association, served as Chairman of the Advisory Council and Henrietta Herbolsheimer, M.D., Springfield, Chief of the Division of Maternal and Child Hygiene, State Department of Public Health, served as Executive Secretary. Dr. Herbolshiemer also served as Director of Study for the Survey.

The schedule of information prepared by the National Commission on Hospital Care was used. These schedules were sent in September 1945 to almost 1,200 institutions listed as hospitals and nursing homes excluding, however, hospitals operated by the federal government and other institutions not serving the general public such as infirmaries, prisons, etc. By December 1945 the completed schedules had been collected. Thirty-seven per cent of the institutions were deleted from the study because, on the basis of data submitted, they did not

[1]Such provision was made by Public Law 725 enacted in 1946 by the 79th Congress of the United States. In a letter dated April 16, 1947 and addressed to Raymond M. Hilliard, Secretary of this Commission, Dr. Henrietta Herbolsheimer, Director of Study, Illinois Hospital Survey, states: "The United States Public Health Service Regulations on the administration of Public Law 725 clarify to some extent the difference between nursing home facilities and chronic and convalescent hospitals. None of the nursing homes listed as such in the tables and portrayed in the maps in the report of the Illinois Hospital Survey can qualify as hospitals for the long-term convalescents or chronically ill, and cannot receive favorable consideration for grants-in-aid under Public Law 725. . . . . Public Law 725 affects only those institutions for long-term patients wherein there is detailed medical supervision, high level of nursing care, and facilities and programs for occupational, recreational, and rehabilitation therapy."

qualify as hospitals or allied institutions. Only five institutions refused to co-operate with the Survey by submitting the desired information. The final report was based on data submitted by 320 hospitals and 362 nursing homes, a total of 682 institutions.

The report of the Illinois Hospital Survey and Plan is now under final draft and will be made available in printed form. Through the courtesy of the Illinois Department of Public Health and the Advisory Council on Hospitals, the Commission on the Care of Chronically Ill Persons was given access to the Survey findings as assembled in preliminary drafts of the report and has been given permission to reproduce portions of this material which have bearing on the care of the chronically ill.

According to the Illinois Hospital Survey and Plan there were in Illinois, as of 1945, 682 institutions providing hospital or allied services. These institutions were built to accommodate 67,204 persons but at the time of the Survey they actually had set up 80,625 beds. The most serious overcrowding occurred in hospitals for those afflicted with nervous and mental diseases.

Although nervous and mental ailments and tuberculosis are types of "chronic disease," the Illinois Hospital Survey distinguished facilities for these patients from facilities for other types of chronic and convalescent patients because, as stated by Dr. Henrietta Herbolsheimer, "the problems of provision of facilities for tuberculous and psychiatric patients are large enough in themselves to warrant all the special attention which they have been receiving and continue to receive, and adding them to the problem of persons chronically ill from other causes only confuses the whole picture." The same distinction has guided this Commission in pursuing its investigations.

In Section IX of the Appendix there are printed by permission excerpts from the Illinois Hospital Survey and Plan which have reference to the care of chronic and convalescent patients.

In order that the excerpts regarding the care of the chronically ill may be related to the total picture of medical and nursing facilities in Illinois as of 1945, there is reproduced below a table from the Illinois Hospital Survey indicating the number of institutions of all types and the number of beds.

It will be observed from the following table that a little over 53 per cent of all institutions included in the Illinois Survey were devoted to the care of the chronic and convalescent exclusive of specialized facilities for the tuberculous and the nervous or mentally ill.

Overcrowding was not a problem in the chronic and convalescent institutions to the same extent that it was in the general hospitals and

TYPE OF HOSPITALS AND BEDS, BY TYPE, ILLINOIS 1945

Type of Hospital	Hospitals		Beds*			
			Number		Per Cent of Total	
	Number	Per Cent of Total	Normal	Complement	Normal	Complement
TOTAL	682	100.0	67,204	80,625	100.0	100.0
General	228	33.4	27,451	28,447	40.8	35.3
Allied special	37	5.4	2,721	2,590	4.0	3.2
Nervous & mental	25	3.7	21,955	34,414	32.7	42.7
Tuberculosis	30	4.4	3,556	3,661	5.3	4.5
Chronic & Convalescent†	362	53.1	11,521	11,513	17.1	14.3

*"Normal" is used to denote the number of beds for which the various institutions were built or the number of beds which normally should be in use. The term "complement" is used to denote the number of beds which were actually set up and in use at the time the survey was made.

†Mostly nursing homes providing little in addition to domiciliary care.

in the hospitals for the nervous and mentally ill probably because chronic and convalescent institutions admit only those patients for whom they have space, requiring those who need care to remain on a waiting list or in the beds of general hospitals. The Survey also revealed that existing facilities are poorly distributed as will be noted from the five maps on pages 56 through 60.

The Illinois Hospital Survey also undertook to determine the extent to which hospitals of one type provide facilities for patients of other types. Data were assembled for institutions of 25 beds or more and the findings were as set out in the table below:

BEDS AVAILABLE FOR CERTAIN TYPES OF PATIENTS IN HOSPITALS OF 25 BEDS OR MORE, BY TYPE OF HOSPITAL, ILLINOIS 1945

Type of Hospital	Type of Patient					
	Nervous & Mental		Tuberculosis		Chronic & Convalescent	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
TOTAL	32,616	100.0	6,847	100.0	8,104	100.0
General	549	1.7	357	5.2	168	2.1
Allied special	.....	.....	.....	.....	51	0.6
Nervous & mental	32,059	98.3	2,265	33.1	35	0.4
Tuberculosis	.....	.....	3,651	53.3	.....	.....
Chronic & Convalescent*	8	.....	574	8.4	7,850	96.9

*Mostly nursing homes providing little in addition to domiciliary care.

It will be observed from the above table that only a very small number of beds for chronic patients was provided in facilities other than institutions specializing in caring for chronic and convalescent patients. It is important, however, to note that while general hospitals actually could care for only 168 chronic and convalescent patients without sacrificing beds badly needed for acute cases, many general hospitals actually had 20 per cent of the total beds occupied by chronic disease and other long-term cases.[1]

Although there has been considerable change since the Illinois Hospital Survey was made in 1945 in the development of facilities for the chronically ill (especially as a result of beds made available through the conversion of the former county "poorhouses" into county nursing homes for the infirm and chronically ill), the Illinois Survey findings with respect to the chronic and convalescent are significant for further planning for the care of the chronically ill. The high lights of Dr. Herbolsheimer's report as given in detail in Section IX of the Appendix may be summarized as follows:

1. Of the total of 362 institutions in 1945 which specialized in care of chronic and convalescent patients, 274 or nearly 76 per cent were proprietary or profit institutions. The Survey considered only 20 public institutions or 5.5 per cent of the total. The remaining 68 institutions were not-for-profit institutions operated by religious and fraternal associations or similar voluntary associations.
2. There was slight overcrowding in proprietary and public institutions but the nonprofit institutions actually had set up slightly fewer beds than the institutions were constructed to accommodate. The per cent of occupancy in governmental institutions for the chronic and convalescent was 23.9[2] as compared with 72.6 per cent occupancy in nonprofit and 60.9 per cent occupancy in the proprietary institutions.
3. The average per diem cost of operation in these institutions in 1945 was estimated at $1.81 based on incomplete reporting from the institutions.

After evaluating its information on facilities for the convalescent and chronically ill in relationship to its findings with regard to facilities for all types of patients, the Illinois Hospital Survey report recommended that:

1. General hospitals should be used only for diagnosis and intensive treatment of chronically ill or convalescent patients.

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[1]See Dr. Henrietta Herbolsheimer's statement on p. 194.

[2]Compare this low occupancy of 1945 with the near capacity occupancy in 1947 in county institutions which had been converted into nursing homes for the infirm and chronically ill under the terms of the Rennick-Laughlin Bills (see Section XIV of the Appendix).

2. The nonacute chronically ill and convalescent patient should be cared for either in a special wing of the general hospital or in a separate institution affiliated with a general hospital. The appointments of such facilities should conform to the type of illness being cared for with provision for occupational, rehabilitative, and recreational therapy.
3. There should be established a special hospital affiliated with a teaching institution to provide training of physicians and research in the incapacitating diseases.
4. The State should pay or contribute toward the payment of costs of care for persons afflicted with chronic diseases who cannot themselves pay for needed care.
5. County homes should be converted into facilities for the chronically ill and affiliated with a general hospital.
6. The standards for licensing private nursing homes should be raised and these homes closely supervised. Furthermore, the licensing program should strengthen its educational and consultation services.
7. Visiting nurse facilities should be extended to each county in the State in order to provide home care for those who would not need institutional care if home care were provided.

Local Surveys

Supplementing the 1945 State-wide Illinois Hospital Survey and providing more current and detailed information concerning conditions in two counties were the 1946 Chicago-Cook County Health Survey and the survey in Sangamon County on the extent of chronic disease and other long-term illness as of January 1947.

CHICAGO-COOK COUNTY HEALTH SURVEY

The need for a survey of health and hospital facilities in Chicago and Cook County was recognized early in 1946 by The Institute of Medicine of Chicago, the Chicago Medical Society, and the Health Division of the Council of Social Agencies. At the invitation of the Mayor of Chicago and the President of the Board of Cook County Commissioners the United States Public Health Service was requested to conduct such a survey.

The Survey was carried out during the spring and summer of 1946 and the information gathered assembled in a report during the fall of 1946. The report was released in mimeographed form early in 1947.

The Survey was under the direction of Colonel K. E. Miller of the United States Public Health Service. It included a study of public health work and sanitation as well as hospital and medical care and treatment offered by both voluntary and tax-supported agencies. The need for service, the amount and character of services being rendered,

the appropriateness of the scheme of organization, the efficiency of operation, the effectiveness of program, and the adequacy of funds, staff, and facilities were studied. Colonel Edward T. Thompson of the United States Public Health Service was in charge of the medical and hospital care section of the Survey. An Advisory Committee (of which Samuel A. Goldsmith, Executive Director of the Jewish Charities of Chicago, was Chairman and Alexander Ropchan, Executive Secretary of the Health Division of the Council of Social Agencies, was Secretary) was appointed by the Mayor and the Chairman of the Board of Cook County Commissioners.

By permission the Section of the report of the Chicago-Cook County Health Survey which pertains to the chronically ill is reproduced in full in Section X of the Appendix. The findings of this Survey relative to chronic invalidism and the need for beds have been adapted and utilized in Chapter VIII (see pages 81 through 83) to arrive at a current estimate of the extent of chronic invalidism and the need for beds in the State as a whole.

Sangamon County Survey

The Sangamon County Survey was carried out under the auspices of the Commission on the Care of Chronically Ill Persons in January 1947. It was limited to a study of chronic and other long-term illness. The survey was directed by Robert Rosenbluth, Consultant to the Illinois Public Aid Commission. He was assisted by physicians and health and welfare agencies of Sangamon County in collecting the information.

A detailed report on the Sangamon County Survey is contained in Section XI of the Appendix. The findings of this Survey have been utilized in assembling the information set out in Chapters II, III, and VIII.

County Homes for the Infirm and Chronically Ill

The most effective program of the 1945-1947 biennium in terms of actually making available additional beds sorely needed by chronic invalids who could not be cared for in their own homes yet who did not need the extensive care provided by general hospitals was the program for converting the former county "poorhouses" into county nursing homes for the infirm and chronically ill. The Rennick-Laughlin Bills, which were strongly endorsed by the predecessor Committee to Investigate Chronic Diseases Among Indigents, made this program possible. Full details concerning the progress of this program are given in Section XIV of the Appendix. The standards governing the operation of these homes are set out in Section XV of the Appendix.

Because of the importance of the county home program in meet-

ing the immediate needs of persons in Illinois who are invalided by chronic diseases, it is well to summarize here the following high lights from the more detailed account given in Section XIV of the Appendix.

1. By April 1947, 15 counties having a total capacity of 916 beds had converted their plants into modern nursing homes for the infirm and chronically ill. These counties were the following:

Champaign	Jackson	Mercer
De Kalb	Knox	Rock Island
De Witt	Lee	Vermilion
Fayette	Livingston	Warren
Henry	Menard	Whiteside

2. Within the next few months Peoria, Ford, Macon, and White Counties will have completed the conversion of the county plant, making available an additional 480 beds.
3. Extensive work is underway in eight other counties with a reported capacity of 500 beds. Conversion in these counties will probably be completed before the end of 1947.
4. An additional 23 counties with buildings of varying adaptability are considering the possibility of conversion.
5. Ten counties with no county plant are giving consideration to the possible purchase of a suitable building for a county nursing home or the erection of a new building for this purpose.
6. The change in function of these county institutions is vividly illustrated by an analysis of the present population. Whereas the report of the predecessor Committee[1] showed that in November 1944 these institutions for the State as a whole were only 59.2 per cent occupied and some almost empty, the converted institutions are now almost 100 per cent occupied and many have a long waiting list. Eighty-two per cent of the total patient population in the converted institutions are persons who require nursing care. Significantly, 56 per cent are persons who are paying for their care from Old Age Pension and Blind Assistance grants; 27 per cent are supported by township General Relief funds; and 17 per cent are private pay patients.
7. Progress has been impeded in many counties because of difficulties in obtaining materials and competent personnel. Indications are, however, that these difficulties are being overcome and that the program will move forward with increasing emphasis on better medical supervision (as exemplified by the program in Vermilion County) and that in time therapeutic services, such as occupational and phy-

[1]Interim Report, p. 16.

sical therapy and social services, will be established as part of the program.

The Illinois program for converting the former county "poorhouses" into modern public infirmaries for the chronically ill has established a pattern which may result in amendments to the Federal Social Security provisions and in the social welfare laws of other states. At present, because of prohibitions in the Federal Social Security Act against federal contributions toward assistance grants made to persons residing in public institutions, the State of Illinois and local governmental units must meet all the costs for financially dependent chronically ill persons given care in these county homes.[1]

The significance of the county home program for Illinois and for the nation as a whole is summarized by Raymond M. Hilliard, Public Aid Director, Illinois Public Aid Commission, in an article entitled, "The Emerging Function of Public Institutions in Our Social Security Structure,"[2] Mr. Hilliard says, ". . . the last eleven and one-half years of administering our social security laws and the experiment recently inaugurated in Illinois to convert the former 'poorhouses' into county institutions for the chronically ill have these implications for the emerging new function of the institution, especially the public institution, in our total planning to meet the present-day health and welfare needs of our people:

1. "Provision for sheltered or institutional care is a necessary part of total planning for the social welfare. Home relief alone is not sufficient to meet the needs of people in a modern welfare program, especially in view of the growing problem of chronic disease and other long-term illness.
2. "The public institution has a vital and important part to play in meeting the institutional needs of persons who are sick and infirm or who otherwise cannot adjust to living in the normal community. Such public institutions should be locally placed and locally controlled, under proper supervision by an appropriate state agency. Yesterday's almshouse must be transformed into today's public infirmary for the chronically ill.
3. "Public institutions should be conceived of as only one of many units in total community planning for the sick, the infirm, and the chronically ill. The public assistance recipient, as well as the self-

[1]According to an article appearing in the March 1947 issue of *Public Aid in Illinois* (monthly publication of the Illinois Public Aid Commission), the Social Security Administration now "believes that it would be desirable to permit federal matching of the cost of care of persons living in public or private medical institutions other than mental hospitals and tuberculosis sanatoriums." The American Public Welfare Association has endorsed such change in the Federal Social Security Act in its platforms for 1946 and 1947.

[2]*Social Service Review*, Vol. XX, No. 4, December 1946, University of Chicago Press, p. 493.

supporting person of moderate means, should have free choice of facility, whether public or private. He should also have freedom to move into or out of the institution, according to whether or not the care and service are satisfactory.

4. "A new function appears to be emerging, for units of government statutorily responsible for maintaining and operating public institutions as well as for private philanthropy maintaining and operating private institutions. The governmental body and the board of the private philanthropic institution are now more and more being called upon to establish, maintain, staff, and operate the institution, as a facility at which care can be purchased by rich and poor alike. This system will and should supplant the former system whereby a pauper or a charity stigma attached to all persons in the institution merely because they were given so-called 'free care' in the institution.
5. "Rethinking and reshaping the relationship between home relief and institutional care, between public institution and private institution, between local, county, and district or state institution, constitute a challenge for welfare planning in the next decade. It is to be hoped that the same constructive evolution can occur in this field as has occurred during the past decade in the development of federal-state-local and public agency-private agency relationships in the field of home asistance and social services."

Further improvements in the Illinois laws governing the establishment and operation of county homes for the chronically ill are contemplated in the proposed Public Assistance Code of Illinois which was introduced in the Sixty-fifth General Assembly on April 2 through Senate Bill 205 and House Bill 328. The proposed Public Assistance Code of Illinois was the result of the work of the Illinois Public Assistance Laws Commission which was created by Act of the Sixty-fourth General Assembly. Section 4-17 through Section 4-24 of Article IV of this Code further revise the language of the present Act enabling County Boards to erect and maintain county homes and clarify the County Boards' authority to operate the home, to fix rates, and to control admissions. The Code also makes revisions in the language of sections of the Blind Assistance and Old Age Assistance provisions which pertain to recipients of these two types of public assistance who need care in county homes. The Code, however, retains the present provisions whereby the Illinois Public Aid Commission is responsible for prescribing standards for such homes as desire to admit Old Age Assistance and Blind Assistance recipients. The report of the Illinois Public Assistance Laws Commission comments as follows on this matter:

"The present provision whereby . . . regulation is assigned as

the responsibility of the Illinois Public Aid Commission with respect to county infirmaries for the chronically ill which choose to sell care to recipients of Old Age Assistance and Blind Assistance is a stopgap. This is not properly a function of the State agency assigned responsibility for administering the public aid programs. Regulation of hospitals and nursing institutions, whether public or private, is more properly a function of some other State agency such as the Department of Public Health. The Commission recommends that if the General Assembly considers a uniform system of regulating hospital and nursing institutions, that it include all such institutions. Until such action is taken, it is necessary to continue in the Public Assistance Code the standard-approving functions now assigned the Illinois Public Aid Commission."[1]

House Bill 283 introduced March 12, 1947 by Representatives Homer B. Harris of Lincoln, John W. Lewis of Marshall, and Homer Caton of Stanford provides for licensing and regulation of all public and private hospitals and sanitariums, maternity hospitals, lying-in-homes, rest homes, boarding homes or other institutions and places providing hospitalization or inpatient or nursing care of persons. Responsibility for administration of the Act is placed in the Department of Public Health and other previous separate licensing acts are repealed. This Bill, if favorably acted upon by the General Assembly, will include county homes for the infirm and chronically ill. House Bills 281, 282, and 284 by the same sponsors amend other acts in the light of the proposal in the key Bill, House Bill 283. Any necessary amendment to the Public Assistance Code will undoubtedly be made should the hospital licensing Bills receive favorable action.

Licensing of Private Nursing Homes

Paralleling the program for converting county institutions into nursing homes for the infirm and chronically ill, in its immediate practical effect in providing better facilities for the chronically ill, was the program of the State Department of Public Health for licensing private nursing homes. Prior to July 17, 1945 when Governor Dwight H. Green approved House Bill 252 passed by the Sixty-fourth General Assembly,[2] Illinois did not make provision for state licensing and regulation of such institutions. House Bill 252 defined a nursing home as a "private home, institution, building, residence or other place which undertakes, through its ownership or management, to provide maintenance, personal care or nursing for three or more persons who, by reason of ill-

[1] *A Proposed Public Assistance Code of Illinois: Report of the Illinois Public Assistance Laws Commission*, Springfield, April 1947, p. 21.

[2] House Bill 252 was sponsored by Representatives William F. Gibbs of Quincy, Bernice T. Van der Vries of Winnetka, James L. Wellinghoff of Belleville, and Franklin U. Stransky of Savanna.

ness or physical infirmity, are unable properly to care for themselves." Excluded, however, were state, local, or municipal public institutions, institutions for persons afflicted with mental or nervous diseases, hospitals and maternity or lying-in-homes otherwise required to be licensed by the State. Also, only limited state regulation was stipulated for homes or institutions conducted for those who rely upon treatment by prayer or spiritual means. The Act also did not apply within any municipality which had enacted an ordinance for local licensing and regulation provided the ordinance substantially complied with minimum requirements set out in the State Law.

Upon the Governor's approval of the Act, the Director of Public Health appointed a Nursing Home Committee consisting of the chiefs of the Divisions of Local Health Administration, Maternal and Child Hygiene, Public Health Nursing, Communicable Diseases, and Sanitary Engineering. Direct responsibility for administering the Act was placed in the Division of Sanitary Engineering inasmuch as the end in view was largely the improvement of sanitation. Minimum standards were prepared and general policies evolved by the Committee and submitted to the Director of Public Health for approval.

Approximately ten days after the Act was approved, copies of the Act, application forms for licenses, and letters explaining in general the provisions of the Act were mailed to all establishments appearing on the nursing home list. All establishments from which no reply had been received by September first were sent a follow-up letter requesting them to inform the Department as to the status of their homes in regard to licensure.[1]

In Section XII of the Appendix there is printed a progress report on licensure of private nursing homes prepared by Mr. C. W. Klassen, Chief Sanitary Engineer, State Department of Public Health. In Section XIII of the Appendix will be found the minimum standards prescribed by the State Department for private nursing homes.

The high lights of Mr. Klassen's report may be summarized as follows:

1. As of February 1947 there were in Illinois 533 private homes or institutions giving nursing services to the infirm or chronically ill. Two hundred and seventy-two of these homes were exempt from the provisions of the 1945 State Licensing Act.
2. The State Department received 254 applications for licenses. Two

[1]The information contained in this and the preceding paragraphs has been taken verbatim from an article entitled, "State Department of Public Health Assumes Responsibility for Licensing Nursing Homes" by Roland R. Cross, M.D., Director, Illinois Department of Public Health. This article appeared in the November 1945 issue of *Public Aid in Illinois*.

hundred and eighteen homes have been inspected and 163 have licenses in effect.

3. The predominant defects in the homes inspected are inadequate plumbing, improper food handling, insufficient records concerning patients, and poor provisions for general hygiene.
4. Service in the homes operated by religious or fraternal or other non-profit associations is superior to that offered in the other homes. Service in homes catering primarily to self-supporting patients is fairly satisfactory but there is lack of personal interest in the patient other than providing him with fair physical care. The homes housing Old Age Pension and other public aid recipients at present barely meet standards.
5. Postwar difficulties in obtaining equipment and personnel have made it necessary to give temporary acceptance to conditions which normally should not be permitted to continue. The greatest future needs are education of home operators to provide better insight into the needs of chronically ill persons and the strengthening of licensing and regulation, either through the abolition of local licensure or by provision of a closer relationship between the state licensing program and local licensing programs.

Not-for-Profit Homes for the Aged

Complete information is not available concerning all not-for-profit homes for the aged now operated in Illinois. Those homes which do provide nursing services for the infirm and thus come under the provisions of the Illinois Nursing Home Act were included in the report prepared for this Commission by the Chief Sanitary Engineer of the State Department of Public Health but Mr. Klassen does not list such homes separately in his statistical report. As noted by Mr. Klassen, however, the not-for-profit homes for the aged which do provide nursing facilities for the infirm and chronically ill are in general superior to all other types of nursing homes coming under the Illinois regulatory act.

In Section II of the Appendix of this report there is quoted testimony by Frank D. Loomis, Executive Director of the Chicago Community Trust, indicating some of the factors which have prevented the full development of homes for the aged as facilities for the chronically ill (see pages 110 through 113).

More complete information is available, however, on homes for the aged which are willing to admit recipients of Old Age Pension and Blind Assistance. Information on such institutions is available to the Illinois Public Aid Commission. The private homes for the aged

caring for recipients of Old Age Pension and Blind Assistance are listed in the map and chart on page 62.

In its *Interim Report* the predecessor Committee to Investigate Chronic Diseases Among Indigents reported on 49 private homes for the aged admitting public aid recipients as of May 1945. The Committee made this comment in its report:

> "There is a growing trend among these institutions toward the development of facilities for caring for chronically ill persons. The Chicago Home for Incurables has always cared for chronic patients. Such facilities have more recently been developed by the Home for Aged Jews, the Orthodox Jewish Home, Rosary Hill Convalescent Home, St. Ann's Home in Cook County and by St. Joseph's Hospital in Adams County, the I. O. O. F. Home in Coles County and the Eastern Star Sanitorium in Macon County.
>
> "It is expected that such facilities will be developed in more of the Institutions of this type as the problem of the chronically ill receives increasing attention and as equitable bases of payment for care in such institutions are developed in co-ordination with payment rates for other types of facilities."[1]

At the time of the *Interim Report* the Illinois Public Aid Commission had a policy whereby the general home income was deducted from per capita costs and Commission payments fixed at the difference. As implied in the report of the predecessor Committee this basis of payment was not considered "equitable" in relationship with payment rates for other types of facilities.

In its meeting of June 3, 1946 the Illinois Public Aid Commission adopted a new policy under which the amount of the assistance grant to a resident of a nonprofit private institution was to be based, in most instances, upon the per capita cost to the institution for care and maintenance of its residents.

Information available to this Commission indicates that Illinois is one of the few states in the nation that has made a genuinely liberal provision for assistance grants to needy persons residing in nonprofit institutions. Some states do not permit public assistance to be given to residents of such institutions. Because of its importance in developing this type of facility for the chronically ill, a description of the new Illinois policy (as reported in the August 1946 issue of *Public Aid in Illinois*) is quoted in full below:

> "The new policy, which in general permits larger grants to recipients of public aid who are residing in these institutions, replaces the former policy whereby grants were based on the differ-

[1] *Interim Report*, p. 15.

ence between the per capita cost and the per capita general home income. The old policy operated to the disadvantage of Old Age Pension and Blind Assistance recipients in gaining admission to such institutions, and appeared to have retarded the development of the facilities of such institutions as units in community and state-wide planning for care of the chronically ill.

"Observing the effect of the policy then in operation, the Commission began late in 1943 to analyze various aspects of the policy and to explore alternatives which would offer a more practical basis for agreeing on rates with the institutions, for encouraging these institutions to admit more assistance recipients, and to develop infirmary and other facilities for those who require institutionalization because of chronic illness. As the study progressed, it became obvious that nonprofit private institutions, especially homes for the aged, represented one of the most important resources for developing high type facilities for care of the chronically ill.

"Dissatisfaction with the old policy became more pronounced in 1944. In September of that year the Commission adopted a new policy providing for nursing care of the aged and the blind in private profit nursing homes with a fee schedule allowing for some profit and providing for grants in excess of $40 per month when needed to purchase care in such homes. In December of that year the Commission announced a plan for paying full medical and hospital care costs for Old Age Pension and Blind Assistance recipients, with hospital rates to be determined with each hospital at an amount representing a certain percentage of actual cost for ward or comparable accommodations. Both the nursing home and the hospital care plans provided for a fixed rate to be negotiated within Commission standards and did not entail financial scrutiny of the institution's income from patients, endowments, contributions or other sources, as was the case with the private nonprofit institution policy.

"These seemingly more equitable and less involved plans for payment for care in private nursing homes and hospitals focused attention anew on the Commission's policy with respect to nonprofit private institutions, especially because of the wide discrepancy in the rates paid the nonprofit institutions as compared with the fee schedule allowed for care in nursing homes operated for profit.

"The old policy, however, had definite advantages. It was in essence 'deficit financing' and was thus closely related to the pat-

tern used by the Community Fund of Chicago in determining contribution of community fund drive proceeds to such institutions. There was also the factor that nearly all such institutions followed the practice of conducting independent drives for contributions over and above support received from endowments and from community fund contributions, such drives basing their appeal on the claim that the institution was rendering 'charitable care' to the aged, the ill, and the unfortunate.

"The policy was also similar in principle to the 'individual budget' method used in determining the amount of the assistance payment to public aid recipients living in their own homes. This principle provides that the assistance grant supplements rather than precedes any other income or resources available to a recipient.

"As applied to nonprofit institutions, this principle conceived the assistance grant as being a supplement to endowments and contributions made to the institution for support of residents, and that such endowments and contributions are made for the benefit of public aid recipients as well as other residents of the institution.

"Because the old policy was therefore consistent with community patterns and with the assistance budget principle of public aid, careful thought had to be given to the implications in changing it. There were, however, the following disadvantages in the former policy:

1. "It discouraged nonprofit private institutions in making additional openings in the institutions available to Old Age Pension and Blind Assistance recipients who needed the care offered.
2. "The payments rate in these homes compared unfavorably with the fee schedule adopted for private nursing homes, even if allowance were made for 'charity' in the former and for 'profit' in the latter. This fact was commented on in the *Interim Report of the Committee to Investigate Chronic Diseases Among Indigents*, submitted to the Sixty-fourth General Assembly of Illinois on June 7, 1945.
3. "The policy to some extent deprived the recipient of the 'bargaining power' he had with his grant in similar situations, such as negotiating for board and room in a rooming house. In this respect the policy was a 'restrictive payment' policy, which criticism was advanced by the Social Security Board in a study made in April 1943, three months before the Commission became responsible for administration of the Old Age Pension and related social security programs. The Social Security Board

pointed out that the policy was 'based more on the eligibility of the institution than on the financial situation of the applicant . . . The financial standing of the institution, not consideration of the need of the individual, determined whether the resident was eligible or ineligible for public assistance.'

4. "The policy, based as it was on 'deficit financing' of private charitable funds, represented a contradiction of the principle that public funds should not subsidize private charity, nor should private organizations administer public funds.
5. "The policy became particularly difficult to justify after the Commission adopted in September 1945 a plan for payment for care of Blind Assistance and Old Age Pension recipients in county homes for the chronically ill which provided for negotiation of a rate based on per capita cost.

"Prior to the adoption of the new policy, staff of the Commission discussed the proposed change with a number of institutions throughout the State and with the Illinois Homes for the Aged, Inc. The majority of the homes have approved of the new policy as a distinctly forward step. It is hoped that, as a result of the new policy, private homes for the aged and similar institutions will become important units in Illinois' facilities for care of the chronically ill."[1]

Illinois Children's Hospital-School

Illinois pioneered again when the State established the first state-sponsored institution in the United States equipped to give medical care and education to children who have all types of severe physical handicaps. House Bill 412 was introduced[2] in the Sixty-fourth General Assembly by Representatives Bernice T. Van der Vries of Winnetka, W. O. Edwards of Danville, and Anthony Prusinski of Chicago as a result of studies by the Illinois Commission for Handicapped Children and the Division of Services for Crippled Children of the University of Illinois. This Bill was approved by Governor Dwight H. Green on June 29, 1945.

An appropriation of $420,000 was made to the Department of Public Welfare, to "establish and maintain services and facilities, including a hospital-school, for the care and education of physically handicapped but educable children." Under the statute any child who is a resident of Illinois may be considered for care at the hospital-school

[1]From article entitled, "Commission Adopts New Policy for Payments for Care in Private Institutions," *Public Aid in Illinois*, August 1946, p. 3.

[2]This Bill was endorsed by the Committee to Investigate Chronic Diseases Among Indigents. The Committee commented: "It may provide, among other services, some opportunity for the rehabilitation of spastic children for whom facilities are practically nonexistent." *Interim Report*, p. 30.

if he is educable but so severely handicapped that he cannot take advantage of the system of public school education.

The Department of Public Welfare leased the building at 2551 North Clark Street, Chicago, formerly occupied by the North Chicago Community Hospital. Despite the need for structural changes and renovation of the building, which were necessarily delayed by shortages of labor and material, sufficient progress was made so that 13 children were admitted in September 1946. At the time information was collected for this report (January 1947) there were some 20 children in the institution which will have an eventual capacity of 90 to 100.

The professional services provided by the school include the fields of medicine, nursing, education, physical therapy, occupational therapy, speech therapy, dietetics, psychology, social work, and religion. In addition, nonprofessional men and women with understanding of children's needs give direct care to the children. A maintenance staff completes the roster of persons required in an institution serving as a home, school, and medical center for handicapped children.

Richard Eddy, Superintendent of the Hospital-School, has vividly described the field of service of this unique state institution in an article entitled "Give Them a Chance to Learn."[1] Mr. Eddy says:

> "As the fields of public health, education, and welfare expanded their facilities to discover and provide opportunities for handicapped children, the Illinois Commission for Handicapped Children and the Division of Services for Crippled Children of the University of Illinois remained alert to evidence of still unmet needs. Children were found who were so physically limited that they could not stand the exertion required to attend even special day schools for the handicapped. There were others whose condition would not respond even to the marvels of modern surgery. Some boys and girls were placed at the end of the waiting lists for care in hospitals for crippled children because only through years of intensive treatment, if then, could physical improvement be expected. With bed space in demand it seemed unfair to bestow upon one child with a doubtful prognosis the care and attention which might bring complete restoration to three or four who seemed more hopeful. Physical therapy and home teaching were made available to some of these eager though less eligible youngsters, but too often the amount was insufficient or parents were unable or unwilling to lend the necessary co-operation. In some instances parental rejection, frustration, or overburdening made life in the home dismally unpleasant or emotionally deadening for

[1] *Public Aid in Illinois*, February 1947, p. 6.

the child, the parents, and other members of the family. Rarely could qualified foster parents be found for the severely handicapped child for whom removal from the family home was indicated.

"An important gap in services to crippled children had been discovered. Children with good minds were idling at home without proper physical or mental nurture. Worse yet, some were mistakenly thought to be mentally as well as physically defective. Superficial diagnosis or no diagnosis had led to the hasty conclusion that the imprisoned brain was an enfeebled brain. Reliable estimates pointed to the presence in Illinois of thousands of possible educable children suffering from the restricting pressures of cerebral palsy, muscular dystrophy, spina bifida, postpoliomyelitis, and other physically limiting conditions so severe or so slowly responsive to known methods of treatment that little of real value was being done for them."

The planning for the Hospital-School has progressed with the help and guidance of an Advisory Board of 15 persons established by law and appointed by the Governor and of an especially created Medical Advisory Board. Sound planning has resulted in an institution meeting the needs of children with severe physical handicaps who appear educable, are not being properly served in their present environment, and could not receive appropriate care or educational training through other available resources. When the institution's construction and renovation program is completed, its program will make a substantial contribution to meeting the problem of caring for a very special group of the chronically ill.

Hospitalization and Medical Needs Commission

The Sixty-fourth General Assembly, which created this Commission, also passed Senate Bill 336 creating a Commission to study the hospitalization and medical needs of the State and report findings and recommendations relative thereto to the Sixty-fifth General Assembly together with recommendations concerning the establishment of a State system of hospitalization and medical care. Senate Bill 336 was sponsored by Senators R. G. Crisenberry of Murphysboro, John T. Thomas of Belleville, and John W. Fribley of Pana and approved by Governor Dwight H. Green on July 18, 1945. The Commission was to consist of three members of the Senate, three members of the House, and three members appointed by the Governor, two of the latter appointments to give consideration to the recommendations of labor groups or organizations.

Although the work of the Hospitalization and Medical Needs

Commission was not limited to the chronically ill, its findings and recommendations will have significance for those who are afflicted with chronic disease or permanent impairment.

Disability Unemployment Compensation Payments Commission

This Commission was created by Senate Bill 553 introduced in the Sixty-fourth General Assembly by Senators Arthur J. Bidwill of River Forest and John T. Thomas of Belleville and signed by Governor Dwight H. Green on July 24, 1945. This Commission consisting of three members of the Senate and three members of the House was to investigate the payment of disability unemployment compensation payments to residents of Illinois, to study the disability unemployment compensation needs of the State, and to report findings and recommendations to the Sixty-fifth General Assembly.

The findings and recommendations of this Commission should have an important bearing on planning for care of the chronically ill as well as the acutely ill since loss of income through illness often causes persons to neglect conditions which if properly cared for would not result in chronic invalidism. The findings will also have significance because of the close relationship between illness and resulting wage losses, and poverty and dependency.

Improvement in Medical Programs for the Chronically Ill Receiving Public Assistance

The Illinois Public Aid Commission has taken a number of steps which have resulted in making better facilities available to the chronically ill. In addition to the co-operative county home program and the program for developing additional facilities in nonprofit private homes for the aged (described elsewhere in this report), the Public Aid Commission has explored the possibility of encouraging the development of better private nursing homes operated for profit.

For several years the Public Aid Commission has worked in close co-operation with the Department of Public Health in relation to standards of care in nursing homes. Prior to the establishment of the state licensing program for nursing homes the Public Aid Commission obtained advice from the Department of Public Health on conditions in nursing homes that might constitute hazards to patients there. Since the licensing program became effective in July 1945, the Public Aid Commission has relied completely on the decision of the Department of Public Health with regard to homes subject to licensing. From this close working relationship and from the experience which the Commission has had over a period of years it has become evident that, while much improvement has resulted in private nursing home care, there is room

for much more. Part of this, it became evident, was due to lack of sufficient income in the nursing homes because of the increases in salaries, cost of food and supplies, and other expenses which nursing home operators must meet. In January 1947, therefore, the Public Aid Commission increased considerably the allowance authorized for nursing home care of recipients of Old Age Pension, Blind Assistance, and occasionally, Aid to Dependent Children parents.

The time which has elapsed since this increase does not permit an evaluation of the effect it has had in improving care, but it appears that the increased payments in profit nursing homes will permit more adequate staff and should discourage the crowding which has sometimes existed.

Local Activities

Much activity in planning for care of the chronically ill has been noted in local communities. This activity has been marked by co-operation between public and private agencies, professional and lay citizen groups, and a general recognition of the need for sound planning. It is not possible within the scope of this report to include details of the many projects that are under consideration, have been announced as actual plans or have been completed. The Commission is forced, therefore, to mention but a few.

Belleville (St. Clair County)

The Southern Illinois Synod of the Evangelical Church is considering the erection of a home for the aged and a general hospital to be located at Belleville. Some of the beds in each institution would be available for the chronically ill, and the close relationship between the home and the hospital would result in excellent care for such patients.

Chester and Ruma (Randolph County)

St. Clement's Hospital at Ruma, Illinois, which is operated by the Sisters Adorers of the Most Precious Blood, is a 22-bed hospital to which is being added a new wing which will provide for 25 additional beds. The institution will then be able to set aside 20 beds for chronically ill patients. The same order is planning to erect a 100-bed hospital at Chester near St. Ann's Old Folks Home. It is hoped that 30 beds in this institution will be available for convalescent and chronically ill patients.

Chicago (Cook County)

The past year has brought close to fruition many plans that will improve the care of the chronically ill in Chicago. To quote in part from a report made by Miss Edna Nicholson, Director, The Central

Service for the Chronically Ill of Chicago, at a meeting held by that agency on December 3, 1946:

1. "Five general hospitals in Chicago and the suburbs have announced their plans for construction of facilities for the care of long-term patients. And more are now considering it.
2. "One home for the aged has completed construction—and is now using—a new building which provides additional facilities for chronic patients. Two homes for the aged have their architects' plans completed and are ready to start construction of new buildings. Others are now in the process of planning new units and raising funds for this purpose.
3. "The Catholic Charities of Chicago, the Jewish Charities, the Lutheran Charities, and the Salvation Army, all are thinking and planning actively for the development of new services through their member agencies. Some of the new services already announced for hospitals and homes for the aged are the result of this planning.

   "There are prospects for very considerable increases in the number of beds available under Catholic auspices for care of chronically ill patients.

   "Plans have been publicly announced by the Jewish Charities for expansion of their present excellent services in their homes for the aged and for erection of new units for long-term care in connection with Michael Reese and Mt. Sinai Hospitals. Mr. Goldsmith, and members of his board and staff, can tell you something of how long it takes to plan wisely and lay a sound foundation for good new facilities. The Jewish Charities Committee on Care of the Aged and Chronic Sick has been working intensively on plans of this kind for almost ten years. They have done excellent work—and there is every reason to believe that when the new facilities become available they will reflect the careful work which has gone into this planning stage.

   "Homes for the aged affiliated with the Lutheran Charities of Chicago are now planning the development of new facilities. Some of them are well along in their planning and fund-raising. Others are still in the earlier stages. As these facilities develop they, too, will reflect the care which has gone into the planning stages.

   "One of the first new facilities to develop in Chicago after 1944 —when The Central Service for the Chronically Ill was established —was the Salvation Army Convalescent Home. It is a small, but excellent unit, and it has been highly encouraging to know that there is hope of adding additional stories to the present building, and increasing the present capacity of the home.
4. "Other church groups are also actively planning new services. Mr.

Munsterman has told us something about the plans of the Evangelical Church in its home and hospital. Methodist, Baptist, and Swedish Covenant groups are working on the problem and there will soon be new facilities resulting from their efforts—including the Bethany Home and Hospital and others.

5. "Under public auspices we have seen the development of additional services of excellent quality for long-term patients in the Chicago Welfare Department's Convalescent Home.

"The new State Hospital School for severely handicapped children was brought into existence largely as a result of the efforts of the Illinois Commission for Handicapped Children. The Hospital School has made an excellent start toward meeting a very real need for constructive program and good facilities for these chronically ill children.

"The Cook County Infirmary at Oak Forest has been operating under many handicaps. Its isolated location, and other factors, have made it difficult to staff the institution adequately and to maintain medical and nursing services at a good level. Some building changes have been badly needed. Construction work is now under way at the Infirmary and some improvements can be expected in the safety and efficiency of the buildings."

Plans for research in Chicago are being undertaken by a number of voluntary hospitals and medical agencies. Among these are St. Luke's Hospital which has established a Department of Research headed by Dr. William F. Petersen; Northwestern University Medical School which is planning for an Institute for the Study of Rheumatic Fever; Mercy Hospital which hopes to have in its new building an elaborate research department which will devote particular attention to poliomyelitis; and the Illinois Division of the American Cancer Society which in March announced grants of $69,115 to 12 Chicagoans for research in the field of cancer.

Douglas County

Douglas County, which has successfully operated the Douglas County Jarman Memorial Hospital as a real community facility, has considered the possibility of erecting a county nursing home affiliated with the hospital and serving the entire community just as the hospital does. No decision has as yet been made.

Springfield (Sangamon County)

The Springfield Council of Churches has been intensely concerned with the need for more good chronic care facilities in Springfield which is a medical center for a number of surrounding counties. At the time

of this writing no conclusions have been reached as to definite steps to be taken, but it is hoped that the Council's interest will be the nucleus of community action.

Wilmette (Cook County)

An example of the way in which a local public agency stimulated interest in planning for a voluntary institution for the chronically ill is found in the progress which has been made in the suburbs north of Chicago. The New Trier Township Relief Administration recognized the need for additional chronic care facilities, not only for relief recipients or for the community of Wilmette, but for all the people in the North Shore suburbs. After a number of meetings arranged by Mr. J. Gordon Pegelow, New Trier Township Supervisor, a committee was formed under the chairmanship of Frank D. Loomis, Executive Secretary of the Community Trust of Chicago. The committee is exploring the possibility of raising funds for an institution which would be closely affiliated with the Evanston Hospital and which would probably be built near the hospital and perhaps operated by the Evanston Hospital Association.

County and Multiple-County Health Departments

In 1943 the Searcy-Clabaugh Bills were enacted enabling counties or groups of counties to establish county or multiple-county health departments. There are now in operation nine county health departments and two multiple-county health departments (Alexander-Pulaski and Lawrence-Wabash). Nine additional counties have by referendum authorized the establishment of health departments which will come into existence within the next several months.[1] The established and prospective county health departments, as of January 1947, are shown on the map on page 63.

The county and multiple-county health departments may have an important role to play in the development of local services for the chronically ill particularly if the recommendations of the United States Public Health Service are followed.

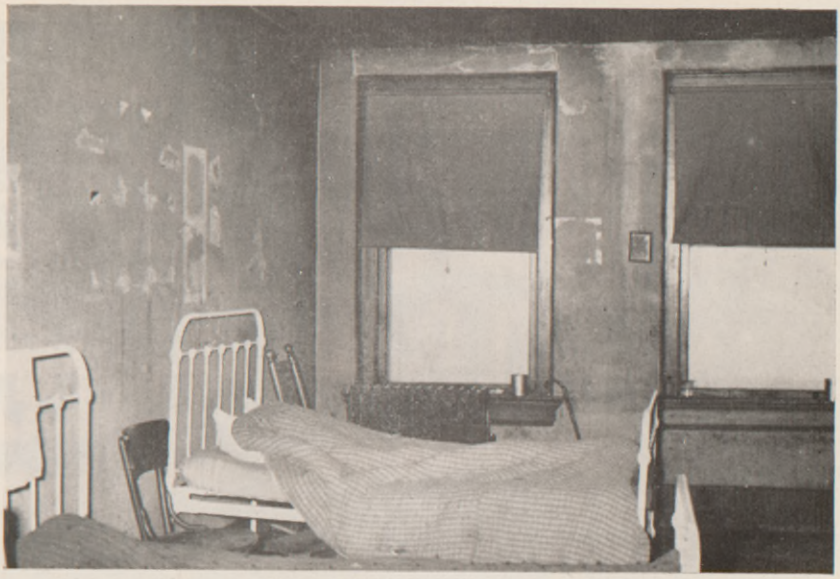
In a letter addressed to this Commission on December 17, 1946 the United States Public Health Service stated:

> "While it is true that many official health agencies do not provide this type (visiting nurse service to the sick at home) of nursing service, the Public Health Service is recommending that as

[1]For a comprehensive report on the origin and functions of the county and multiple-county health departments see "The Development of Full-Time County Health Departments in Illinois," by Richard F. Boyd, M.D., M.P.H., Chief, Division of Local Health Administration, Illinois Department of Public Health, *Public Aid in Illinois*, March 1947, p. 11.

soon as sufficient staff is available, Health Departments should provide this type of service."

The Committee of the Illinois State Nurses' Association, Consultant to this Commission, has suggested that "in rural communities all visiting nurse service, including care of the sick at home, is best administered and supported by the health department." (See page 159.)



Ward in Illinois County Home Before Conversion

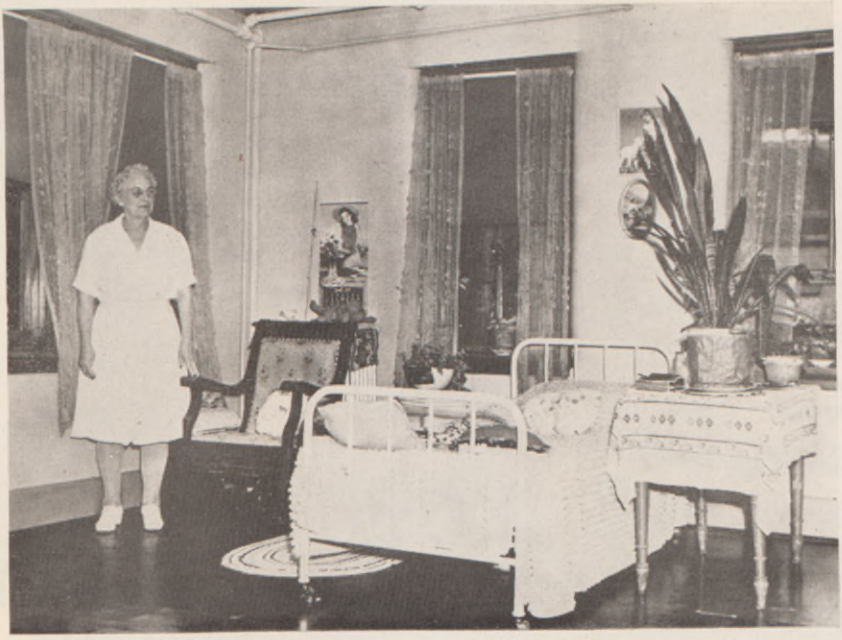
Ward in Illinois County Home After Conversion

Fayette County Nursing Home

Day Room, DeKalb County Home

Individual Recreation, Knox County Home and Hospital

Group Recreation, Knox County Home and Hospital



Bed Room, Rock Island County Home

Nurses' Station, Vermilion County Nursing Home

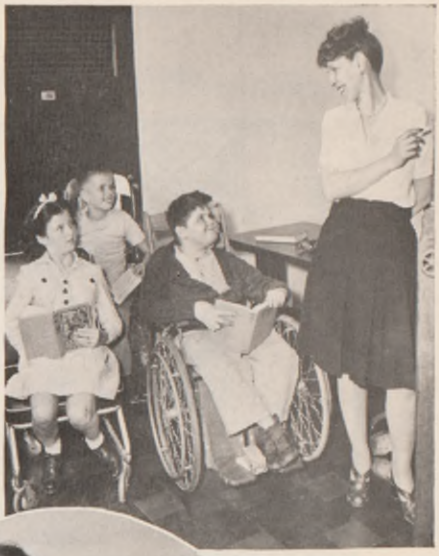
Dining Room, Vermilion County Nursing Home

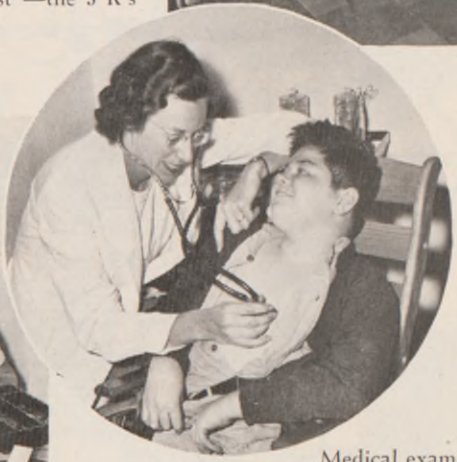
Kitchen, Champaign County Home and Hospital

Reproduced by permission of the Illinois Public Aid Commission from *Public Aid in Illinois*, June, 1947, p. 14.

ILLINOIS CHILDREN'S
HOSPITAL-SCHOOL

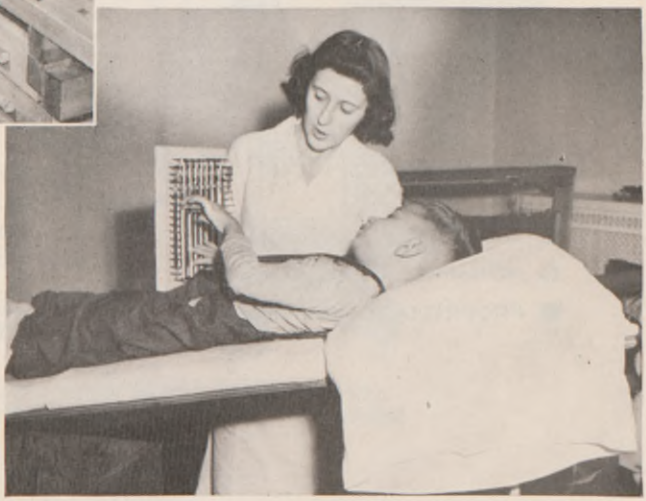
A daily "must"—the 3 R's





Medical examinations
can be fun.

Making a bird house.



Weaving improves
muscle co-ordination.

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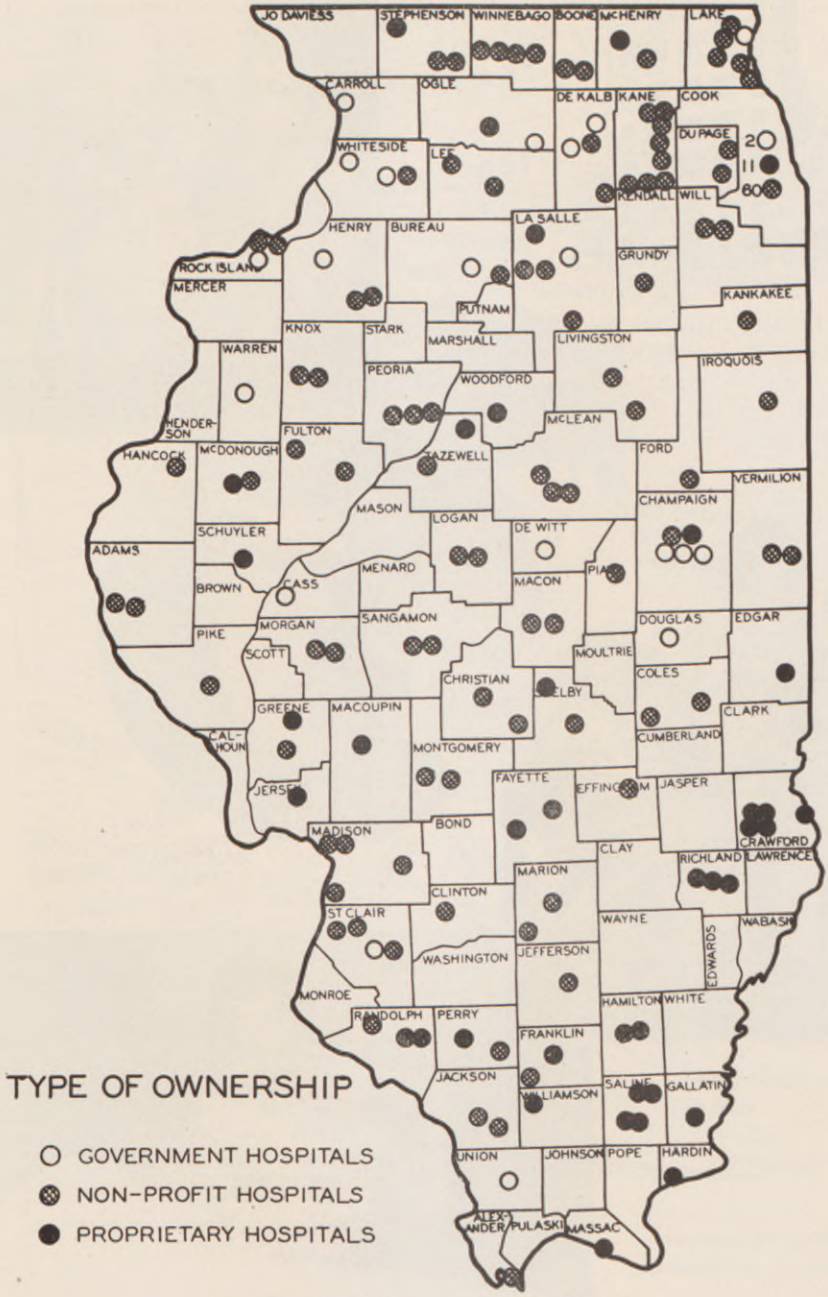
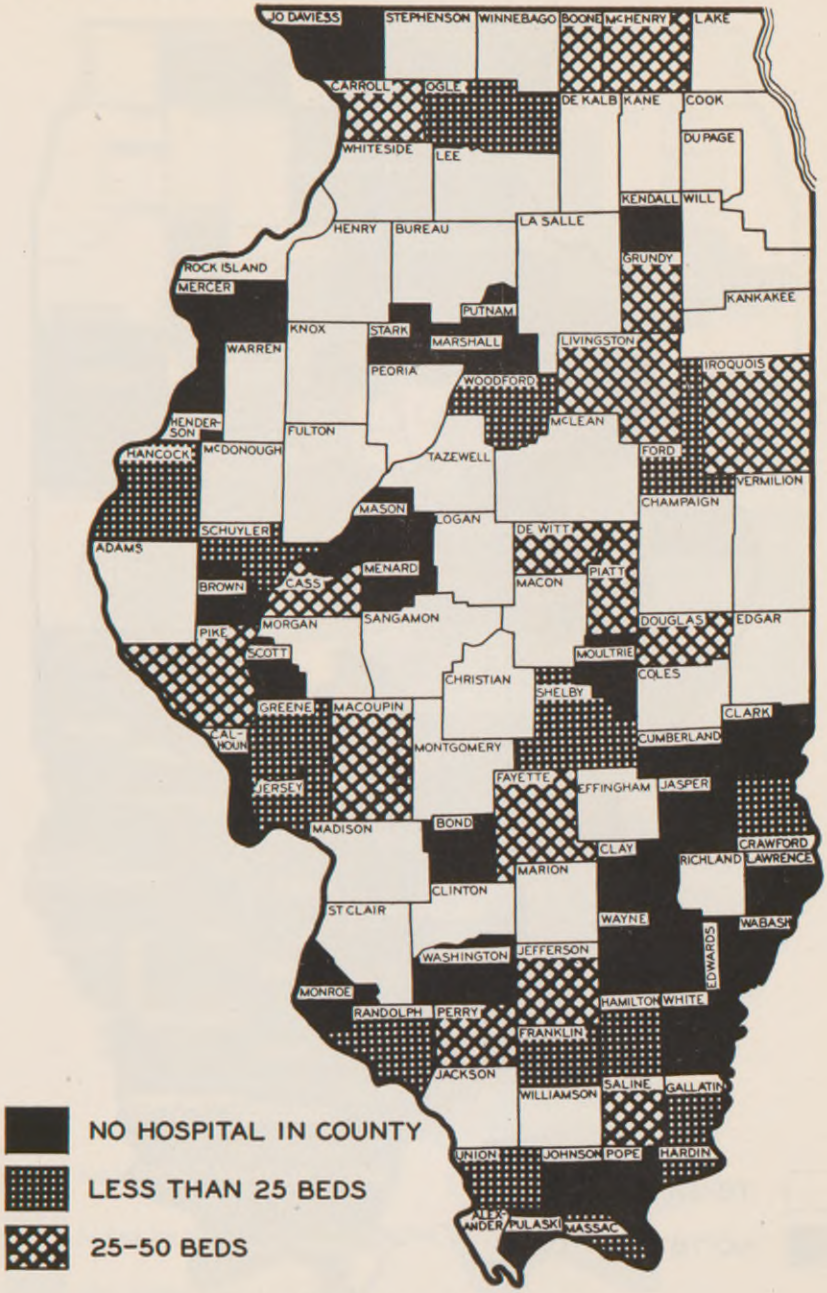
Public Aid in Illinois,
February 1947

GENERAL HOSPITALS IN ILLINOIS—1945



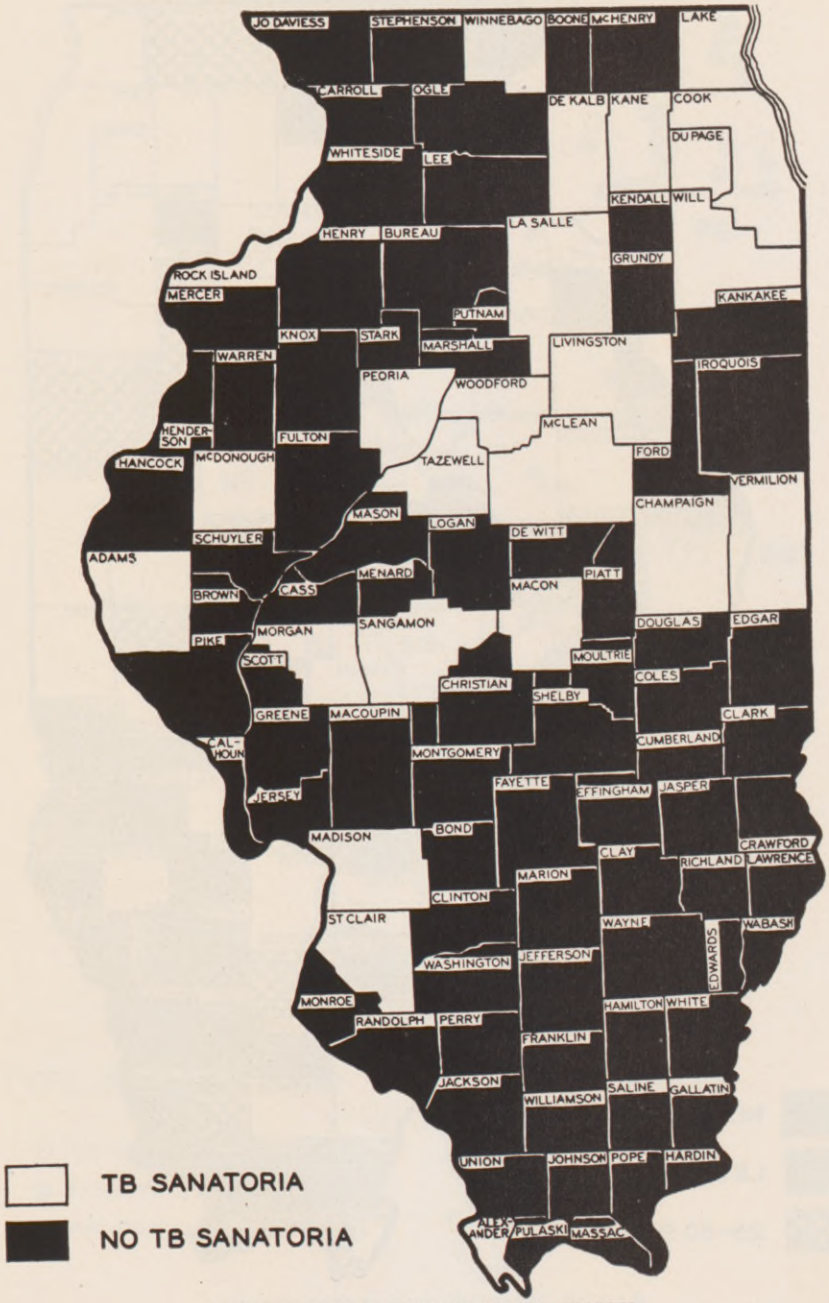
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Reproduced by courtesy of the Illinois Hospital Survey

COUNTIES HAVING ONLY SMALL OR NO HOSPITALS IN ILLINOIS—1945



ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Reproduced by courtesy of the Illinois Hospital Survey

TUBERCULOSIS SANATORIA IN ILLINOIS—1945



ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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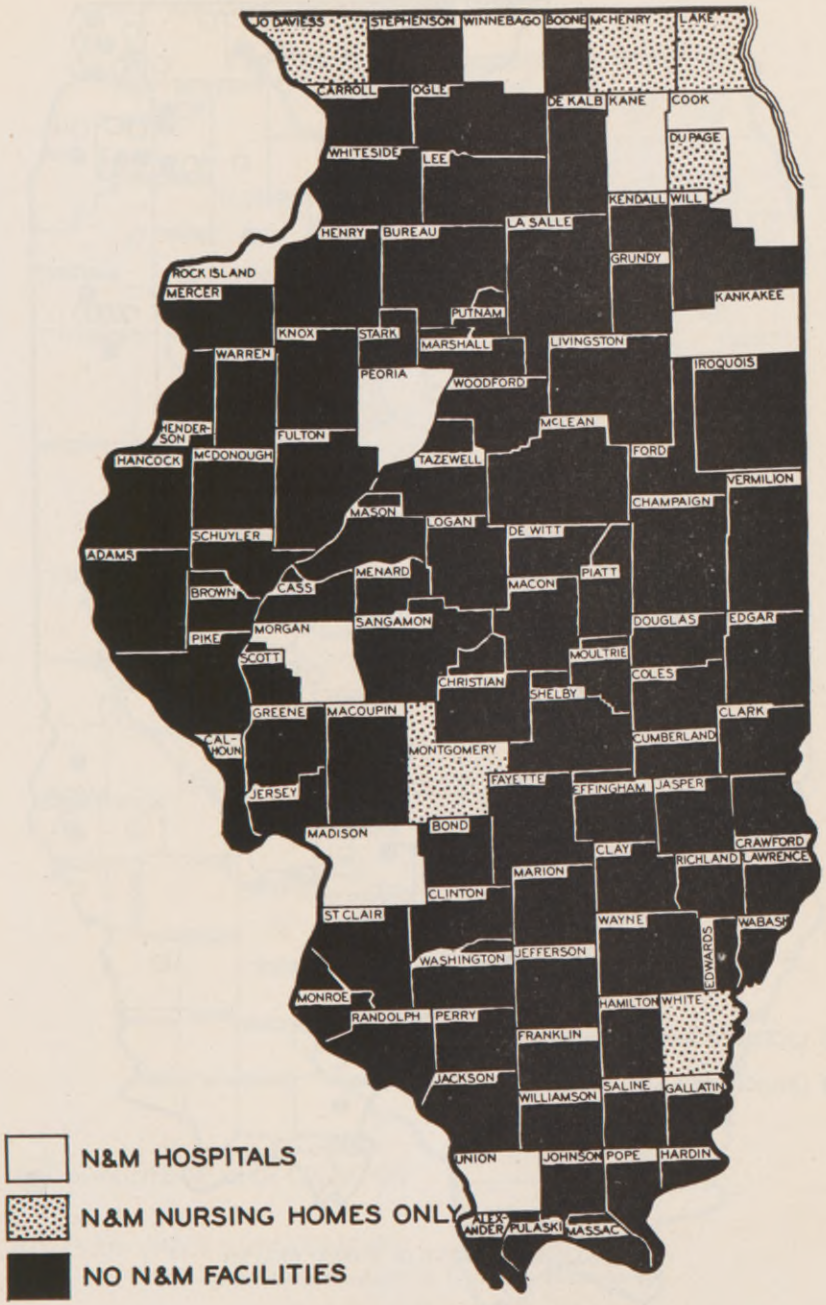
NERVOUS AND MENTAL FACILITIES IN ILLINOIS—1945



ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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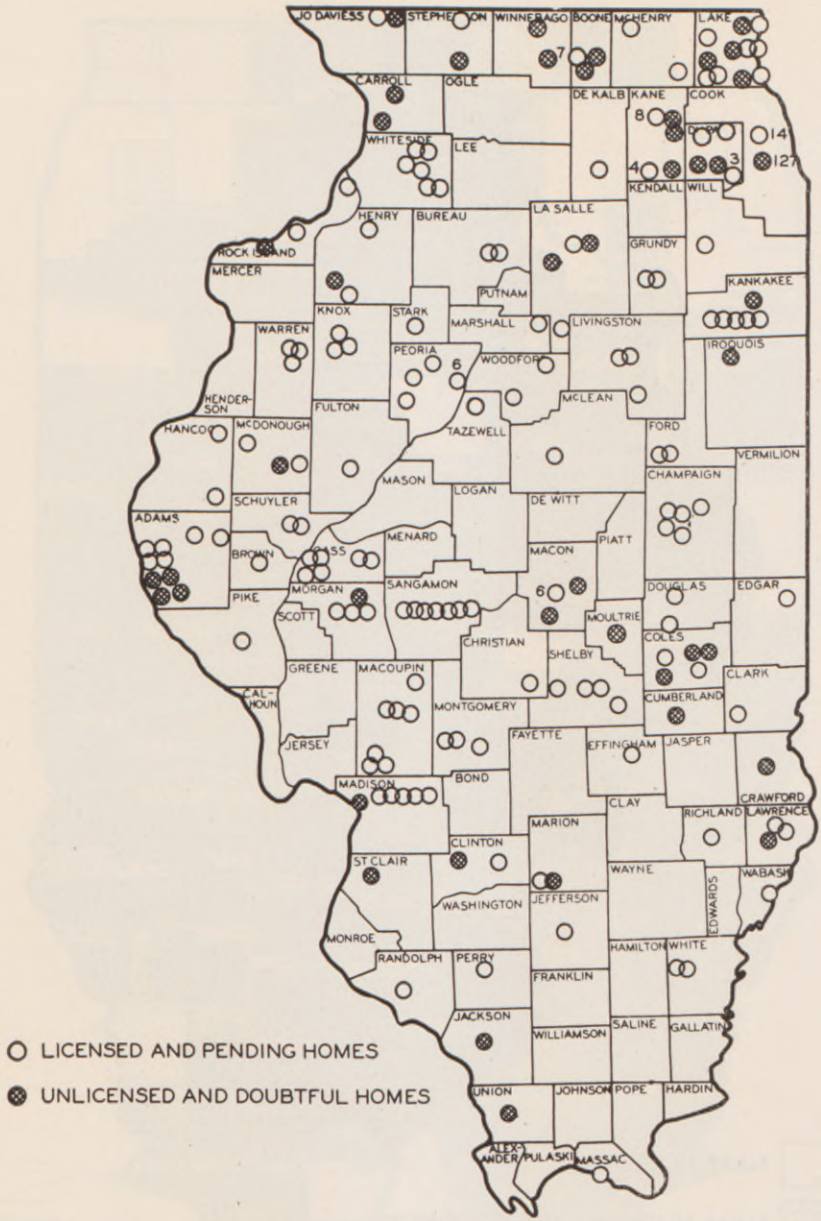
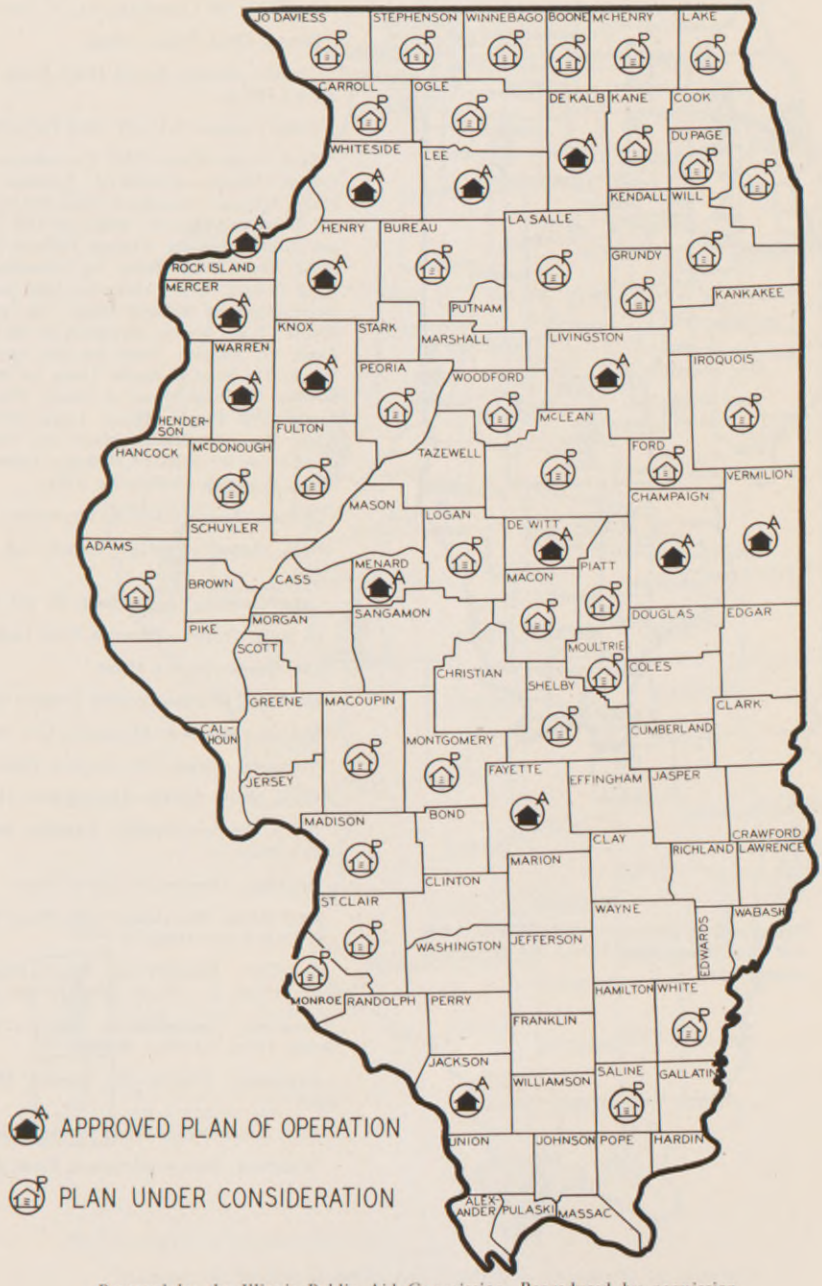
PRIVATE NURSING HOMES IN ILLINOIS—1945



ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Reproduced by courtesy of the Illinois Hospital Survey

PROGRESS OF COUNTY HOME PROGRAM
FOR CARE OF THE CHRONICALLY ILL IN ILLINOIS
APRIL, 1947



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PRIVATE INSTITUTIONS CARING FOR RECIPIENTS OF OLD AGE PENSION AND BLIND ASSISTANCE

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Adams, Quincy—Methodist Sunset Home, St. Joseph Hospital for the Chronically Ill, St. Vincent Home.

Bureau, Ohio—Mercy Home.

Clinton, Aviston—Sacred Heart Home. Carlyle—St. Mary's Home.

Coles, Mattoon—I.O.O.F. Old Folks' Home.

Cook, Argo—Rosary Hill Convalescent Home. Arlington Heights—Evangelical Lutheran Old Folks Home. Chicago—Augustana Home for the Aged, Bethany Home and Hospital, Bohemian Old Peoples Home and Orphan Asylum, Chicago Holland Home for the Aged, The Chicago Home for Incurables, Home for Aged Colored People, Home for Aged Jews, The Norwegian Lutheran Bethesda Home, The Norwegian Old People's Home Society, Orthodox Jewish Home for the Aged, St. Joseph's Home for the Aged, St. Pauls House, The Swedish Baptist Home for the Aged, The Swedish Covenant Home of Mercy, Western German Baptist Old Peoples Home. Lyons—Illinois Colony Club, Maywood—Baptist Home and Hospital, Maywood Home for Soldiers' Widows. Techny—St. Ann's Home. Wheeling—Addalorato Villa.

DuPage, Bensenville—The Bensenville Home.

Kane, Aurora—Jennings Terrace, Inc., St. Joseph Home.

Lake, Gurnee—Viking Home for the Aged.

La Salle, Ottawa—Pleasant View Luther Home.

Lee, Dixon—Jacob's Home.

McHenry, Woodstock—Old People's Rest Home.

McLean, Meadows—Mennonite Old Peoples Home.

Macoupin, Girard—The Brethren Home.

Ogle, Mount Morris—The Brethren Home.

Peoria, Peoria—Apostolic Christian Home, St. Joseph's Home.

Randolph, Chester—St. Ann's Home.

Rock Island, Rock Island—The Prince Hall Masonic and Eastern Star Home.

St. Clair, Belleville—St. Paul's Evangelical Old Folks' Home, St. Vincent Home for the Aged.

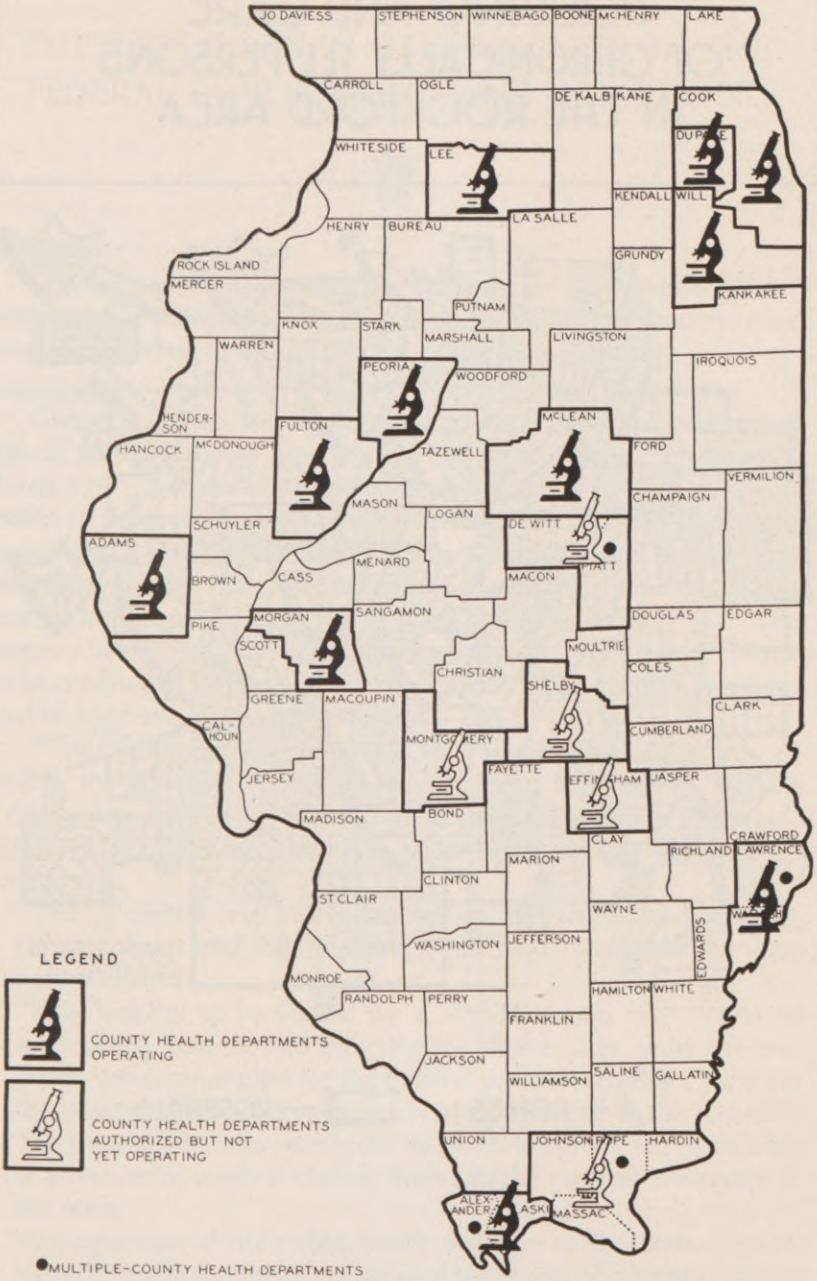
Sangamon, Springfield—St. Joseph's Home, Mary Bryant Home for Blind Women.

Stephenson, Freeport—St. Joseph's Home for the Aged.

Will, Joliet—Salem Home for the Aged.

Woodford, Eureka—Mennonite Home for the Aged.

COUNTY HEALTH DEPARTMENTS IN ILLINOIS
JANUARY 1947



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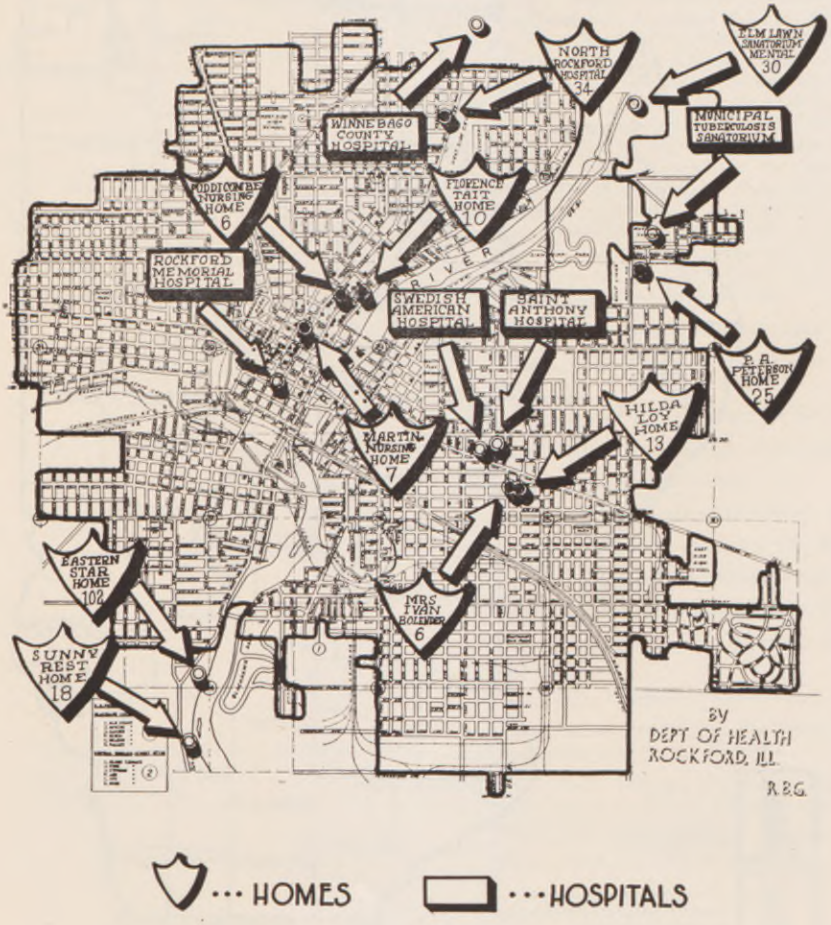
HOUSING AND CARE OF CHRONICALLY ILL PERSONS IN THE ROCKFORD AREA



VII

DEVELOPMENTS IN OTHER STATES, IN THE FEDERAL GOVERNMENT, AND IN ENGLAND

California

The care given at Rancho Los Amigos, the Los Angeles County institution for the chronically ill, is outstanding in the country. More complete reference to this institution is found on page 269.

Connecticut

Connecticut has had a special Commission on the care of chronically ill persons. In the report submitted to the State Legislature in March 1947, the outstanding recommendation, other than calling attention to the great extent of the problem and to the need in developing additional facilities for care, was that the state should provide for a research center for the study of chronic diseases and that such center must be located in connection with a medical college. They also called attention to the fact that "The mildly confused elderly person should not be confined in a hospital for mental illness." The report of the Commission concluded with this summary:

"Your Commission believes that more medical studies may be applied to the afflicted and the more enlightened approach to the care of the aged and infirm would be to institute health activities that would help to defer, if not eliminate the rapid deterioration. We therefore recommend:

A. "That a central institute for the study and treatment of cancer, arthritis, heart and kidney disease and mild mental deterioration be established.

"This hospital to be staffed by a medical group who would be available to examine and prescribe for all the cases under the program. Refresher studies for the medical practitioner and a focus for the latest methods of treatment could also be had at this institute. The trained scientific staff could do much to spread the knowledge of advances in treating chronic illness to the medical profession of the state.

B. "An expansion of the public health activities of the State Department of Health should be encouraged to prevent or postpone chronic disease.

C. "That the activities in the prevention, control and clinic subsidization for cancer being carried on by the State Department of Health with the co-operation of the Connecticut State Medical Society and hospitals should be expanded to include diagnostic facilities for all chronic diseases.

D. "That increases in the chronic bed facilities, by additions to the municipal hospitals and state-aided hospitals be encouraged thereby at the earliest moment relieving the immediate needs.

E. "That encouraging and enlarging of the facilities of the fraternal, religious and private homes for the care of both private cases and state wards both by grant and by subsidy be undertaken."

In Connecticut, in 1944, it was shown that about 20,000 assistance recipients out of an estimated 100,000 persons were handicapped by chronic illness or disabled; and an additional 13,000 such persons were in special hospitals and institutions. Here again there is proof of the impact of chronic invalidism in enforcing persons in need of public assistance.

Maryland

The longest and most carefully conducted study of the occurrence and effects of chronic disease was that conducted in the Eastern Health

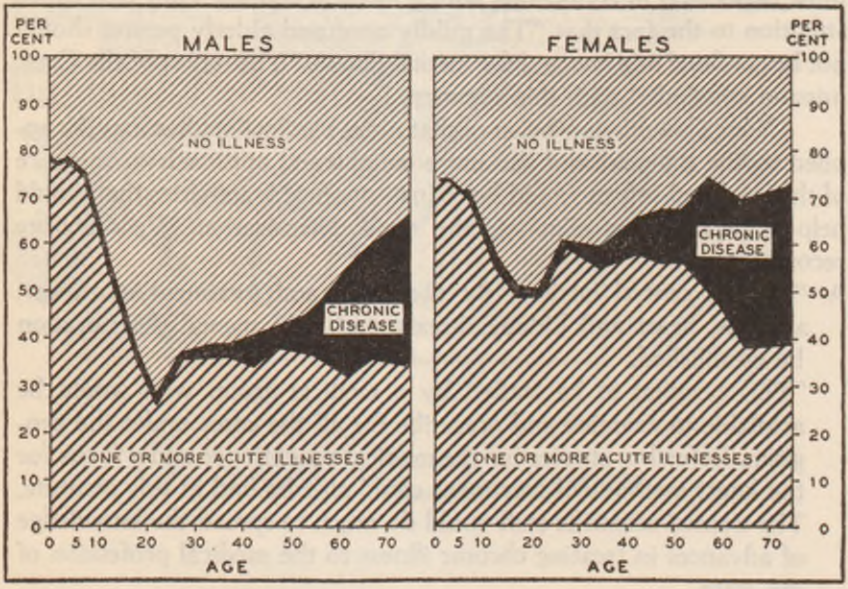


FIG. I. PROPORTION OF THE TOTAL POPULATION BY SEX WHO (1) REPORTED NO ILLNESS, (2) REPORTED THE PRESENCE OF CHRONIC DISEASE, AND (3) THOSE WHO REPORTED ONLY ONE OR MORE ACUTE ILLNESSES IN 1,243 CANVASSED WHITE FAMILIES. EASTERN HEALTH DISTRICT OF BALTIMORE, 1938-1939.

district of Baltimore where, over a period of five years, careful records were kept of contact between all doctors serving an area with 13,800 families and all cases of illness among those families. Tabulation of the results of that survey are being completed now after interruption during the war (see chart on page 66 for example of information gathered in this study). The most significant fact brought out is that out of this total of 13,800 families, 381 "chronic disease families had 54 per cent of the total illness and received about 50 per cent of the medical care given to the total population. Persons from these few families also constituted almost 40 per cent of the persons hospitalized." This survey also showed that 90 persons per thousand were afflicted with chronic disease.

Massachusetts

Massachusetts in 1946 appropriated seven million dollars for an 800-bed institution for the care of chronic invalids in addition to a state institution of similar capacity and in addition to two separate state institutions for cancer patients. The new institution was to feature research. A site was picked by the Governor, about twenty miles outside of Boston.

The medical authorities, however, objected to the selection of such a site because all authorities agreed that research of any real significance could only be carried on in connection with one or several of the medical colleges of the state, all of which were located in Boston itself. It was felt that without the assistance of the faculties of such medical schools and centers it would be impractical to expect significant results, and therefore, even though money was available and a site chosen, it was felt better to delay the start of the project and to seek amendment to the Act authorizing this research center so that it could be located in Boston in connection with the medical schools and centers.

This experience and findings are of great significance, conforming to the judgment and recommendations of the Commission on the Care of Chronically Ill Persons in Illinois, as reported elsewhere in this report.

Of considerable interest in Massachusetts is the geriatric clinic at the Peter Bent Brigham Hospital which, with its motto that "life begins at seventy" finds that "old age should not bring the depression that it does * * * Confident living will help reduce the depression that commonly plagues old folks and this depression often is mistaken for senile psychosis." Many valuable facts have already been developed out of the work of this clinic during the past several years, and they emphasize the importance of a research center for more severe cases and a co-ordinate program of treatment and research extended throughout the state using all available resources.

Minnesota

A study made by the Wilder Charities of St. Paul, Minnesota, provides an important reference to the study of chronic disease and chronic invalidism. One of the important results of that survey was to establish a ratio of 3.3 beds per thousand population as a basic minimum for the care of the chronically ill.

New Jersey

This state has released a report entitled "The Problem of the Long-Term Patient in New Jersey," by Emil Frankel, Director, Division of Statistics and Research of the New Jersey Department of Institutions and Agencies. The following points are made in the report:

A broad research program by the medical profession and allied health authorities for the development of measures which definitely may be applied in the prevention of chronic illness.

A medical care program whereby physical signs in individuals pointing toward eventual chronic illness are detected at the very incipiency and adequate medical attention afforded at the earliest moment.

Recognition that the type and quality of care required by the chronic disease patient practically are the same as those required by any other patient and should be available to rich and poor alike.

Recognition that in order to meet the needs of the long-term patient a variegated program of medical, hospital and home nursing care must be built up and adequate funds, public and private, be provided to support such a program.

The availability of a Central Information Service in the community to promote public understanding of the problems of chronic illness.

In addition, New Jersey, for a number of years, has followed a program providing for changing emphasis in the County Welfare Homes, so that these institutions provide care for the chronically ill.

For New Jersey's statistics as to the importance of chronic disease as a causative factor in dependency see page 245.

New York State

New York State has had a Health Preparedness Commission (New York State Commission to formulate a Long Range Health Program) which for several years has been making special studies concerning chronic invalidism. The final report of this Commission (May 1947) summarizes the findings of several years of study. The Commission found that there were a minimum of 164,000 persons in New York State classified as permanent invalids. Added to these are thousands of

others whose disabilities, although not complete, constitute serious deterrents to economic and social productivity. In more than 70 per cent of the cases these disabling conditions have been caused by chronic diseases.

The major recommendations of the New York State Commission include:

A State agency for administering a program of education, research, rehabilitation, and improvement of facilities and services for the care of chronic illnesses exclusive of tuberculosis and mental diseases (the latter were excluded from the report as state programs now exist for the care of such patients).

The State should establish a chronic disease hospital center in each of five geographical regions with such centers associated with and administered by general hospitals or medical schools.

That provision be made in general hospitals for the care of the chronically ill.

That emphasis be placed on rehabilitation in the proposed centers, general hospitals, and public homes.

That the expense of such care for those unable to pay be shared by the state with local communities.

The Commission's report stresses also the serious social and economic aspects resulting from the presence of a chronic invalid in the home. (These findings coincide with the findings of our own State Commission and add emphasis to the need for action in creating additional resources for chronic invalids.)

Also noteworthy among the Health Preparedness Commission's findings are:

1. Whenever possible, convalescent care should be provided in the patient's own home, supplemented if necessary by such community resources as visiting nurse, housekeeper and rehabilitation training service. Yet a number of factors make it impossible for some homes properly to provide this care . . . . Under such circumstances care may have to be provided in "between hospital and home facilities."

The "between hospital and home" facilities are either convalescent or medical domiciliary in type. Convalescent care might be part of the care provided in the long-term care wing of the general hospital. It might be provided in a voluntary (nonprofit) convalescent home established contiguous to and as a part of a voluntary general hospital. It might be provided in a public "custodial" or "medical domiciliary" institution such as a county nursing home. It might be provided in a proprietary nursing home. It might be provided in the

infirmary of a voluntary home for the aged. It might be provided in the patient's own home.

A wing of the general hospital caring for long-term patients is neither the ideal nor the most economical place for such care. A county nursing home, on the other hand, could provide such care for the chronically ill if its facilities and staff were adequate. However, in utilizing the county nursing home for this purpose it should be stressed and reiterated that the case of each patient should be reviewed periodically to determine the possibility of his discharge either to his own home or to some other more appropriate place of care. Ideally, institutional convalescent care should be given in institutions especially designed for the purpose. Since such care chronologically and medically follows that given in general hospitals, the most reasonable development would be that of institutions which would be, in effect, extensions of such hospitals.

2. For purposes of discussion a nursing home is regarded as one providing shelter, board, and nursing care and services under medical supervision to sick, infirm or handicapped persons not in need of hospitalization.

   Many of the medically indigent, chronically ill are cared for in nursing homes which also admit paying patients. Therefore information on the homes caring for the indigent gives a general picture of the types of homes available to and used by a majority of the general population. Public welfare officials generally patronize neither the very poor quality nor the very expensive nursing homes but the average homes.

3. Regulation of standards and facilities of nursing homes is needed. Regulation should apply to all nursing homes and should be on the state level to obviate problems of jurisdictional boundaries between counties and within counties and to insure a high quality of inspection service to communities financially or otherwise unable to provide such service. One or two methods suggest themselves: (a) Comprehensive licensure of all institutions caring for ill persons including nursing homes; or (b) regulation of nursing homes only. Comprehensive licensure seems the desirable method for New York State to adopt as its long-range objective in promoting a high quality of medical and nursing home care. However, if this method of regulation is not established at an early date, it would seem advisable immediately to initiate some method of regulation addressed to nursing homes only; but this is clearly a second choice.

4. A number of persons with whom the subject of Public Nursing Homes has been discussed are convinced that: (a) Each public

home which plans to admit or continue to house chronically ill persons should, in whole or in part, be converted into a cheerful, homelike nursing home of high quality under public auspices; (b) the converted homes should become community facilities and should admit those able to pay for care as well as the indigent, especially since future admittees may be recipients of Old-Age and Survivors Insurance benefits able to pay for at least part of their care; (c) the care of chronically ill public charges admitted to homes meeting minimum standards should be reimbursed by the State Department of Social Welfare under the same formulae applicable to reimbursement for care outside such institutions; (d) every effort should be made to assist the public homes to throw off their social stigma and insure their acceptance as medically related institutions just as state tuberculosis and mental hospitals are regarded; (e) the alcoholic, senile psychotic, and cerebral arteriosclerotic cases should not continue to be part of the general population of the average public home, but should be provided with proper care either in special institutions or specifically designated sections of the larger public homes.

The State of New York has for many years maintained a great cancer research institute affiliated with the University of Buffalo Medical College. Appropriations have been made to expand both the bed capacity and the research at this institute.

Nassau County

Nassau County, New York (suburb of New York City), found 38 per cent of all persons on relief to be chronic invalids.

New York City

New York City maintains, under the jurisdiction of the Department of Hospitals, a City Home for Aged and Infirm People as one institution and the Goldwater Hospital for Chronic Invalids as another on Welfare Island. The two institutions are approximately three fourths of a mile apart but work in very close relationship to each other. At the City Home there are both ambulant and bed cases, but any case of serious illness is transferred to the Goldwater Hospital. The City Home, despite the fact that it is an old building (soon to be replaced), has worked out a very excellent program, particularly of therapy and rehabilitation.

Goldwater Hospital, with approximately 1,600 beds, is modern in every way. There are three "divisions" to supervise medical care: One under the jurisdiction of the Columbia University Medical College; the second under the supervision of the New York University

Medical College; and the third under General Staff and Consultants. In the two sections under the direction of the medical colleges there are in each 45 beds for intensive research. In February 1947, when visited by Robert Rosenbluth as representative of this Commission, the Superintendent stated that the Columbia University group intended to withdraw and that their section would be taken over by New York University. It was particularly interesting to note that intensive research could be conducted in only 90 out of a total basic group of 1,600. The hospital meets the requirements of a Grade A hospital in every way and the entire staff is geared to the idea that they are not a custodial group but a professional and research group.[1]

The Home for Aged and Infirm Hebrews has worked out a very excellent classified service. For the aged who are well, apartments are rented in regular apartment houses in convenient areas of the city but reasonably close to the parent institution. These apartments are in charge of a registered nurse with doctors from the staff or parent institution on call. If sick over 24 hours or if seriously sick or if diagnosed as more seriously sick, transfer is made to the parent institution or in emergencies to an affiliated general hospital. At the parent institution besides provision for ambulant cases there is an increasing percentage of chronic invalids who are severely afflicted. The facilities at the parent institution for all forms of therapy are most excellent. Particular note was given to the fact that arrangement is made not only for the professional therapist but that groups of volunteers serve in this work. These volunteers, however, are not left to haphazard service but are first trained and then their work carried on according to regular plans. (This feature was also noted in other New York City institutions and has much significance, particularly for the public institutions in Illinois where budgets are limited.) Provision is also made for research. Equally significant is the fact that cases requiring major surgery or more intensive work than can be given at the parent institution are transferred to a companion institution or general hospital. Again the fact that this general hospital is at some distance from the parent institution for chronic invalids is not deemed any handicap.

Montefiore Hospital in New York City has the longest and most conspicuous history in the care of chronic invalidism in the country. Outstanding features of this institution are its program of research, of therapy (physiotherapy, recreational and occupational therapy, and all forms of rehabilitative work). Mentioned elsewhere in this report is the belief of E. M. Bluestone, M.D., Director, Montefiore Hospital, that

[1]Refer to the February 1947 issue of *Hospitals*, Journal of the American Hospital Association, for an interesting account of this institution by Chrisman G. Scherf, Superintendent.

chronic invalids should be taken care of as part of a general hospital setup.[1]

St. Barnabas Home has unusual facilities for the care and treatment of its patients. Perhaps most significant is the fact that the name of the institution has just been changed from "Home for Incurables." The institution contemplates a program of research connected with one of the leading medical schools and arrangements for transfer of its seriously ill patients to its companion institution, St. Luke's Hospital. There is no doubt in the mind of the medical director of St. Barnabas Home that the fact that the general hospital (St. Luke's) is at some distance entails no difficulty because of needed transfer or mutual arrangement for care between a chronic invalid institution and a general hospital.

Ohio

There was an excellent study on "Care of the Chronically Ill in Cuyahoga County" by Mary C. Jarrett, prepared for the Benjamin Rose Institute of Cleveland, Ohio. Under the auspices of this Institute many programs for the care of the aged and the chronically ill have been developed in Cleveland.

Wisconsin

Reference is made on page 247 to the study in Dane County, Wisconsin.

Federal Government

Two laws enacted by the 79th Congress should stimulate the states in developing facilities and services for the chronically ill as part of the larger undertaking of developing adequate public health and medical care facilities for all.

PUBLIC LAW 725

The 79th Congress amended the Public Health Service Act by Public Law 725 to authorize grants to states for surveying their hospitals and public health centers and for planning construction of additional facilities and to authorize grants to assist in such construction. Survey and planning grants are available only to states which have designated a single state agency for carrying out these functions. The construction grants, though available for ultimate expenditure for "public and other nonprofit hospitals" will be given only to states which have designated a single state agency to administer or supervise the administration of an approved hospital plan.

[1]The Journal of the American Medical Association for April 12, 1947 has an article by Dr. Bluestone in which he emphasizes his belief that prevention of long-term illness is most important and that the medical profession must carry major responsibility for prevention.

Public Law 487

This law, also enacted by the 79th Congress, amended the Public Health Service Act to provide for research relating to psychiatric disorders and to aid in the development of more effective methods of prevention, diagnosis, and treatment of such disorders. Upon the request of any state mental health or other state health authority, Federal personnel may be assigned to assist the state. Grants-in-aid may be made to universities, hospitals, laboratories, and other public or private institutions and to individuals for such research projects as are recommended by the National Advisory Health Council.

The National Health Institute has just embarked on a new series of studies after interruption due to the war. A new development is the co-operative effort between the United States Public Health Service and the City Hospital of Baltimore. A gerontology unit has been started, taking up a study of kidney functions and diseases as a first project. Dr. Floyd S. Daft, Assistant Chief of the physiology division of the institute in which the gerontology unit operates, states, "It is a big if—but if we could understand the aging process, we might be able to slow it down so people could be young at 100."

England

This year (1947) in a volume entitled "Old People" the Nuffield Foundation[1] reported the findings of an extensive survey in England. These findings are strikingly similar to those reported in this country and because of the thoroughness of the study merit summarization in this report. The English findings are:

1. That the chronic or long-term sick represent an outstanding problem.
2. That many, particularly among the aged, failing to recover their full health after periods of sickness go into a decline resulting in "long-term sickness" because they are unable at the critical moment to take a suitable period of convalescence away from their homes in an atmosphere of care. Even if they desire to do so, there are few places available for their care.
3. That senile dementia cases should be maintained in special institutions. (The report cites the London County Council Institution at Tooting Bec where some 2,000 senile dements are housed. Here emphasis is placed on the adequacy of medical treatment and frequency of examination because "recoveries are not infrequent" and it is essential that recovered persons be removed from among senile dements whenever possible.)
4. That those who are "light senile" or otherwise only mildly disturbed

[1] *Old People*, Nuffield Foundation, London, 1947.

but who are unable to live in an ordinary community without annoyance to other people are best cared for in private nursing homes when they are able to afford such; otherwise they should be transferred to a public institution where proper facilities exist.

5. With regard to all other long-term sick cases, there are the same two schools of thought as in the United States:
   a. That special units should be constructed in connection with a general hospital and for all practical purposes be a part thereof. The advantages are the assurance of a higher level of medical and nursing care, the facilitation of prompt treatment of acute illness, and the furtherance of research into the physical and psychological processes of aging. Its disadvantages lie in the somewhat regimented life of the average hospital with its inevitable emphasis on sickness which is unlikely to ensure the contentment of the aged, even when they are sick.
   b. That the patient should go to a general hospital for diagnosis and treatment but that, when no further specific treatment is considered advisable, he or she should be transferred to an ordinary home. The term "long-term sick" covers a multitude of different conditions and, though many of the patients will obviously need to remain permanently in a nursing home if not in a hospital, others, especially those suffering from disabling diseases, would stand a better chance of being made to feel that they are still part of the general community if they were transferred to an ordinary home under a good matron. In this way they would enjoy as near an approach to ordinary living as possible and would learn not to regard the hospital as the center of their future lives. They would, of course, still need regular visits from their doctor, and it might be necessary for them to spend periods in a hospital from time to time for treatment.

      Although the homes just described were referred to as "ordinary" they would need a higher proportion of staff to residents than is usual in homes for the able-bodied aged, and it would be advantageous, though not essential, for them to have special features such as passenger lifts, easy access to the garden, a sun lounge, and provision for the use of invalid chairs. Where possible a special sick-bay should be provided in these homes so that the old people can remain there until they die, and so avoid the distress and shock of being moved to strange surroundings when they are approaching their end.

6. That institutions and homes providing for the aged should be of the following types:

a. *Small Homes.* The Committee agreed with the opinion, which is coming to be held by an ever-growing number of persons who have studied the subject, that all normal old people who are no longer able to live an independent life should be accommodated in small homes rather than in large institutions.

Clearly this objective can be attained only gradually, but it is important that the goal to be aimed at should be defined as clearly as possible.

Undoubtedly a considerable number of aged persons will continue to be accommodated in homes provided by voluntary agencies, but the majority will have to be accommodated in homes administered by local authorities. It may be thought that, however desirable it may be to replace large institutions by small homes, the cost will be prohibitive. Such, however, is not the case. Experience has shown that quite small homes can be run at costs not appreciably higher per resident than those of well-conducted large institutions. An intimate homey atmosphere can best be created if the number of residents in homes is kept as low as 20, but it is doubtful if this figure is economical. Overheads cease, however, to have an undue influence on the cost per resident when the numbers reach 30 to 35. In some homes of this nature (the exact proportion being determined by experience) provision should be made for the "long-term sick," at any rate until there is conclusive evidence that some other way of dealing with them is both practicable and preferable. Since, under the new National Health Service the "long-term sick" like all categories of sick persons become a responsibility of the central government and as their retention in homes, which is certainly necessary at present and may be permanently desirable, raises substantially the cost of running those homes, it appears reasonable that the central government should pay a subsidy for each "long-term sick" person kept in a home for the aged whether such home is run by a local authority or by a nonprofit-making private body. The amount of such subsidy should be equal to the additional cost incurred by the home over that of maintaining a resident who does not need special nursing care or to the cost of keeping the same patient in a central government hospital, whichever is less.

b. *Highly Classified Institutions.* Although the aim should be to accommodate in small homes all normal old people who can no longer lead independent lives, this will certainly not be possible for some time. As an interim measure there is merit in highly classified institutions of medium size, possibly accommodating up to 200 aged

residents plus the proportion of "long-term sick" found to be necessary. These institutions should be homelike in their atmosphere and there should be a large degree of personal liberty. Very few of the old workhouses are suitable for this purpose. In some cases it will be possible to convert buildings erected for other purposes.

c. *General-Purposes Institutions.* A small proportion of old people may be permanently unsuited by nature or temperament to either of the foregoing types of accommodation. There will, therefore, have to be accommodation for them in a General-Purposes Institution which should be a mixed institution varying in size according to the density of the population that it is designed to serve.

d. *Institutions for Senile Dements.*

e. *Special Dwellings for Old People.* Forty-eight thousand small houses, especially designed for old people, were built in England and 27,270 in Scotland. It was believed that five per cent of the houses in any community should be subjected or suited to the special needs of old people. Stress is placed on the fact that location of such houses should be within easy reach of relatives and friends and accessible to medical care and should permit convenient access to the community's institutions of modern life such as shops, postoffice, transportation, library, church, and places of recreation. The best solution seems to be the perfection of small groups of houses for old people interspersed among houses built for other age groups.

f. *Utilization of Existing Institutions.* England reports the need of modernizing the old almshouses wherever these are suitable, estimating that in this way accommodations for 20,000 chronic invalids may be provided. This survey in England confirms the findings in Illinois that the existing public institutions, where susceptible to conversion, should be utilized. Particlar attention is also called to the need for adequate staff and services.

g. *Research.* The report also stresses the need for research in geriatrics and gerontology.

VIII

CURRENT ESTIMATES OF THE EXTENT OF CHRONIC INVALIDISM AND THE NEED FOR BEDS IN ILLINOIS

Revised Estimate of Chronic Invalidism

The predecessor Committee to Investigate Chronic Diseases among Indigents applied the findings of the 1935-36 National Health Survey to the Illinois population as of 1940 to arrive at an estimate of the number of chronic invalids in Illinois.[1] The Committee's figure was 90,200. On the basis of the study made in Sangamon County in January 1947 under the auspices of the present Commission it would appear that the actual number is considerably more (117,679) than the original estimate, assuming that the Sangamon County figures can be projected for the entire State. (See Section XI of the Appendix for a detailed report of the Sangamon County Survey and for a comparison of findings with other studies.)

The Need for Beds

The need for beds for chronically ill persons has been recognized in every part of the United States. A number of states not only have been conducting current investigations of such need but have appropriated large sums to provide facilities. For example, the State of Massachusetts has a $7,000,000 appropriation for an 800-bed state institution for chronic invalids to supplement its present institution for chronic invalids and its two special state institutions for cancer cases.

Illinois has taken leadership in providing that recipients of public assistance and General Relief may have their grants continued in institutions of their own choice, including county nursing homes, provided these meet standards set by the Public Aid Commission. The Commission requires approval of the county institution by the State Health Department and the State Fire Marshal. Under the regulations of the Illinois Public Aid Commission there also must be satisfactory arrangements for medical care, generally under the supervision of the county medical society. This policy will have the desirable effect of obviating

[1] *Interim Report*, p. 6.

need for state institutions merely for the care of chronic invalids and instead will encourage the development of facilities closer to their homes.

The Illinois county home legislation also allows counties to enter into agreements with other counties so that jointly they can create needed facilities where any one of them might either be too small or financially unable to provide necessary facilities. It is believed that, since the state policy assures payment for cost of care of persons in satisfactory institutions, it will be unnecessary for the State to undertake to provide for any special institution merely for the care of chronic invalids. The one State institution should be that for research and teaching as above outlined.

The only possible exception to this might arise because of the financial difficulties and economic weaknesses of a group of counties in the extreme southern end of the State. But further investigation and only a finding that the counties themselves could not financially advance such an enterprise provided they joined together for such purpose would justify a recommendation for a state institution in that area. Such study and effort to organize by local resources the development of very much needed institutions for that area should be a major concern of a successor Commission.

Pending reduction of the incidence of chronic disease through adequate research it is, of course, necessary to provide facilities for the care and treatment of those who are now afflicted.

Many studies have been made as to the number of beds needed for chronic invalids. It is significant that in no place where a study has been made has there been a finding that there are adequate facilities available. In every case without exception the need for additional facilities has been found to be the greatest single need of the community with respect to provisions for adequate medical care.

Since the need has everywhere been found so great, the estimates have been based in almost every case on minimum requirements for urgent immediate need. It is certain, however, that with the development of adequate facilities at moderate cost and with acceptance of the fact that the social and economic problems posed by chronic invalidism for the other members of the household can be better solved as well as better care given to the chronic invalid if satisfactory special facilities are provided, all present estimates regarding number of beds needed will be found to be too low.

In the Chicago-Cook County Survey (see Section X of the Appendix) the figure of 3.3 beds for chronic invalids per thousand total population was used. This figure was based on the findings of a survey made in St. Paul by the Wilder Foundation.

In the table on page 81 the Chicago-Cook County Survey figures have been used with the figures from the Illinois Hospital Survey to arrive at a separate estimate for downstate, Chicago and Cook County, and for the State as a whole. This table shows that chronic invalids, other than the tuberculosis and persons afflicted with nervous or mental ailments, need 35,000 beds but only 11,521 are available, that is, there is a deficiency of 23,479 beds.

On the basis of the Commission's study in Sangamon County in January 1947, however, the need would appear to be considerably greater. As a result of the Sangamon County study it was found that 5.5 beds for chronic invalids per thousand total population would be needed. Studies in other states, not yet officially released, also indicate that more beds than have previously been deemed necessary would be required.

On the basis of the Sangamon County study there are 118,000 chronic invalids in the State for whom 43,149 beds would be needed as against a finding by the Illinois Hospital Survey of present provisions for 11,521, that is, there is a deficiency of 31,628 beds. The staff has also considered every possibility of reducing the numbers needing care outside their own home which might be effective in the next decade and has concluded that this would still leave a need for at least 4.5 beds per thousand total population for chronic invalids. A conservative figure for the number of beds needed for chronic invalids is 35,000. An absolute minimum would approximate 26,000 and as many as 43,000 might be needed. These figures are set forth for each county in the table on pages 82 and 83.

Of course, conditions vary in each county so that for any one area the figures may likewise vary. It is doubtful, however, if in any case there will be found ample provisions even to meet the absolute minimum estimate of requirements to say nothing of the probable minimum. The tables should serve a useful purpose in allowing each county to determine how far it must go to meet even minimum need for beds to provide adequately for its chronic invalids.

As the incidence of chronic invalidism increases with advancing age and as the proportion of older people in the population increases, it is probable that the need for beds and for adequate provision for chronic invalids will grow as will the need because of the other factors above cited.

On the other hand there is hope for effective attack on invalidism through medical research, provision for earlier diagnosis, and for more effective treatment in the initial stages of these diseases providing proper care is given. There is also hope, or even better, assurance, as proved

Deficiency in Beds for Chronic Invalids (All Causes)—Illinois 1947

Type of Institution	Beds Needed	Beds Available	Deficiency in Beds
Chicago-Cook County[a]			
Nervous—Mental	4,563[b]	1,000[b]	3,563[b]
Tuberculosis	4,915	2,640	2,275
Chronic Invalids	13,000	7,059	5,942
Downstate[c]			
Nervous—Mental	33,178[d]	21,804[d]	11,374[d]
Tuberculosis	2,793	1,955	838
Chronic Invalids	22,000	4,462	17,538
Total State[e]			
Nervous—Mental	37,741[f]	22,804[f]	14,937[f]
Tuberculosis	7,708	4,595	3,113
Chronic Invalids	35,000[g]	11,521[h]	23,479[h]

a-See footnote (*), page 83, for number of beds needed for chronic invalids.

b-Figures for Nervous—Mental in Chicago—Cook County should really be considered for the *area*. The Illinois Hospital Survey considers the Chicago, Elgin, Kankakee, and Manteno State Hospitals as serving the Chicago area with 22,527 patients in institutions with normal bed capacity of 13,212 or a deficiency of 9,315 beds for the *area*. (See also note "f.")

c-Figures for "Downstate" represent the difference between Chicago-Cook County and the totals for the State figures from the Illinois Hospital Survey. The latter figures are authoritative, and any change in the Chicago-Cook County figures will merely represent a difference in distribution of needed facilities, the total remaining the same.

d-Reference should be made to note "b" showing a deficiency of 9,315 beds in the Chicago *area* which would leave a deficiency of 5,622 beds for the rest of the State outside of the Chicago *area* as defined in the Illinois Hospital Survey.

e-Illinois Hospital Survey and Plan, 1947.

f-The *deficiency* in beds for Nervous—Mental cases differs from the others in that *actually* there are *34,414* beds in institutions with *normal* capacity for 21,995. Actually, therefore, the total "deficiency" of 14,937 includes 11,293 for whom beds are "available" in overcrowded institutions with "*absolute*" *deficiency* of 3,327.

g-See table on page 82 for adjustments in this figure as indicated by findings of the Sangamon County Survey.

h-For the "Chronic Invalids" the deficiency of 23,479 beds is "absolute." By far the great majority of "available" beds for Chronic Invalids are most unsatisfactory, and if even minimum standards were applied, the deficiency would be at least 30,000 beds.

ESTIMATED NUMBER OF CHRONIC INVALIDS (EXCLUSIVE OF THE TUBERCULOUS AND THE MENTALLY ILL) AND NEED FOR BEDS IN ILLINOIS 1947, BY COUNTY

County	Population Based on 1940 Census (Excludes Institutional Pop.) (a)	Number of Chronic Invalids (b)	Beds Needed for Care of Chronic Invalids Outside Own Home*		
			Absolute Minimum (c)	Probable Minimum (d)	Probable (e)
TOTAL	7,845,300	117,679 (107,000 to 118,000)	25,890	35,304 (30,000 to 35,304)	43,149 (34,000 to 43,000)
TOTAL DOWNSTATE COUNTIES	3,786,489	56,797	12,496	17,039	20,826
Adams	65,229	979	215	294	359
Alexander	25,496	383	84	115	140
Bond	14,540	218	48	65	80
Boone	15,202	228	50	68	84
Brown	8,053	121	27	36	44
Bureau	37,600	564	124	169	207
Calhoun	8,207	123	27	37	45
Carroll	17,987	270	59	81	99
Cass	16,425	246	54	74	90
Champaign	70,578	1,059	233	318	388
Christian	38,564	579	127	174	212
Clark	18,842	283	62	85	104
Clay	18,947	284	63	85	104
Clinton	22,912	344	76	103	126
Coles	38,470	577	127	173	212
Cook	4,058,811	50,141-60,882	13,394	13,000-18,265	13,000-22,323
Crawford	21,294	319	70	96	117
Cumberland	11,698	175	39	53	64
De Kalb	34,388	516	113	155	189
De Witt	18,244	274	60	82	101
Douglas	17,590	264	58	79	97
Du Page	103,480	1,552	341	466	569
Edgar	24,430	366	81	110	134
Edwards	8,974	135	30	40	49
Effingham	22,034	331	73	99	121
Fayette	28,069	421	93	126	154
Ford	15,007	225	50	68	83
Franklin	53,137	797	175	239	292
Fulton	44,627	669	147	201	245
Gallatin	11,414	171	38	51	63
Greene	20,292	304	67	91	112
Grundy	18,398	276	61	83	101
Hamilton	13,454	202	44	61	74
Hancock	26,297	394	87	118	145
Hardin	7,759	116	26	35	43
Henderson	8,949	134	30	40	49
Henry	43,798	657	144	197	241
Iroquois	32,496	487	107	146	179
Jackson	37,920	569	125	171	209
Jasper	13,431	201	44	61	74
Jefferson	34,375	516	114	155	189
Jersey	13,636	204	45	61	75
Jo Daviess	19,989	300	66	90	110
Johnson	10,727	161	35	48	59
Kane	124,798	1,872	412	562	686
Kankakee	51,424	771	170	231	283
Kendall	11,105	167	37	50	61
Knox	52,250	784	173	235	287
Lake	121,094	1,816	400	545	666
La Salle	97,801	1,467	323	440	538

ESTIMATED NUMBER OF CHRONIC INVALIDS (EXCLUSIVE OF THE TUBERCULOUS AND THE MENTALLY ILL) AND NEED FOR BEDS IN ILLINOIS 1947, BY COUNTY

	(a)	(b)	(c)	(d)	(e)
Lawrence	21,075	316	70	95	116
Lee	31,303	470	103	141	172
Livingston	36,108	542	119	162	199
Logan	25,271	379	83	114	139
McDonough	26,944	404	89	121	148
McHenry	37,311	560	123	168	205
McLean	73,930	1,109	244	333	407
Macon	84,693	1,270	280	381	466
Macoupin	46,304	695	153	208	255
Madison	147,671	2,215	487	665	812
Marion	47,989	720	158	216	264
Marshall	13,179	198	44	59	72
Mason	15,358	230	51	69	85
Massac	14,937	224	49	67	82
Menard	10,663	160	35	48	59
Mercer	17,701	266	58	80	97
Monroe	12,754	191	42	57	70
Montgomery	34,499	517	114	155	190
Morgan	33,166	497	109	149	183
Moultrie	13,477	202	44	61	74
Ogle	29,869	448	99	134	164
Peoria	150,802	2,262	498	679	829
Perry	23,438	352	77	105	129
Piatt	14,659	220	48	66	81
Pike	25,340	380	84	114	139
Pope	7,999	120	26	36	44
Pulaski	15,875	238	52	71	87
Putnam	5,289	79	17	24	29
Randolph	30,138	452	99	136	166
Richland	17,137	257	57	77	94
Rock Island	111,120	1,667	367	500	611
St. Clair	166,899	2,504	551	751	918
Saline	38,066	571	126	171	209
Sangamon	117,912	1,769	389	531	649
Schuyler	11,430	172	38	51	63
Scott	8,176	123	27	37	45
Shelby	26,290	394	87	118	145
Stark	8,881	133	29	40	49
Stephenson	40,646	610	134	183	224
Tazewell	58,362	875	193	263	321
Union	19,341	290	64	87	106
Vermilion	86,791	1,302	286	391	477
Wabash	13,724	206	45	62	76
Warren	21,286	319	70	96	117
Washington	15,801	237	52	71	87
Wayne	22,092	331	73	99	122
White	20,027	300	66	90	110
Whiteside	43,338	650	143	195	238
Will	108,271	1,624	357	487	595
Williamson	51,424	771	170	232	283
Winnebago	121,178	1,818	400	545	666
Woodford	19,124	287	63	86	105

*In determining the number of chronic invalids in Cook County modifications were made because of the facts revealed by a population study of Chicago and Cook County made by the Illinois Public Aid Commission. This showed a great growth in population since the 1940 Census which would indicate a proportionate increase in the number of chronic invalids. Similarly, allowances have been made in the above table for the increased percentage of aged persons in 1947 as

(Footnote continued at bottom of p. 84.)

by the rehabilitation work in Army hospitals and in the very few institutions for chronic invalids where rehabilitation work has been thoroughly undertaken, that rehabilitation programs can reduce the numbers who would otherwise be chronic invalids.

Chronic Invalidism Among Persons Receiving Public Assistance

The Illinois Public Aid Commission, reporting new grants authorized for January 1947, shows the following for the entire State:

For Old Age Pension, 1,663 grants were authorized, for which 494 were because of illness or disablement of the recipient. This constitutes 29.7 per cent of all authorized grants.

For Blind Assistance, of 45 grants authorized 10 or 22.2 per cent were because of illness or disablement of recipient.

For Aid to Dependent Children, 773 grants were authorized with 176 or 22.8 per cent because of illness or disablement of parent or relative acting in parent's place.

For the three assistance programs, out of 2,481 grants authorized 680 or 27.4 per cent of the total were for illness or disablement as the cause.

For General Relief cases, of 3,842 cases 694 or 18.1 per cent of the total were for medical or hospital care.

While these figures do not identify the illness or disablement as necessarily being chronic invalidism, it can be assumed that a short general illness would not, in most cases, force people to apply for public support.

It is surprising how closely these figures correspond to the more detailed analysis revealed in the Sangamon County Survey (see Section XI of the Appendix) and how strongly they support the hypothesis that chronic invalidism is the greatest cause (other than economic) of poverty and dependency.

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against the 1940 Census figures for age distribution; this results in an increase in the estimated number of chronic invalids.

The Federal Hospital Survey and Construction Act stipulates that ". . . the total number of beds required to provide adequate *hospital* services for chronic disease patients shall not exceed 2 per thousand population." In 1947 the Hospital Council of Greater New York estimated that there would be needed 3 hospital beds for chronically ill persons per thousand population. The Cleveland Survey in 1944 estimated 4 beds per thousand general population.

At least for many years to come the Commission's staff believes that a majority of beds needed for chronic invalids will have to be provided in nursing homes or special institutions meeting suitable standards rather than in general hospitals. The number of such beds, therefore, will be in addition to those estimated as needed in general hospitals.

NOTE: Referring to the table, column (b), the figure of 1.5 per cent of general population is used to determine the number of chronic invalids. Column (c) is derived by applying 0.33 per cent (this number based on 1945 findings of St. Paul, Minnesota, Survey by Wilder Charities) to general population figures; column (d) is derived by using the figure 0.45 per cent of general population (based on modification of 1947 Sangamon County, Illinois, Survey); column (e) by applying the figures of 0.55 percent of general population (based on unmodified 1947 Sangamon County Survey, Appendix, and other recent unpublished studies) to give the number of beds needed.

Chronic Illness Among Old Age Pension Recipients

During the six-month period from June through November 1946 a survey was conducted by the Illinois Public Aid Commission in seven downstate Illinois counties for the purpose of obtaining detailed data on the cost of medical care to public aid recipients. The counties were chosen so as to present statistical information which might be considered representative of conditions existing throughout downstate Illinois and perhaps, under certain circumstances, of the whole of Illinois.

Of particular interest with regard to chronic illness and its cost were the data collected on costs of medical care of Old Age Pension recipients. It is estimated that of the total amount of mony spent for such medical care approximately 95 per cent is spent because of chronic illness. It is also estimated that about 67 per cent of all persons receiving Old Age Pension during a year will require medical care during that year and about 60 per cent of all persons will require care for chronic illness. This would mean that of the 140,793 persons who received Old Age Pension at some time during 1946 about 94,000 received the $3,700,000 in medical care. Of this number over 84,000 required about $3,500,000 of the total for the care of chronic illness some time during the year.

IX

TECHNICAL ASPECTS OF SOUND FUTURE PROGRAM PLANNING, AS RECOMMENDED BY TECHNICAL CONSULTANTS TO THE COMMISSION

For competent opinion and suggestions regarding the medical, nursing, and other technical aspects of a sound policy for the care of the chronically ill the Commission sought the assistance of those professionally qualified to give such advice and recommendations. The reports of these consultant groups are given in full in Sections IV, V, VI, VII and VIII of the Appendix. The high lights of these reports are summarized below.

The Field of Research (Dr. Andrew C. Ivy)

Provision for custodial care is only one half of the solution of the problem of chronic illness. Research in those diseases which cause chronic illness and premature aging will provide the only hope for rendering old age more efficient and for decreasing the future tax burden for the custodial care of the chronically ill. The State of Illinois should therefore establish a research institute to study how to prevent and improve the present methods of treatment of such diseases as arthritis, high blood pressure, hardening of the arteries, kidney diseases, chronic cardiorespiratory diseases, cirrhosis of the liver, and ulcerative colitis. A co-operative arrangement should be developed between the Research Institute and county homes for the chronically ill and private homes for the aged whereby the results of research could be extended to these homes. A suitable institute would provide beds for 200 patients, outpatient service for 15,000 patients a year, and suitable facilities for research.

Medical Supervision and Care in Institutions for the Chronically Ill (Committee of the Illinois State Medical Society)

Chronic care institutions other than the chronic disease hospital (which should be as well equipped and staffed as the general hospital) may be defined as those which provide custodial or nursing domiciliary care in homelike surroundings. They include nursing homes (both

public and private), private homes for the aged with infirmary sections, and voluntary institutions for the chronically ill. In order that the patients in institutions of this type may have the full benefit of modern medical science and receive the nursing care best suited to their needs, medical supervision must be provided by qualified physicians. *Minimum* requirements for a medical care program in such an institution are as follows:

1. According to the size, program, and location of the institution, medical direction may be provided by one or more of the following: (a) A full or part-time medical director; (b) an organized medical staff; (c) a medical committee representing the local medical society.
2. The medical director should establish and carry out general policies with regard to admission of patients, periodic re-examination of patients, medical treatment of patients, discharge of patients, record keeping, and standing orders and drugs, and the standards established should be such as will be acceptable to the American Medical Association for registration of the institution as a "related medical institution."
3. It is essential that county nursing homes operated under the provisions of the Rennick-Laughlin Bills have competent medical supervision. In most counties this could best be provided by an advisory committee representing the county medical society. The Oak Forest Infirmary in Cook County (not yet operating under the Rennick-Laughlin Bills) is not comparable with institutions in other counties because of its size. Oak Forest offers unlimited opportunity for development into an actual chronic disease hospital. The Board of Cook County Commissioners should take necessary action to meet the requirements of the American Medical Association so that this institution may affiliate with the Class A medical schools and thereby become able to offer suitable care and treatment to its patients.
4. There is cause for particular concern with medical care in nursing homes operated for profit. Unless the proprietor retains a physician (done far too seldom) there is no responsibility for medical supervision nor is there an administrative board to safeguard the patient from possible exploitation or neglect. This should be remedied by particular attention under the licensure program of the State Department of Public Health.
5. In planning the construction of new institutions for the chronically ill, every possible effort should be made to provide for the closest possible affiliation with a well-staffed and equipped hospital. Wherever possible, there should be a joint medical director or an interlocking medical staff. Where possible, provision should be made for

screening patients for research study. The proposal for a State Research Institute is endorsed in principle and if established, plans should be made for referral of patients from chronic care institutions and the hospitals with which they are affiliated.

As time goes on, physicians responsible for the medical direction of chronic care institutions should enrich the program beyond these *minimum* standards. For the purpose of rehabilitating the patients to the fullest possible extent there should be provided such adjuvant services as occupational therapy, recreational therapy, medical social service, and vocational rehabilitation.

Minimum Standards for the Care of the Chronically Ill
(Committee Chairmaned by Malcolm T. MacEachern, M.D.)

The trend is away from the special hospital and back to the general hospital for the chronic disease patient in need of active medical care. The patient in need of active medical care should not be relegated to a custodial home but should be placed in the general hospital and affiliation with a nursing home arranged for patients in need of nursing care only. This institution should be in close proximity to the general hospital although there are already many institutions in existence today that could meet minimum requirements by affiliation with a general hospital. County institutions should be of the nursing home type and after having met minimum requirements should be affiliated with an approved community or county hospital which would care for the chronically ill patient in need of active medical care. Two or three such nursing homes might serve and be affiliated with a centrally located hospital. Pay or part-pay patients as well as the medically indigent should be admitted to these nursing homes. A Research Institute would stimulate interest in the prevention of chronic disease and in the chronic disease patient. All voluntary and county hospitals should have the privilege of referring interesting and problem cases of chronic illness to the research center. The Committee outlined minimum standards for institutions caring for chronically ill patients (see Section VI of the Appendix).

Nursing Service for the Chronically Ill
(Committee of the Illinois State Nurses' Association)

Home nursing service is at present available from voluntary nursing agencies in only 23 communities in Illinois. There is great need for the extension of home nursing service for the acutely ill and the chronically ill patient alike. The manner of providing such extension will vary with the community and the existing services, public and private. To provide a complete nursing service, which is most satisfactory for the patient and his family, each nurse in her home visits should combine

the functions of health teaching, prevention and control of disease, and care of the sick. In rural communities all visiting nurse service, including care of the sick at home, is best administered and supported by the health department. In small cities there has been some success with a combination nursing service jointly administered and financed by public and voluntary agencies. In large cities the health department has undertaken the preventive services and the voluntary associations have done the bedside nursing. Further study should be given during the next biennium to the best manner of extending and integrating home nursing services throughout the State. Such study should embrace the proper division of responsibility between public and voluntary agency, methods of financing and administration, and other factors. The Committee recommended that a qualified graduate registered public health nurse be retained to study and report on the entire question.

Basic Considerations in the Development of Facilities and Services (The Central Service for the Chronically Ill, Chicago)

The following nine basic principles should guide the development of facilities and services for the chronically ill in any community:

1. There should be a comprehensive program of well-integrated services directed toward prevention, control, and rehabilitation as well as long-term care of patients.
2. Facilities and services in the community should provide care to patients without economic barriers.
3. Voluntary philanthropy, private initiative, and government should work together on a partnership basis in meeting the problems of chronic illness.
4. The problems of chronic illness, including long-term care of chronically ill people, are primarily medical problems.
5. All chronically ill patients, wherever they may be and in whatever stage their need for treatment may be, should have competent and continuous medical supervision and should have easy access to all of the specialized facilities and services needed in the prevention, diagnosis, and treatment of diseases of any type.
6. Institutions for the long-term care of patients should be so developed, located, and administered that they will provide opportunity and encouragement for the best possible care and rehabilitation of patients, for medical research, for research into the social and economic factors related to invalidism, and for professional education of physicians, nurses, nutritionists, social workers, and others.
7. Specialized institutions are rarely desirable though specialized units, wards or whole buildings operated as part of a general hospital or medical center may be.

8. In general, facilities for the long-term care of patients during periods when they do not require intensive treatment should be developed through a series of relatively small institutions spread throughout the community rather than in one or two large centralized units.
9. Adequate financing is the foundation on which good care for patients must rest.

X

CURRENT LEGISLATION BEARING ON THE CARE OF THE CHRONICALLY ILL

Several bills have been introduced in the current Sixty-fifth General Assembly of Illinois which will have bearing on planning for care of the chronically ill. These are summarized below.[1]

Alcoholism

Senate Bills 25 and 26 introduced January 28, 1947 by Senators Roland V. Libonati, William G. Knox, and Frank Ryan of Chicago propose to establish an Illinois State Alcoholics Hospital for the care and treatment of persons afflicted with alcoholism. The Hospital would be located in the City of Chicago on a site chosen by a Commission of three persons appointed by the Governor. Supervision, management, and control would be vested in the State Department of Public Welfare. An initial appropriation of $900,000 is proposed. The Hospital would be classified as one of the "State Charitable Institutions."

Cancer

Senate Bills 28 and 29 introduced January 28, 1947 by Senators Roland V. Libonati of Chicago, Martin B. Lohmann of Pekin, and Frank Ryan of Chicago propose to establish an Illinois State Cancer Hospital for the care and treatment of persons afflicted with cancer. The Hospital would be located on a site chosen by a Commission of three persons appointed by the Governor. Supervision, management, and control would be vested in the State Department of Public Welfare. An initial appropriation of five million dollars is proposed. The Hospital would be classified as one of the "State Charitable Institutions."

Poliomyelitis

House Bill 183 introduced on March 5, 1947 by Representatives Franklin U. Stransky of Savanna, Marvin F. Burt of Freeport, John K. Morris of Chadwick, David Hunter, Jr. of Rockford, and James M. White of Oregon would authorize county boards to levy a tax of not to exceed .075 per cent of the value of local property for the treatment and care of persons afflicted with poliomyelitis. The tax for the Polio-

[1]This summary includes only bills introduced through April 10, 1947.

myelitis Fund would be in addition to all other taxes and would not be included within any limitation of rate for general county purposes. Provision is also made whereby the voters of the county might petition the board to make such levy and to submit the proposition for vote at the next general election. If the program is adopted either by action of the county board or by vote in the general election, the county board is to appoint a board of three directors, one of whom is to be a licensed physician and all of whom are to be chosen with reference to their special fitness for such office. Overlapping terms are provided. The board of directors would have exclusive control of the expenditure of moneys in the Poliomyelitis Fund. The board would arrange for the care and treatment of afflicted persons by contract with public and private hospitals in the State. Hospitals under such contract would provide free care for the benefit of all afflicted inhabitants of the county making the contract. Provision is made for the board of directors to receive contributions or donations of money or property toward the Fund. Provision is made that all reputable physicians shall have equal privileges in treating poliomyelitis patients in any hospital with which an agreement has been reached under the Act.

Tuberculosis

Senate Bill 130 introduced March 11, 1947 by Senator Arthur J. Bidwill of River Forest proposes to establish a State Institute for Tuberculosis Research and Control to be located in the City of Chicago. The purpose of the Institute is the production, distribution, and application of methods and materials for prevention of tuberculosis and for conducting research in methods of tuberculosis control. Professional operation and all other management and control would be vested in the Board of Trustees of the University of Illinois which would exercise its authority through appointment of a board of six directors serving for overlapping terms. The board of directors is authorized to hire a managing officer and other necessary personnel. To launch the project appropriations would be made to the State Department of Public Health as follows: $25,000 for purchase of land; $400,000 for construction and equipment of a building; and $32,000 for operation and maintenance.

House Bill 280 introduced on March 12, 1947 by Representatives Homer B. Harris of Lincoln, John W. Lewis of Marshall, and Homer Caton of Stanford, proposes to establish a series of state tuberculosis sanatoriums for the free care and treatment of residents of the State suffering from tuberculosis. The locations would be selected by the State Department of Public Health in which would be vested responsibility for management and control. Provision is made for inpatient and

outpatient care and for admission of suspected tuberculosis patients for diagnostic purposes. Counties, municipalities or districts which have established facilities for the tuberculous under other Acts would reimburse the State for the per diem costs of patients admitted from their communities. If the patient is a resident of a governmental unit which has not provided facilities for the tuberculous, the county board would be required to reimburse the State for per diem costs. No patient would be admitted to a State Sanatorium without prior approval of the governmental unit responsible for paying for his care and treatment.

Mental Illness

Senate Bills 116 and 117 introduced March 4, 1947 by Senator William J. Connors of Chicago provide that 25 per cent of all moneys received from the Retailers' Occupation Tax shall be paid into a Welfare Institution Fund. Such a fund would be added to the "special funds in the State Treasury" as set out in the Act in relation to State Finance and the stipulation made that this fund shall be used exclusively for the maintenance and operation of the several state hospitals for the mentally ill.

Medically Indigent

House Bill 420 introduced on April 9, 1947 by Representatives Bernice T. Van der Vries of Winnetka and Vernon W. Reich of Forest Park, would make the General Relief authorities in the City of Chicago and the Incorporated Town of Cicero responsible for meeting medical, nursing, and burial expenses of the medically indigent, that is, persons "not coming within the definition of a pauper." Under the present law responsibility for the medically indigent residing in these two communities rests with the County of Cook whereas responsibility in the other communities of Cook County and elsewhere in the State rests with the General Relief authority. House Bill 420 would also repeal the charge-back provisions for care given medically indigent persons who have residence in some unit other than the unit giving care.

County Homes

See page 33 for a statement concerning amendments to the County Home Act as provided in the Proposed Public Assistance Code of Illinois (Senate Bill 205, House Bill 328).

Illinois Children's Hospital-School

Senate Bill 139 introduced March 11, 1947 by Senator T. Mac Downing of Macomb would appropriate $400,000 to the State Department of Finance to acquire the building now occupied by the Illinois Children's Hospital-School. The state is now renting this building.

Licensing and Regulation of Hospitals

Two series of Bills have been introduced proposing the licensing

and regulation of public and private hospitals and sanatoriums, maternity hospitals, lying-in homes, rest homes, nursing homes, boarding homes, and other institutions and places providing hospitalization or care for persons requiring care, treatment or nursing by reason of illness, injury, physical or mental infirmity or other disability. House Bills 13 and 14 were introduced on January 8, 1947 by Representative Edward A. Welters of Chicago. House Bills 281, 282, 283, and 284 were introduced on March 12, 1947 by Representatives Homer B. Harris of Lincoln, John W. Lewis of Marshall, and Homer Caton of Stanford.

House Bills 281, 282, 283, and 284 are endorsed by the State Department of Public Health as fulfilling the requirements necessary to qualify Illinois for federal grants-in-aid under Public Law 725. (See page 34.)

Expansion of Public and Nonprofit Hospital Facilities

House Bill 315 introduced on March 18, 1947 by Representatives Homer B. Harris of Lincoln, Calistus A. Bruer of Pontiac, J. Ward Smith of Ottawa, and John E. Miller of Tamms, proposes to give authority to the State Department of Public Health to prescribe minimum standards and such other regulations as may be required to qualify hospital construction projects for state and federal grants-in-aid. The Bill proposes to appropriate to the Department of Public Health $5,580,000 for the purpose of making grants-in-aid for the construction of public and nonprofit hospitals as provided in the State plan.

Hospital Authorities

House Bill 329 (introduced on April 2, 1947 by Representatives John W. Lewis of Marshall, M. E. Lollar of Tuscola, and G. O. Frazier of Marshall) and Senate Bill 221 (introduced on April 3, 1947 by Senators Robert W. Lyons of Oakland, Everett R. Peters of St. Joseph, and R. G. Crisenberry of Murphysboro) would authorize the establishment of a Hospital Authority in any contiguous territory of the State having a population of not less than 5,000. On petition of 500 or more electors, the county judge would be required to order a referendum on the proposition to organize a Hospital Authority. If the proposition is approved, the Authority so established is to be governed by a board of commissioners to be appointed in the manner set out in the Act. The Hospital Authority would be empowered to establish and maintain a public hospital and public hospital facilities and to construct, develop, expand, extend, and improve any such hospital or facility and to carry out all other functions related to the maintenance of the hospital. A tax not to exceed .075 per cent of the fair value of local property would be authorized for the support of such a hospital.

APPENDIX

SECTION I

PERSONS ATTENDING THE PUBLIC HEARINGS

ABERNATHY, ELIZABETH, R.N., Anna, Superintendent, Hale Willard Hospital

ALKIRE, A. D., Springfield, Relief Administrator, Capital Township, Sangamon County

ALTUS, GEORGE, Waterloo, Commissioner, Monroe County

ANDERSON, BYRON R., Belvidere, Superintendent, Boone County Department of Public Assistance

ARDNER, JOHN F., Urbana, Executive Secretary, Champaign County Council of Social Agencies

ARNOLD, IRENE, Benton, Case Work Supervisor, Franklin County Department of Public Assistance

AUGUSTA, SISTER M., Belvidere, St. Joseph's Hospital

BAKER, CHARLES W., Davis Junction, State Senator, 10th District

BARNEY, RUTH, Marion, Case Work Supervisor, Williamson County Department of Public Assistance

BECK, F. E., Harvard, Chairman, McHenry County Board of Supervisors

BERRY, MRS. JAMES, Rockford, League of Women Voters

BIERMAN, PEARL, Chicago, Medical Assistance Consultant, Illinois Public Aid Commission.

BLOOM, C. H., Rockford, Mayor of Rockford

BREHM, L. P., Nashville, Superintendent, Washington County Department of Public Assistance

BRADFORD, ISABELLA, Springfield, Executive Secretary, American Red Cross

BRENNAN, EDMUND J., Chicago, Representing Cook County Board of Commissioners

BROWN, CHARLES F., Rockford, Chairman, Winnebago County Infantile Paralysis Foundation

BROWN, GEORGE W., Rockford, Overseer of the Poor, Town of Owen, Winnebago County, and Chairman, Farm Home Committee

BRUNK, ARTHUR, Champaign, Regional Representative, State Department of Public Welfare

BRYAN, W. J., M.D., Rockford, Superintendent, Rockford Municipal Tuberculosis Sanatorium

BUCHER, C. S., M.D., Urbana, President, Champaign County Medical Society

BURTON, COY H., Danville, Superintendent, Vermilion County Department of Public Assistance

BUTCHER, MAXINE, Murphysboro, Jackson County Representative, Illinois Public Aid Commission

CAMPBELL, CHARLES, Danville, Assistant Supervisor, Town of Danville, Vermilion County

CASSIN, THE VERY REV. MSGR. WILLIAM J., Springfield, Diocesan Director of Catholic Charities

CAVAN, RUTH SHONLE, Rockford, Lecturer in Sociology, Rockford College

CHARD, EDWIN, Rochester, Overseer of the Poor, Town of Rochester, Sangamon County

CHESNUT, NELSON H., M.D., Springfield, Chairman, Sangamon County Medical Advisory Committee

CLABAUGH, CHARLES W., Champaign, State Representative, 24th District

CLINTON, E. M., Oregon, Superintendent, Ogle County Department of Public Assistance

COLWELL, C. H., Champaign, District Representative, Illinois Public Aid Commission

CONKEY, ELIZABETH, Chicago, Cook County Board of Commissioners

COWDIN, FRED P., M.D., Springfield, Sangamon County Medical Advisory Committee

CRANSTON, CRYSTAL, Kewanee, District Representative, Illinois Public Aid Commission

CRISENBERRY, R. G., Murphysboro, State Senator, 44th District

CUNNINGHAM, WILLIAM H., M.D., Rockford, Winnebago County Medical Advisory Committee

DEMETRIA, SISTER M., Belvidere, Accountant, St. Joseph's Hospital

DIETZ, MARGARET, Danville, St. Elizabeth's Hospital

DILLAVOU, ORA D., Urbana, State Representative, 24th District

DIVER, EVELYN L., Woodstock, Acting Superintendent, McHenry County Department of Public Assistance

DONALDSON, MARTHA J., Waukegan, Lake County Representative, Illinois Public Aid Commission

DORN, REV. J., Urbana, Champaign County Ministerial Association

DOWNING, MARGARET S., Macomb, Housewife

DRAPER, LESTER R., Pawnee, Overseer of the Poor, Town of Pawnee, Sangamon Co.

DRISCOLL, REV. THOMAS P., Carbondale, Representative of Belleville Diocese

DYE, ROY, Christopher, Overseer of the Poor, Town of Christopher, Franklin County

EASTON, BYRON, Rockford, Overseer of the Poor, Town of Harlem, Winnebago County

ECKHOFF, WILMA, Danville, St. Elizabeth's Hospital

EDWARDS, W. O., Danville, State Representative, 22nd District

ENGLAND, R. W., Mounds, Chairman, Pulaski County Board of Commissioners

ENGLISH, HARLAN A., M.D., Danville, Chairman, Vermilion County Medical Advisory Committee and District Councillor, Illinois State Medical Society

EUGENIA, MOTHER, Red Bud, Superior, St. Clement's Hospital

EVANGELINE, SISTER, Chester, Superior, St. Ann's Home

EVERSMAN, PHIL C., Cairo, Superintendent, Alexander County Department of Public Assistance

FARLEY, WILLIAM H., Harrisburg, District Representative, Illinois Public Aid Commission

FARMER, D. MILLARD, Golconda, Superintendent, Pope County Department of Public Assistance

FEDER, NAT, Rockford, Child Welfare Worker

FETZER, CHARLES E., Springfield, Auditor, Capital Township Relief Administration

FETZER, MRS. L. E., Rockford, Board of Social Service Index

FIELDS, JOHN M., Enfield, Overseer of the Poor, Town of Enfield, White County

FIELDS, W. W., Carmi, Superintendent, White County Department of Public Assistance

FOSTER, JAMES E., Chicago, Chief, Informational Service, Illinois Public Aid Commission

FRINGER, MRS. WILLIAM R., Rockford, Executive Secretary, Winnebago County Tuberculosis Association

GALVANONI, R. B., Rockford, Field Sanitarian, Rockford Health Department

GARMAN, THOMAS M., Urbana, State Representative, 24th District

GATTON, THE VERY REV. MSGR. J. L., Springfield, Dioceson Director of Hospitals, Springfield Diocese

GATTON, L. A., Pawnee, Overseer of the Poor, Town of Pawnee, Sangamon County

GIFFIN, D. LOGAN, Springfield, State Senator, 45th District

GLEASON, ALICE M., Rockford, Superintendent, Winnebago County Department of Public Assistance

GREISER, FERD, Danville, Assistant Supervisor, Town of Danville, Vermilion County

GRUBER, CARL, Danville, Case Work Supervisor, Danville Township, Vermilion County

GUNDERSON, IRENE, Rockford, Director, Visiting Nurses Association

GUNDERSON, N. O., M.D., Rockford, Rockford Commissioner of Health

HALL, THAMIE F., Anna, Superintendent, Union County Department of Public Assistance

HAMANN, C. H., M.D., Rockford, Medical Director, Elm Lawn Sanitarium

HAMILTON, ROBERT H., McLeansboro, Superintendent, Hamilton County Department of Public Assistance

HARRISON, ISABEL, Freeport, Acting Superintendent, Stephenson County Department of Public Assistance

HARTMAN, M. L., M.D., Belvidere, Chairman, Boone County Medical Advisory Committee, and President, Boone County Medical Society

HATTEN, VIRGIL, Chatham, Overseer of the Poor, Town of Chatham, Sangamon County

HAWN, A. E., Oregon, Overseer of the Poor, Town of Oregon, Ogle County

HERBOLSHEIMER, HENRIETTA, M.D., Springfield, Director, Illinois Hospital Survey, State Department of Public Health

HILLER, F. B., M.D., Pinckneyville, Superintendent, Hiller Hospital

HINCHLIFF, MRS. EDWARD C., Rockford, Member, Winnebago County Public Aid Advisory Committee and Council of Social Agencies

HINRICHSEN, ANNE, Springfield, Informational Representative, Illinois Public Aid Commission

HOAGLUND, MAX, Champaign, Superintendent, Burnham City Hospital

HOSKINSON, C. H., Rockford, Former Township Supervisor

HOWARD, LANDO, Springfield, Special Field Representative, Illinois Public Aid Commission

HUNTER, EDWARD C., Rockford, State Representative, 10th District

IVY, ANDREW C., M.D., Chicago, Vice President, University of Illinois in charge of Schools of Medicine, Dentistry, and Pharmacy

JAMES, DAVID E., M.D., Belvidere, Physician

JEREMIAH, CLIFFORD C., Chester, Superintendent, Randolph County Department of Public Assistance

JOHNSON, HENRY V., Capron, Overseer of the Poor, Town of Manchester, Boone Co.

JOHNSON, HERBERT F., Rockford, Assistant Supervisor, Town of Rockford, Winnebago County

JOHNSON, MARY-CLAIRE, Chicago, Administrative Assistant, Illinois Public Aid Commission

JONES, JOHN R., Springfield, Former Sangamon County Treasurer

JORDAN, WILLIAM, Murphysboro, Superintendent, Jackson County Department of Public Assistance

KAPP, JOHN W., Springfield, Mayor of Springfield

KELLER, NICK, Waukegan, State Representative, 8th District

KELLEY, JUANITA, R.N., Anna

KELSEY, HAROLD D., Barrington, State Representative, 8th District

KIMMEL, ROGER T., Murphysboro, Chairman, Jackson County Public Aid Advisory Committee

KINZER, ARTHUR, Urbana, Chairman, Champaign County Board of Supervisors

KLEIN, E. H., Mt. Vernon, District Representative, Illinois Public Aid Commission

KLOPFENSTEIN, FRIEDA, Springfield, Executive Secretary, Family Welfare Association

LANAN, D. J., Kingston, Chairman, De Kalb County Home Committee

LAUGHLIN, EDWARD E., Freeport, State Senator, 12th District

LIEFER, ALBERT, Red Bud, Commissioner, Randolph County

LIERE, MRS. A., Danville, Child Welfare Nurse

LINDSTROM, DR. DAVID E., Urbana, Professor of Rural Sociology, College of Agriculture, University of Illinois.

LINNE, ALBERT L., Danville, Overseer of the Poor, Town of Danville, Vermilion County

LITTLE, T. N., McLeansboro, Overseer of the Poor, Town of South Crouch, Hamilton County

LOEWENBERG, I. S., Chicago, Chairman, Council for the Aged and Chronic Sick, Jewish Charities

LOGAN, A. D., Rockford, Secretary, Civic League

LOGAN, JAMES A., Benton, Superintendent, Franklin County, Department of Public Assistance

LOOMIS, FRANK, Chicago, Executive Director, Chicago Community Trust

LOVEL, E. J., Springfield, District Representative, Illinois Public Aid Commission

LOY, HILDA, Rockford, Manager, Nursing Home

LYONS, LEO M., Chicago, Director, St. Luke's Hospital

McDONALD, W. J., Murphysboro, State Representative, 44th District

McINNES, R. J., Rockford, Winnebago County Representative, Illinois Public Aid Commission

MAASBERG, IRMA R., Rockford, Assistant District Representative, Illinois Public Aid Commission

MacEACHERN, M. T., M.D., Chicago, Director of Hospital Activities, American College of Surgeons, and President, Chicago Medical Society

MAHER, J. T., M.D., Danville, Director, Vermilion County Tuberculosis Sanatorium

MARLIN, JOHN M., Vienna, Superintendent, Johnson County Department of Public Assistance

MARSHALL, MRS. HELEN, Danville, Visitor, Vermilion County Department of Public Assistance

MARTIN, IVA A., Rockford, Manager, Martin Rest Home

MEEKER, CHARLES R., Rockford, Regional

Representative, State Department of Public Welfare

MEYER, FRED, E. St. Louis, District Representative, Illinois Public Aid Commission

MODGLIN, L. E., Ava, Overseer of the Poor, Town of Ora, Jackson County

MORRIS, JOHN K., Chadwick, State Representative, 12th District

MYERS, CHARLES W., Danville, Superintendent, Vermilion County Home

NELSON, A. R., Chicago, President, Illinois Homes for the Aged, and Superintendent, Swedish Covenant Home of Mercy

NOBLES, C. D., M.D., Anna, Superintendent, Anna State Hospital

NORMAN, L. D., Carbondale, Regional Representative, State Department of Public Welfare

O'BRIEN, JAMES, Coulterville, Commissioner, Randolph County

ORTSCHEID, DORIS M., Galena, Superintendent, Jo Daviess County Department of Public Assistance

OTTEN, HARRY, M.D., Springfield, Sangamon County Medical Advisory Committee

OWENS, J. W., Buffalo, Overseer of the Poor, Town of Buffalo, Sangamon County

OWENS, RAY, Harrisburg, Superintendent, Saline County Department of Public Assistance

OXTOBY, MRS. FRIEDA B., Rockford, Case Worker, Family Consultant Service

PALMER, D. H., Danville, Relief Administrator, Town of Georgetown, Vermilion County

PAULSON, NORMAN T., Chicago, County Home Consultant, Illinois Public Aid Commission

PFLEIDERER, E. R., Springfield, Lions Club

PIERCE, CHARLES M., Belvidere, Overseer of the Poor, Town of Belvidere, Boone County

POOLE, SUSANNAH, DuQuoin, Superintendent, Marshall Browning Hospital

RAHN, Mrs. ROSE, Springfield, Relief Office, Town of Capital, Sangamon County

RIFE, Berry V., M.D., Anna, President, Union County Medical Society

RIGGS, GORDON, Elizabethtown, Superintendent, Hardin County Department of Public Assistance

RIPPELMEYER, ARMIN, Waterloo, Superintendent, Monroe County Department of Public Assistance

ROPCHAN, A. L., Chicago, Executive Secretary, Health Division, Council of Social Agencies

ROSENBLUTH, ROBERT, Chicago, Consultant, Illinois Public Aid Commission

ROSS, PRUDENCE, Rockford, Consultant, Illinois Division of Child Welfare

RUDDICOMBE, MRS. EDITH V., Rockford, Manager, Ruddicombe Convalescent Home

SCHLUETER, C. H., Nashville, Overseer of the Poor, Town of Nashville, Washington County

SCHULTZ, OTTO R., Danville, Credit Manager, Lakeview Hospital

SERBIAN, ANDREW, Cairo, Chairman, Alexander County Board of Commissioners

SETZKORN, VERNE, Pinckneyville, Superintendent, Perry County Department of Public Assistance

SHEEHE, MRS. NORMAN L., Rockford, Assistant Supervisor, Town of Rockford, Winnebago County

SHIELDS, CLIFFORD, Danville, Chairman, Vermilion County Board

SHONTZ, VERNON L., Springfield, President, Council of Churches

SISSON, RIX A., De Kalb, Superintendent, De Kalb County Home

SPORE, RUE, Metropolis, Superintendent, Massac County Department of Public Assistance

STENERSON, O. H., Poplar Grove, Chairman, Boone County Board of Supervisors

STEVENSON, DR. MARIETTA, Urbana, Director of Graduate Curriculum in Social Welfare Administration, University of Illinois

STOCKHUS, MERYLE, Rockford, Board of Illinois Children's Convalescent Home and Cottage

SWANK, HAROLD, Chicago, County Home Consultant, Illinois Public Aid Commission

TAIT, FLORENCE, Rockford, Manager, Tait Nursing Home

TAYLOR, R. A., Carbondale, Member of Jackson County Public Aid Advisory Committee

THOMPSON, COL. E. T., M.D., Chicago, Director of Medical Care, Chicago-Cook County Health Survey

THORNTON, THOMAS J., Chester, State Representative, 44th District

TOBIN, MRS. MARGARET, Urbana, Champaign County Family Service Bureau

TRUTTER, Ann, R.N., Springfield, Director, Public Health Nursing and Tuberculosis Association of Sangamon County

VAN METER, KATHERINE, Springfield, Illinois Public Aid Commission

VEIRS, W. L., M.D., Urbana, Chairman, Champaign County Medical Advisory Committee

VENARDOS, ELIZABETH, Springfield, Assistant District Representative, Illinois Public Aid Commission

VIRTUE, MRS. BETH, Rockford, Ward nurse in charge, Winnebago County Hospital

WAKERLIN, GEORGE E., M.D., Chicago, Assistant Dean, University of Illinois Medical School

WALKER, M. R., Danville, State Representative, 22nd District

WALSH, JAMES M., Springfield, Overseer of the Poor, Town of Capital, Sangamon County

WATSON, ISABELL H., Riverton Overseer of the Poor, Town of Clear Lake, Sangamon County

WEEKS, J. M., Rochelle, Overseer of the Poor, Town of Flagg, Ogle County

WESTFALL, HOWARD F., Mounds, Superintendent, Pulaski County Department of Public Assistance

WESTON, MAX A., Rockford, States Attorney, Winnebago County

WHEATLEY, M. J., Sparta, Relief Administrator, Randolph County

WHITE, JAMES M., Orègon, State Representative, 10th District

WHITE, LEON H., Springfield, Superintendent, Catholic Charities

WINSTON, G. B., Springfield, Urban League Executive

WISE, LEONA B., Harvard, Relief Officer, Town of Durham, McHenry County

WITTE, THE VERY REV. MSGR. F., Ruma, General Manager of Hospitals for Sisters Adorers of the Most Precious Blood

WOOD, HARLINGTON, Springfield, Sangamon County Judge

WOOD, PEGGY, Carbondale, Child Welfare Regional Supervisor, State Department of Public Welfare

YATES, KATHERINE, Metropolis, Relief Administrator, Massac County

YOUNGBERG, JAMES A., Springfield, Assistant Secretary, Springfield Council of Social Agencies

ZAUN, DONALD R., St. Charles, Juvenile Parole Officer, State Department of Public Welfare

ZOLD, A. E., Illiopolis, Overseer of the Poor, Town of Illiopolis, Sangamon County

ZUROWESTE, THE RT. REV. MSGR. ALBERT R., E. St. Louis, Diocesan Director of Charities, Belleville Diocese

SECTION II

EXCERPTS FROM TESTIMONY AT CONSULTANTS' MEETING AND PUBLIC HEARINGS

Need for Research

Malcolm T. MacEachern, M.D., Chicago
Director of Hospital Activities,
American College of Surgeons, and
President, Chicago Medical Society
Public Hearing, Chicago, July 11, 1946

"For many years I have felt that the chronically ill person has been forgotten. He has been left in his physical condition without much consideration. Nor has adequate effort been made to cure it, or at any rate to rehabilitate him into a productive and happy life. We also can do that.

"I believe that the medical profession has not done as much as it should for retarding old age diseases in the long-term patient which we call 'chronic' or 'incurable'. We don't like these words in our medical language. They are discouraging. We like the designation 'long-term illness' better.

"I have always favored special consideration in connection with treating patients with long-term illnesses, that is, providing some of the pleasantries of life to make them happy—give them work if they can do it—and open to them an enjoyable existence. They can never be brought to a fully rehabilitated state but medicine has had good results in the use of occupational therapy, recreational therapy, hydrotherapy, electrotherapy, and other forms of physical therapy. Since the war large sums of money have been given for the advancement of this work and has made it possible to develop departments of physical medicine and research in old age diseases.

"We must not forget research in this connection because I feel there is a great deal we should know and a great deal we should do that will help materially in the proper care of long-term illnesses and the diseases of old age. I believe that there is much thought which should be given to these subjects; we must find out why diseases become chronic or long-term; why did they become that way; what can be

done to counteract such conditions and avoid reaching this state. Here is a wonderful field for research. The University of Illinois College of Medicine has developed a fine program of research. This institution is most fortunate in having Doctor Ivy with them now—his work in research is known the world over. Under his inspiring enthusiasm and leadership much will be accomplished. The Government of the United States has recognized his work in the war. The State is very fortunate to have such a man. This State institution, the Illinois University College of Medicine, is attracting to its staff the best men in the country to be a part of the great medical center.

"There are two things we can do in this field, and I have very definite ideas on this: first, we can relieve these patients, rehabilitate them; secondly, there is research. Therefore, we have before us a great challenge which is not to be set aside. We need money to do it. In the end we would be contributing toward making people self-sustaining, and this would be better than having them become charges on the State or the county . . . ."

George E. Wakerlin, M.D., Chicago
Assistant Dean,
University of Illinois Medical School
Public Hearing, Chicago, July 11, 1946

"I don't think there is any question of the need for hospital space for care of the chronically ill of Illinois. Since we must make a beginning, I think a State research facility for chronic illness should be located in the new West Side Medical Center where it will be in close association with other medical institutions and medical schools, including the University of Illinois. Such a research hospital would be the nucleus of the several hospitals for the care of the chronically ill which I hope the Legislature will establish throughout the State.

"Here in Chicago, I think, the proposed hospital for the chronically ill should be in a teaching center where students from the various medical schools will obtain valuable experience for subsequent medical practice. This should apply to the students of all medical schools, not only the University of Illinois.

"Research in the fields of the aging processes and the diseases of older years is in its beginning. There is a great deal to be learned especially from the standpoint of preventing the aging processes from setting in prematurely and from the standpoint of preventing, delaying, and treating such diseases as hardening of the arteries, high blood pressure, arthritis, and cancer.

"I think that one chronic hospital in the West Side Medical Cen-

ter in Chicago is the first and most important need. Later on it might be desirable to have more distributed throughout the State.

"I would like to emphasize again that I am here merely as a private citizen and as such I am of the opinion that the research hospital for the chronically ill to be located in the West Side Medical Center should be under the jurisdiction of the University of Illinois College of Medicine. I feel also that the other medical schools in the Chicago area should participate in the medical teaching and research that would be afforded by such a hospital. It would be unfair not to give the other schools this opportunity.

"It is my opinion that the patient should always be informed of any contemplated experimental procedure and his consent obtained. Most patients are very glad to cooperate. Furthermore, I believe all doctors in conducting medical research on human subjects are governed by the Golden Rule—they won't do anything that they wouldn't want done to themselves."

Andrew C. Ivy, M.D., Chicago
Vice President, University of Illinois
In charge of Schools of Medicine, Dentistry and Pharmacy
Public Hearing, Chicago, July 11, 1946

"Some of you may know that in the last century of our existence the span of life has increased from 30 to 65 years. That has been due chiefly to reducing infant mortality in maternal cases and improved means of preventing and curing acute diseases: for example, the prevention of deaths from diphtheria, pneumonia, typhoid, and more recently the use of the sulfa drug and penicillin in penumonia and other types of acute infections.

"Several years ago I analyzed this increase in life expectancy and I concluded that only about five years of this increase could be credited toward an increase in the years of active life in the older age groups.

"We are now confronted with a marked increase in the number of people above the age of 30 in our population, and the range of clinical investigation in the field of medicine must be directed toward the older age groups in making the life of older people more comfortable and more efficient. Obviously, if we are going to extend life spans up to the possible extent of 75-80 years, we will not be serving our people properly unless at the same time we direct our attention to making the added years more comfortable and more efficient. That is why throughout the country at the present time persons interested in the field of public health are giving attention to chronic illnesses, their prevention

and alleviation, in what is called the science of geriatrics. Geriatrics is just the opposite of pediatrics.

"In this field of chronic diseases, I have in mind cancer, heart disease, hardening of the arteries, nephritis, rheumatism, and peptic ulcers—the diseases which kill so many people too early and which make life less efficient and comfortable for a great number of people.

"Before we can expect to prevent, alleviate, or delay the onset of these diseases, we must direct our research efforts toward them. That is going to require patients for clinical study, scientists, and facilities. In regard to the location of a research hospital, I should like to direct attention to the policy adopted by the Veterans' Administration in locating hospitals for veterans near an existing institution for medical research and education. That question has been up in Washington before the National Research Council, of which I am a member and the question has also been before Surgeon General Parran of the United States Public Health Service in relation to the national cancer programs. It has seemed to be most advisable to start this plan for research in relation to medical institutions. In these institutions we have the advantage of men trained in the field of research and at the same time we have the doctors of the future so that we can impress upon them the importance of this field of research and the prevention of chronic diseases, which in the past was not considered very important. As it was pointed out by a previous speaker, we will make our young doctors alert regarding chronic disease only when we are doing research on those diseases in our medical schools. The medical schools which produce the most alert physicians are those schools where every teacher is doing research and has the facilities for doing research. By locating this first research institution, your major institution, in association with a medical center, you will be not only taking advantage of the research facilities but at the same time you will be stimulating the doctors of the future to become more interested in those illnesses.

"I should like to say, in connection with the point raised by Dr. Wakerlin about research being done on patients and their reactions, that I have done clinical investigations on our veterans in the veterans' hospitals and we tell them just exactly what we are after and we haven't had a veteran turn us down yet. In fact, they deeply appreciate the extra attention and without exception are anxious to help increase knowledge which would help themselves and others."

Everett P. Coleman, M.D., Canton
Chairman, Fulton County Medical Advisory Committee
Chairman, Illinois State Medical Advisory Committee
to Illinois Public Aid Commission
Consultants' Meeting, Chicago, September 7, 1946

"I am interested in the research angle of chronic illness because I believe we should work toward keeping people from developing these illnesses. If something can be done to keep them from these illnesses for even 15 or 20 years more, I am all for it. But it is one of those things where I think we have to be a little bit skeptical. There are a number of things that one can prevent but the difficulty is that we get them too late. Many of these people are victims of high blood pressure or hardening of the arteries and are no longer able to work. Yet, if they are hospitalized for a period of two, three, or four months, many of them can go back and get on the job again. You know that keeping a person hospitalized or not working for too great a period of time never has done any good. Reasonable periods of hospitalization are better. Many heart cases have gone back to work and have continued to work for a long period of time.

"In our own county of Fulton in our 151-bed hospital, I don't know the percentage of chronically ill persons, but we have quite a few. There are a great many cases of fractured hips among old people and it used to be that there was nothing that could be done for them. Now, we have partly solved that problem by a routine of treatment that gets them up and reduces the time of inactivity. They are able to be up and about and some go home in a short time. It used to be that we had to use the rollers and weights and keep the patient in traction for a long time. Now, they don't all get along that well; nevertheless, a decidedly greater number can take care of themselves.

"The same is true in the cases of some old men who are often afflicted with prostatic trouble rendering them incapacitated. Now, with the proper treatment we are restoring them to usefulness and many of them are going back to work. Many of these old men take care of farms.

"There are some cases not so fortunate. In cases of arthritis they are not able to get around and do anything for themselves. Some of these people can't get any help from the children who have grown up and moved away from the home and they are a rather pitiable group to watch. Something should be done so that the children realize their responsibility to their parents. They should be made to assist these old folks. This condition is getting to be the greatest disgrace to the human

race in this section of the country and in the entire Mississippi Valley region."

The Chronically Ill Problem as Seen by Physicians

Everett P. Coleman, M.D., Canton
(See previous testimony for complete identification)
Consultants' Meeting, Chicago, September 7, 1946

"Frequently you hear of cases where families are looking for a place for some member of the family who is unable to properly care for himself while they go away for a while—ones who are apt to set the house on fire or fall down stairs and break a leg. After a while they discover it is nice to be without that person and they leave him in a nursing home. It is seemingly heartless, but there is the viewpoint that he may live another ten years and disrupt the entire family and they feel they have certain rights themselves and that the 'nursing home' is the answer.

"I might mention the question of nursing home care as we have seen it. That varies from very good to very bad. In my community there is a very old building which could be a regular fire trap. I will say, however, that the patients there do receive the best of food and care. This place is being closed now because of the death of one of the operators. It is being succeeded by two or three smaller homes which I fear are ill-equipped and not properly supervised. In the case of a nursing home it is so important that it be properly managed and regularly inspected. It is also important that proper facilities are available and that a certain amount of privacy is given to the patients. It is all right to have wards but they shouldn't all be in wards.

"There are two or three factors a number of us have thought of in my community. First of all, we have thought that we might build a wing to the hospital, and then we could use the surplus in beds to care for the old people or the chronically ill where they could have the facilities of the hospital available for their use when they needed them. We have thought, too, that from time to time they vary in numbers because of the high death rate among the aged, and if necessary we would use part of that wing for general hospital cases. In that way, it would not be a one-sided affair. It would help both the general hospital and the chronically ill patients."

Harlan A. English, M.D., Danville
Chairman, Vermilion County Medical Advisory Committee
District Councillor, Illinois State Medical Society
Public Hearing, Danville, May 9, 1946

"In view of the fact that county homes are supported largely by

taxes, we feel that whatever taxes are levied for that purpose in Vermilion County should be spent here. In times past, the people of the county had considered the county home as a place called the 'Poor Farm.' This county home has gradually been converted into a convalescent type of home.

"As a medical society, we have been most interested in seeing that the quality of care is of the very best for the type of case present in the building. During the war we will admit we were not as exacting as we would like to have been, but many things have been done that will be changed along in November (1946) when we get a more complete staff back from service and can run a rotating physician service out at the county infirmary. We are one group which is certainly trying to make Illinois one of the few states where recipients of public assistance can be taken care of properly and not in some flop house where there is very little food of poor quality . . . About November we hope to have four men working on medicine, surgery, orthopedics, and geriatrics.

"The staffs of the hospitals have warned the hospitals that they had better be very careful in the chronically ill care business for the reason that our population is getting older all the time. If they start making that a big item now, they are going to end up in 1957 needing another infirm section in the general hospitals. General hospitals aren't particularly interested in this type of work.

"It is my opinion that those people who are in the home on a pension and for just custodial care should not pay as much as those who are there for bed care and nursing attention. I would decide between bed care and custodial care and stop right there.

"You are not going to find the physician trained in diseases of the aged—easily. You will find it very difficult to pick a man whose practice consists of older aged groups to serve in a consultant capacity. We have about four or five who grew up with these people and are accustomed to treating their diseases. We will use their knowledge and background in Vermilion County."

F. B. Hiller, M.D., Pinckneyville
Superintendent
Hiller Hospital
Public Hearing, Carbondale, August 7, 1946

"I believe it is quite possible that patients are having difficulty with doctors because doctors now are like the hospitals. They would rather not take care of patients who are chronically ill and very little can be done.

"There are a number of chronic disease patients in the hospitals,

I will admit, that are hard to care for. Nurses can tell you that and they don't like to take care of them. In one hospital in Perry County the nurses went on strike. They won't take care of old people because they take too much care. Now, I find that in these hospitals are chronically ill who have no control of their bodies. Some grow better—but, say a paralyzed person is a patient from now on, where are you going to put him? The people in his home are not able to care for him. That kind of a person has got to be in a hospital, just as much as a surgical case, and he requires more care . . .

"Now, another thing, the State sends out literature on the care of the child. We have been giving this literature to mothers in our hospitals. I believe the State should furnish similar literature on the care of old people and distribute it to the homes. I think part of the trouble is that there is no educational information on the care of old people. . ."

C. S. Bucher, M.D., Champaign
President
Champaign County Medical Society
Public Hearing, Urbana, May 8, 1946

"There was a point made that so many of our mental patients are mentally ill first and then physically ill. Generally it is just the opposite. The mental condition follows the physical condition.

"I know it has been the intention of hospitals and doctors, as soon as possible, to increase the size of hospitals in order to have a place for convalescents and chronically ill. That will give laboratory and X-ray facilities and anything else they may need. Laboratory and X-ray equipment add quite an overhead. It is more economical to have one good laboratory and X-ray department manned with well-trained technicians than several small units.

"In the aged, keeping them occupied is a most important thing."

C. H. Hamann, M.D., Rockford
Medical Director
Elm Lawn Sanitarium
Public Hearing, Rockford, February 14, 1947

"I am the director of a privately owned sanatorium and have been in the field of psychiatry for a number of years. I think that all chronically ill are potentially mentally ill. It is necessary that they have good psychiatric help. Unfortunately, we have only too few well-trained phychiatrists. There are too few psychiatrists trained in the field of good mental hygiene for these people.

"I certainly agree that the private selection of a physician most desirable for the maximum benefit to every patient (young or elderly)

and the preservation of this responsibility should be shared by the family of the afflicted as well as by directors of all public institutions.

"It is necessary that the local community feels an obligation toward the care of these people. They need the aid of larger groups, of state and national resources, to aid them in discharging their responsibility. . . We have to have further widespread education in the schools, in the Legislature, and in the law, if we are going to attack the problem. That also applies to the mental health problem of any person who is ill and particularly those who are chronically ill."

W. J. Bryan, M.D., Rockford
Superintendent
Rockford Municipal Tuberculosis Sanatorium
Public Hearing, Rockford, February 14, 1947

"We are finding that tuberculosis is not so much a disease of infancy as of adulthood. Fewer cases are being found among the very young. The greater percentages of tuberculosis entering our sanatoria today are among the older age group, ranging from 45 to 60; even patients between 70 and 80 are being admitted.

"The problem of disease among older people is a big one and one which requires much thought. In the next few years, I believe we will find more and more physicians specializing in chronic diseases of older people. It is my opinion that in the not too distant future the chronically ill (exclusive of tuberculosis) will be a bigger problem than that of tuberculosis.

"Most of these people will need hospital care for at least a short period of time. Then, when they are able, they may be moved into nursing homes. I believe there are none of you who would not be disappointed if you were assigned to some doctor you did not know, want, or trust. I think we all want to have our own selection of doctors in any plan.

"In our sanatorium, practical nurses handle only daily routine care of the patients. The registered nurses direct the work of the practical nurses and are the only nurses permitted to give medication. I would be in favor of establishing training courses for nurses in the care of chronically ill patients; similar courses might also be given for practical nurses."

J. T. Maher, M.D., Danville
Director
Vermilion County Tuberculosis Sanatorium
Public Hearing, Danville, May 9, 1946

"All of our people at the Tuberculosis Sanatorium are, of course,

chronically ill. We have a capacity of 60 beds at the present. We average 44 patients in the hospital and at present some 13 are from counties other than Vermilion and are paid for by their home counties. As long as I have been here, we have had no problem in admitting any patient who needed care.

"The patient does not receive as much occupational therapy treatment as you would find in orthopedic cases because very few of the tuberculosis patients are able to get up and about and most of them just want to read or listen to the radio. If they were up and around it would be advantageous to have some occupational therapy. At the present time we have five cases which could stand occupational therapy so far as returning them to normal living. We have to wait for the Illinois Tuberculosis Association and the doctors to develop something like that. There are some cases that could stand more than reading and writing and radio listening."

(On May 7, 1947 Dr. Maher reported that beginning October 1, 1947 the sanatorium will have the services of an occupational therapist who will also provide vocational counseling.)

Planning by Voluntary Institutions for the Aged

Mr. Frank D. Loomis, Chicago
Executive Director
Chicago Community Trust
Public Hearing, Chicago, July 11, 1946

"I shall not attempt to present statistics or proofs as to how serious and acute is the need for planning for the chronically ill. You doubtless have in your possession already or easily available to you reports and estimates of the Illinois Public Aid Commission as to the needs of patients in their care, particularly those of the old age group now dependent on Old Age Assistance. For several years it has been my privilege to serve as a member of the Cook County Bureau of Public Welfare Advisory Committee and its subcommittee on Care of the Aged where we have discussed this problem again and again at numerous meetings and we know how difficult and often impossible it is to find safe and wholesome homes where homeless chronics can live at a cost which they can pay even after liberal public monthly allowance.

"The Central Service for the Chronically Ill, a private agency operating under The Institute of Medicine and affiliated with the Council of Social Agencies of Chicago, has prepared estimates and other data on the general needs in this field. Doubtless you have their reports. I would only add that the need is great not only among the very poor or the general population made up mostly of middle-class people of

limited means, but is acute among the well-to-do and even the rich who have ample funds to pay for adequate service were it available. It is often not available even in institutions operating on a de luxe scale at exorbitant and unreasonable costs.

"The Illinois Public Aid Commission, acting under authority of the Legislature, is to be heartily commended for the steps it is taking to meet such needs. The plan to make over or convert the ancient county poor infirmaries into modern homes for the care of chronics is one of the most constructive steps which has been taken for the care of the infirm in many generations. These institutions are maintained, of course, by taxation. Efforts of the Illinois Public Aid Commission to encourage extension and improvement of facilities in institutions privately operated as voluntary tax exempt charities, are likewise to be commended. I wish to speak briefly concerning possible improvements in these institutions.

"We have in the State a large number of old people's homes and some sanitariums, hospitals or agencies with boarding-home services for the chronically ill, operated by charitable corporations.

"In Chicago and near vicinity alone we have 44 institutions operating under the general title of Homes for the Aged. They are reported to have 4,021 beds. Twenty-eight of these homes are endorsed by the Subscriptions Investigating Committee of the Chicago Association of Commerce—27 under this classification. (Chicago Home for Incurables is classified as a hospital. Sanatoriums for tubercular patients are not included in the list.) Concerning the 27 Homes for the Aged, published reports of the Association of Commerce show that they had for the last fiscal year total current income of $1,617,000 and current expenses of $1,395,000, or excess income for the year of $222,000. In addition to this excess current income of $222,000, they received within the year capital gifts and bequests of $796,000, or total increased assets of $1,118,000.

"Examination of reports running back for ten years and more show that this is not an unusual situation. The reports show substantial gains each year, both in current and in capital income. The combined balance sheet for the 27 institutions at the end of the last fiscal year (up to March 31, 1945) showed total institutional property of $6,145,000, and invested capital (i.e. invested for profit) of $13,392,000. Invested capital or endowment equal to plant investment is for institutions of this kind generally regarded as quite adequate. Some have less. Some have a good deal more.

"How do these institutions get that way?

"The general pattern under which these homes are established

and operated calls for an admission fee or permanent contract by which desirable inmates may gain admission. The usual minimum admission fee is $1,000. But there is the further requirement in the policies of most of these homes that the incoming resident turn over to the home any other property he may possess. This is turned over by gift or bequest which is labeled as voluntary. In many cases these gifts or bequests are quite substantial.

"Operations under this policy have proven quite profitable. Once the home is paid for, the well-managed institution makes money. The well-situated home, restricted in its service to socially privileged and ordinarily well-to-do people may make a great deal of money. One could commend such good management and rejoice in such accumulation of wealth if it resulted in increased service even to the well-to-do. But regrettably it usually does not. Whether the home has property of half a million or has risen to five or ten millions it still continues to care for its selected family of a hundred old people. Perhaps one of the elements of attractiveness in such charitable institutions is their exclusiveness.

"Or one could recognize the desirability of and rejoice in a service available to old people which enables them to spend their declining years with people congenial to them, people of the same basic culture, whatever it is, racial, religious, nationalistic, intellectual, economic, artistic; but when there are people of that same culture who have fallen into real misfortune, or perhaps never rose above it, or when even there are people of a different culture lying sore and afflicted at the gate, and the charitable institution has ample money to help them, certainly it ought to find some way to make its charity effective.

"The case is even worse with the highly endowed memorial charity. Established as a monumental institution, with large or excessive endowment even before it is built, to be operated on a highly restrictive basis for the benefit of a limited few, such charities may rise to great wealth while they render service of little special value. We have two or three charitable homes in this country (they are east of here) which began at a modest level many years ago but now are reported to be worth in the neighborhod of a hundred million or more each, while they still continue to care for only a few individuals. There are others whose endowments are probably half that much. We have no institutions of any such wealth in Chicago. We are young. We do have some homes which are moving in that direction, and more are projected in bequests not yet operating.

"I do not mean to criticize any institution or the managers of any institution personally. Many of them would like to do differently but

they are tied by customs and often by the explicit letter of some will which the courts insist on interpreting according to the explicit letter. I believe we will eventually come to the opinion, just as they did in England a hundred years ago, that the public welfare and the usefulness of charitable wealth in our capitalistic system are more important than the letter of ancient wills. In England, long burdened by the accumulation of useless charities, wills today are being broadly interpreted in the light of present-day needs.

"So the rule recently adopted by the Illinois Public Aid Commission that the current income of old people's homes shall be currently used as a condition precedent to any contract with the Illinois Public Aid Commission for compensation for the care of the wards of the State is a sound and wholesome rule. It will help these institutions to modernize their methods and increase their usefulness. Many of the homes are trying to do just that. There is a tendency to abolish the contract rule for admissions, to base charges on what the patient can afford to pay, to accept also at cost wards from the State to the limits of their capacity, and to use capital resources to increase their capacity whenever possible in order that the chronically ill of the State may be cared for . . ."

Mr. A. R. Nelson, Chicago
President, Homes for the Aged, and
Superintendent, Swedish Covenant Home of Mercy
Public Hearing, Chicago, July 11, 1946

"As you know, I am President of the Illinois Homes for the Aged, which is an organization covering the recognized homes in Cook County and neighboring counties.

"There are some remarks which Mr. Loomis made on which I should like to comment. I don't have the figures with me in the matter of home income but I assume those he gave are correct. In many homes a larger part of the income is from contributions from public or private organizations. I know that is true of many homes. It is true of my own, the Swedish Covenant Home of Mercy. Our normal income is around $40,000, but of that about half, $20,000, is in the form of donations from our churches, tag days, and benefits run for the maintenance of the home. In other words, what we receive from each individual is not sufficient to meet the needs of that individual and we must maintain an active campaign through the years in our churches so that at the end we can come out in the black. Many homes are supported by churches and lodges in that manner.

"It is true that most homes require a set fee for admission of $500

or $1,000, or some such sum. But let us consider how many patients there are who are in the home for a considerable length of time. A recent study disclosed that the average length of residence is 7.9 years —approximately 8 years. If you will figure that the cost of keep is $45.00 a month, it would amount to $540 a year for the care of one patient, and you will see that the $500 paid on admission will not nearly cover the cost of his care. Take for instance a case I had of a woman who had been a resident of the home for 28 years and paid $800 when she came. It takes a lot of contributions to care for such a person. . .

"Length of life is increasing and the number of persons 65 years of age or older is much greater now than it was ten years ago, to say nothing of 20 or 30 years ago. The results of a recent survey which have been released indicate that by 1980, which isn't too far away, one out of every six people will be over 65 years of age. So, you see, it is very much a problem for the future and not only the present. This problem of caring for the chronically ill is perhaps the most important that we have facing us, not only in this State but throughout the entire country.

"Mr. Loomis stated that there are 50,000, which figure I presume to be correct, people who are in need of care as chronically ill. I wonder if everybody appreciates this particular situation. Can I give a personal experience just to illustrate this point.

"Just today I received from the Civilian Production Administration a denial to build a building on my premises which would provide for from 50 to 60 chronically ill persons. We have the Swedish Covenant Hospital there with a capacity of 200 beds and the Swedish Covenant Home of Mercy, or old people's home, with a capacity of 100. Then in an old hospital building we have a nurses' home. It was our plan that when we could secure authority to build our new nurses' dormitory we would convert the present dormitory into a home for chronically ill which would relieve the strain on the hospital and the old people's home. This new building would cost us about three or four hundred thousand dollars, but the government will not permit it. We can't get authority to go ahead. This new building would do two things: It would provide a space for the care of persons who are not now in any institution, and it will also relieve the hospital of perhaps 20 or 25 chronically ill who are taking bed space that should be used for those acutely ill. This building would have facilities for that particular kind of care.

"From the hospital standpoint, the hospitals are not in a position to take care of chronics—there are too many who are acutely ill—too many emergency cases have to wait because the beds are tied up with

chronics and convalescents. These beds should be released for those who need them. How we are going to do it, I don't know.

"So far as the home is concerned, those admitted must be in fairly good health, but they don't stay that way. They become chronics and we have to take care of that kind of patient.

"Now then, we have a lot of folks not in either hospitals or homes that require care, and those are the ones we are concerned with. It seems to me that in public institutions we should provide for that particular situation. From what I have heard discussed here, I can't help but feel that in a city like Chicago we should provide facilities for caring for chronic illness and research into the causes of these ailments, especially in the field of geriatrics which today is in its infancy. Thirty or forty years ago the field of pediatrics was in its infancy but today is a well-established field. We have to give lots of study to geriatrics and the best place would be around a medical center. I feel that this should be near the County Hospital or the Illinois Research Hospital so that some real work could be done on it and at the same time provide for a great many who need care.

"There are many, many institutions taking over care of chronics by installing infirmaries. For instance, the Baptist Home in Maywood and the Swedish Baptist Home out in Morgan Park, and some others. Many of them are giving this care through agencies, plus trying to give them something to do to keep them mentally active.

"It would be a tremendous help to have a building program. This problem has been neglected because of the fact that we have not seen very much of it, but it is the future that we have to look out for."

Sister Evangeline, Chester
Superior
St. Ann's Home
Public Hearing, Carbondale, August 7, 1946

"We have a 34-bed institution at St. Ann's Home in Chester. We accept only such persons who are up and about at the time they enter our Home. However, it is my opinion that nearly all aged persons require at least some nursing care, even if they are not completely bedfast. Applications for admission far exceed the number we can accept. In 1945, we admitted four out of 159 applications. In 1946, the disproportion between the two figures will be even greater."

Need for Facilities for the Chronically Ill

Dr. David E. Lindstrom, Urbana
Professor of Rural Sociology
College of Agriculture
University of Illinois
Public Hearing, Urbana, May 8, 1946

"I am hopeful that the Commission won't overlook the chronically sick in rural areas. Chronic illness is higher in rural areas than in urban areas. . . Therefore, I assume you are going to take full cognizance of that kind of treatment which is inadequate, or almost completely lacking, in some rural areas. . . I may add that in these areas are many old people who are chronically ill and try to get along on farms or in little villages not understanding that anything can be done for them. That is the general attitude of the rural sick. . .

"Now, if I am correct, you are looking for a way of caring for such people. This has to be given to them as something they can pay for. It must be clear that it is not a charity. Many of these people feel that if they go to an agency they are lowering themselves in the eyes of their fellow men. I think something needs to be done to overcome that mistaken idea. I think reports should be submitted for the benefit of these people showing what facilities are available and that they can be purchased, and try to see if we can erase this feeling that prevails in rural areas."

C. D. Nobles, M.D., Anna
Superintendent, Anna State Hospital
Public Hearing, Carbondale, August 7, 1946

"There is almost a daily call to Anna State Hospital from some one asking how they can care for some individual who is ill, whether or not it is an individual of 15 or 20 or 90 years of age. There are many people in the Anna State Hospital who would not need to be there if they could find a nursing home. . .

"There is a possibility, to my way of thinking, that many of the poorer counties may have to go together and build modern homes that would house quite a number of people. You can secure in this day and age in Southern Illinois plenty of attendant help."

Berry V. Rife, M.D., Anna
President, Union County Medical Society
Public Hearing, Carbondale, August 7, 1946

"The State Hospital certainly isn't the place for the chronically ill. We need a place for them. We have some 16 or 20 in our county we can't take care of. We have one nursing home and they have quite

a number who need that kind of care for heart disease, arteriosclerosis, etc. We have a lot who will live a long time and will get by, but they don't get the proper care. They need a place with proper housing. A good many could be up and around but they need that kind of a place. We have no facilities."

N. O. Gunderson, M.D., Rockford
Rockford Commissioner of Health
Public Hearing, Rockford, February 14, 1947

"As far as the Rockford area is concerned it appears that the chronically ill need to be cared for locally and not sent to district or state institutions, should these latter be considered in drafting new legislations.

"Caring for these individuals locally, however, requires an environment, (if the building, fire, electrical, plumbing, and health codes are to be complied with) that cannot be met with the money allocated for this purpose at the present time.

"Evidence of this fact is exemplified in the records on file of the City Department of Public Health, covering the official, semiofficial, and private institutions, and homes where the chronically ill are housed in the Rockford area at the present, as shown on this chart,[1] which is specifically made a part of this report.

"Nursing care of the chronically ill likewise needs to be met in terms of qualified personnel, which again increases the cost care per individual, as does the medical care, which should be on the basis of the 'patient's free choice of physician,' which is not too difficult to arrange.

"Rockford citizens appreciate the courtesy extended by coming to this area to get first-hand information confronting us in the proper sympathetic, individual care of the chronically ill."

Mrs. Alice M. Gleason, Rockford
Superintendent, Winnebago County
Department of Public Assistance
Illinois Public Aid Commission
Public Hearing, Rockford, February 14, 1947

"I am inclined to agree with Dr. Gunderson that we do have a problem here in providing care for the chronically ill. We have local nursing homes, private nursing homes, and at the present time we have 30 patients in 'C' Ward at the county hospital. We have 12 patients in the county hospital at regular hospital rates. We have 24 patients who could be cared for in a nursing home if facilities were available.

[1]See chart on p. 64 of text of this report.

One of the greatest problems is to convince the individual that he should leave his home and family and go into a nursing home some distance away.

"We have 52 recipients of assistance living in the community whose health is such that they should have some help. Now, in addition to that, there are some who are being cared for in the hospital proper who could be cared for adequately in a nursing home, but are not because of lack of facilities. Then, there are 25 who should have some kind of convalescent care. If we had some means of caring for these people who could be placed either in the county or a private hospital until such time as they had regained their health sufficiently to be placed in a home for the chronic or convalescent, we could then begin to expand our facilities for care of the acutely ill people.

"We are being pushed day after day to find a place for someone but there are no facilities available. This is a real problem which we are facing in our department every day in the week, and our visitors are constantly on the spot in an attempt to work out a plan. It's a bad situation and the visitor must carry the responsibility for it."

Mr. William Jordan, Murphysboro
Superintendent, Jackson County
Department of Public Assistance
Illinois Public Aid Commission
Public Hearing, Carbondale, August 7, 1946

"We have a number of cases in Jackson County. They are getting by because friends or relatives are taking time to care for them. There is quite a number of these cases. When they get so bad that friends or relatives are unable to care for them, we put them in the hospital. If we could put them in a home for chronically ill, we could give them care within the range allowable made for such care and release the limited general hospital beds, which are needed for emergent cases. A county institution will really be a God-send to this county. It will relieve most conditions in every sense of the word."

Mr. R. W. England, Mounds
Chairman
Pulaski County Board of Commissioners
Public Hearing, Carbondale, August 7, 1946

"I came here to learn. We don't have any facilities in our county and if you would ask us just how we get along I doubt if we could answer. We do have chronically ill and are badly in need of facilities. Just what can be done I am not in a position to say.

"We would be willing to join with other counties as we are rather

poor now. We are hardly able to set up and maintain our own institution. I would suggest that two, three, or four counties go together and build a hospital. It is just impossible to take care of these people without some kind of a building plan. They will just lay there and suffer."

M. L. Hartman, M.D., Belvidere
Chairman, Boone County Medical Advisory Committee
President, Boone County Medical Society
Public Hearing, Rockford, February 14, 1947

"I believe the Sister from St. Joseph's Hospital (Belvidere) has made our problem clear. As she has told you, when a doctor comes to the hospital with a surgical patient, the hospital must have room for that patient. I believe our problem is a local one and that it is up to us to iron it out."

David E. James, M.D., Belvidere
Public Hearing, Rockford, February 14, 1947

"I am from Boone County. We have had quite a problem over there on many occasions in obtaining hospitalization for patients. In many instances we have had to turn away other patients in favor of emergency cases because of lack of bed space.

"At the time of the meeting of our Medical Board we discussed this problem and passed a resolution that the Board of Supervisors turn our county home into a convalescent or nursing home. This has not as yet been presented to the Board but we feel as though it would satisfy the definite need in our county . . . The patients have got to be taken care of some way. We have to make some arrangements. In the future we had in mind not only handling old age pension recipients, but making available facilities for all people not on old age assistance."

The Rt. Rev. Monsignor Albert R. Zuroweste, East St. Louis
Diocesan Director of Charities, Belleville Diocese
Public Hearing, Carbondale, August 7, 1946

"Most of our calls are into homes of people who are chronically ill and who cannot get into the hospitals because they are too crowded. Some may have been patients in a hospital for a time, but they were moved out to make room for someone else. We do have some older men and women who are chronically ill.

"We have had quite a few calls from brothers, sisters, or children of chronic invalids asking us to give them some information as to where they can put these patients. The hospitals and the institutions are too crowded. My only answer is, 'I don't know.' "

General Hospital Problems in Caring for the Chronically Ill

The Rev. John W. Barrett, Chicago
Director, Catholic Hospitals, Archdiocese of Chicago;
Chairman of Committee on Legislation and Governmental Relations, Illinois Hospital Association
Consultants' Meeting, Chicago, September 7, 1946

"I have listened with a great deal of interest and I cannot help but think that the basic answer to the problem might be what a friend of mine answers when asked how he is—'There is nothing wrong with me that money won't cure.' I think that providing adequate beds for the chronically ill is primarily one of money, certainly that is the situation here in Chicago.

"I would like to observe, too, that it is eminently important that this Commission and the Hospital Survey Committee work together on the application of Public Law 725 in Illinois. This Federal law enacted by the 79th Congress will allocate next year $2,750,000 to Illinois for hospital construction.

"I would like to answer in so far as I can the challenge to the collective thinking of the Illinois Hospital Association with regard to care of the chronically ill in general hospitals. It is my judgment that hospital people are tending more and more to think that long-term illnesses of old age amenable to therapy should be treated in general hospitals. There is, of course, a lack of beds and the problem of how to get more. Until such time as general hospitals can spend—it all goes back to money—we must think in terms of other facilities for long-term or chronic cases.

"I am not too familiar with the trend of thinking on this problem among medical people, but obviously hospital administrators are directed and influenced by trends in the medical profession. I am sure that hospitals will become increasingly interested in therapy of long-term cases as more and more medical men become interested in the field of geriatrics and look to the general hospitals to provide modern methods for treatment.

"I'd like to get back to this idea of money—The Illinois Public Aid Commission and the State Department of Public Health have taken a step forward in endeavoring to help hospitals in the State develop facilities for the care of the chronically ill. These agencies are to be congratulated. I am sure that the members of the Illinois Hospital Association which I represent here tonight will be willing in every way possible to assist in the study this Commission is making. There is scarcely a general hospital in Illinois that isn't struggling with this problem of long-term illness. How much the enactment of Public Law 725

helps this situation remains to be seen. May I conclude by referring to my opening observation that financing the facilities for adequate care of the chronically ill is one of our primary problems."

Col. Edward T. Thompson, Chicago
Director of Medical Care
Chicago-Cook County Health Survey
Public Hearing, Chicago, July 11, 1946

"The Chicago-Cook County Health Survey realizes that chronic illness is the number one health problem of this community. We are surveying the entire field and we hope to come out with a report which will have some bearing on the things you are discussing today.

"I would like to supplement something Mr. Lyons said. He has made the statement, and correctly so, that the community is not in a position to take care of acutely ill. The survey while not completed is definitely bearing that out.

"I would like to say that a survey conducted in New York City several months ago showed that about fourteen per cent of all the beds in the hospitals were devoted to taking care of chronically ill. While I don't know the exact figures for Chicago, my impression is that about ten per cent of the beds are being used to care for chronics. The question has been asked of all hospitals: 'How many beds in your hospital at the present time are occupied by patients who could better be taken care of in an institution for long-time illnesses?' From answers received I would say that at least ten per cent are devoted to the care of chronically ill."

Mr. Leo M. Lyons, Chicago
Director, St. Luke's Hospital
Public Hearing, Chicago, July 11, 1946

"I have only a few comments to make which, in all probability, are repetitions of this matter by earlier speakers.

"Certainly in state-wide planning we must be sure to include in our consideration all groups—the State Medical Society, Chicago Medical Society, Illinois Hospital Association, Chicago Hospital Council, State Nursing Association and the Visiting Nurse Association, all of which will provide manpower in the handling of all cases.

"We should also consider whether people should be isolated, designated as chronically ill and cared for in separate buildings, or whether care should be provided in general hospital programs. I am one who believes that they should be cared for in a general hospital.

"In Chicago there are not sufficient beds for the acutely ill; therefore, whether it be in a wing, or in a ward, where possible, provision

should be made in order that duplication of facilities be kept at a minimum.

"The State Hospital Survey should point out the weaknesses of our present facilities, and should be the basis of a building program so that the needs of the people can be met where the people are.

"I am of the opinion these needs should be provided so that patients can be visited with a minimum of inconvenience. This means locating facilities accessible to friends and relatives.

"At present there is no planned program for the care of the chronically ill, and general hospitals have made no concerted effort in this direction due to the pressure for beds for the acutely ill."

Mr. I. S. Loewenberg, Chicago
Chairman, Council for the Aged and Chronic Sick
Jewish Charities of Chicago
Public Hearing, Chicago, July 11, 1946

"The Jewish Charities of Chicago has a Council on the Care of the Aged and Chronic Sick which is a co-operative organization of agencies in the Jewish community which deal with the problems of old age and chronic illnesses; the Home for Aged Jews, Orthodox Jewish Home for the Aged, and The Jewish Social Service Bureau having primary responsibility for the care of old people; Michael Reese and Mt. Sinai Hospitals concerned with chronic illnesses; the Jewish community centers interested in leisure-time activities. The Council provides a channel for joint thinking and action towards the goal of serving the needs of the Jewish community.

"The Jewish Charities, working together with the Council on the Care of the Aged and Chronic Sick, has formulated a definitive program for the care of the chronic sick in the Jewish community. In order to integrate all of the facilities it was decided that a full-time Medical Director for the chronic sick in the Jewish community shall be employed. In this way not only would the medical staffs working in the different facilities be interrelated, but also stimulus would be given to a comprehensive research program.

"The chronically ill person requiring active medical care would be served in a hospital facility. This would include service for (1) patients for whom no therapeutic aid is possible but who require the type of nursing which can best be given in a well-equipped hospital and (2) for patients in the terminal stages of disease who cannot be cared for elsewhere. It is intended that each hospital have a separate unit of approximately 100 beds set apart either in the hospital proper or in a separate building in close proximity to the hospital for use of the chronic sick patients.

"The two Jewish old people's homes will care for the custodial patients who require institutional care in homelike surroundings, nursing services, religious, recreational, and social activities with a minimum of medical care. Each of the homes will provide facilities to care for approximately 65 to 75 custodial patients.

"There will be a separate Outpatient Clinic in association with the chronic sick hospital services to which ambulatory patients may be referred for follow-up care and to which other patients not requiring hospital care may be referred.

"It is also intended that a more adequate home medical service be developed by The Jewish Social Service Bureau under hospital auspices; also, care of the custodial patients in the community either through housekeeping service or boarding house facilities.

"We realize that our program can only care for a very small portion of the chronic sick in the community and that tax-supported agencies would need to carry the major responsibility for care of the chronic sick person. We would strongly urge, therefore, that a new chronic sick hospital be built by the State, preferably on the hospital campus on the West side of Chicago. This new hospital should be of sufficient capacity to adequately care for the chronic sick in our community."

Mr. Max Hoagland, Champaign
Superintendent, Burnham City Hospital
Public Hearing, Urbana, May 8, 1946

"Our beds are inadequate to take care of emergency, critically ill, and surgical cases without thinking of taking care of the chronically ill patients. We need a convalescent hospital right now of at least 150 beds. With good co-operation from the nurses and doctors we could transfer such patients from the general hospital. The logical course would be for persons 80 years old with a fractured hip which would need a pin or some surgery to be brought to a hospital such as ours, and when the patient becomes a convalescent transferred to a nursing home which we do not have.

"We have 13 who have been there more than 45 days. This is 10 per cent of our census today. They could be in one of those nursing homes providing convalescent care. Some of these are people of means. I don't think we have any long-term patients who are old age pension recipients. If we did not work at getting that type of patient out, we would have our hospital 50 per cent filled with them all the time.

"My personal opinion is that in the cities of Champaign and Urbana we need at least 150 more general hospital beds, and an additional 100 beds for long-term patients; so that our rate of occupancy

would approximate 80 per cent instead of the 105 per cent now experienced, with some people not yet receiving needed hospitalization."

Sister M. Demetria, Belvidere
Accountant, St. Joseph's Hospital
Public Hearing, Rockford, February 14, 1947

"Our problem is that we do not have the room in our hospital to care properly for chronically ill patients. We would be only too glad to take them if we had the room. We have only a 55-bed hospital and we feel that we are not able to care for chronically ill. When a doctor calls in and tells us he is sending in a surgical case, we must absolutely have a bed for that patient.

"Most of the old age assistance patients will require two or three months' stay. That is taking up a lot of inpatient days that we might use for surgical and medical cases that do not require so much time. I feel that in Boone County we have a very great need for good nursing and old people homes to take care of the chronically ill, rather than having them take up space and time in general hospital."

Mr. Otto R. Schultz, Danville
Credit Manager
Lakeview Hospital
Public Hearing, Danville, May 8, 1946

"It is the opinion of our Board of Directors that chronically ill patients should not be cared for in a general hospital. The available beds are needed for acute cases. There should be some provision made for the care of these patients either as an adjunct to the hospital or by the County or private sources. These patients are not happy in the general hospital nor do they need the type of nursing care offered."

Monsignor F. Witte, Ruma
General Manager of Hospitals for
Sisters Adorers of the Most Precious Blood
Public Hearing, Carbondale, August 7, 1946

"At the present time we are planning on building a $400,000 addition to the hospital. Mr. Hilliard has asked us to consider the advisability of creating facilities for just the people we are discussing. I can assure Dr. Cross and Mr. Hilliard that we intend to have it in operation by March or April of 1948. There is a great need for care of this kind."

County Homes

Mr. Rix A. Sisson, De Kalb
Superintendent, De Kalb County Home
Public Hearing, Rockford, February 14, 1947

"We have converted our old county home. Our building was in need of a little repair and work, and I found out that after inspections were made, and through the co-operation of the Board, it wasn't such a difficult matter to get it set up and run. Now we have, I believe, 31 getting pensions who are paying their own way. Right now, our per capita cost is $60.00 a month. We have had to stretch that $60.00 per month over repairs due to depreciation, and then we did a little redecorating and things like that. We have practical nurses in our county home. We have used a county doctor, but he was quite an elderly man and had to give up the work. We then discontinued that practice and call any doctor that is available or any doctor the patient might want."

Mr. George W. Brown, Rockford
Overseer of the Poor, Town of Owen, Winnebago County;
Chairman, Farm Home Committee
Public Hearing, Rockford, February 14, 1947

"I am a member of the Board of Supervisors and Chairman of the Farm Home Committee. I think that for some time back we have been reading the handwriting on the wall. The people from the local office are all the time asking us for more room in the convalescent ward. With that in mind, we are at the present time having an architect draw plans that will give us 120 more beds. That will mean a bond issue for Winnebago County, and we could use some funds from the State to relieve that condition we have at the county hospital. We have at the county hospital six or seven graduate nurses and about six or seven practical nurses. Every bed is full and people are in the halls and it is impossible to take in any more patients. We are just doing all we can and we are trying to do a good job and take care of them."

Mr. F. E. Beck, Harvard
Chairman, McHenry County Board of Supervisors
Public Hearing, Rockford, February 14, 1947

"Our experience in McHenry County is probably different from that of the State as a whole because we have a plant which has been adequate for the county up to the present time and we are able to finance it satisfactorily. We are practically up to capacity. Two floors are used as a home and one floor is used as a hospital for the chronically ill.

"There was some mention of nursing staff in the earlier discussion.

We have one registered nurse at the head of the institution. During the last few years we couldn't find enough registered nurses to staff the place, but with the one registered nurse, we have done very well with the practical nurses under the supervision of the one registered nurse. We had a county physician up until a few years ago and then we dispensed with him. We have found it more satisfactory to let the institution be open to all physicians. We find it more practical to let the patient choose his own physician and he attends him at our county home.

"This question of paying patients—we adopted a policy sometime ago that people who were able to pay for part of the medical care and unable to pay for all of it, might go there and pay a fee which we fixed at $1.00 a day. We had to dispense with that because we found too many people who wanted to get in on the cheaper rate—far more than we could handle. There were too many people who could afford to pay for all the care but who wanted to get into the county institution because they could do it more cheaply. We dispensed with that. We would have the same problem if we admitted people receiving old age pensions . . .

"I don't know whether it would be practical to work out a district plan. More than one county could be included in a district for the use of a nursing home or a T.B. Sanatorium. However, I do maintain that the legislature should leave the final authority to the local people . . ."

Mr. A. E. Hawn, Oregon
Overseer of the Poor, Town of Oregon, Ogle County
Public Hearing, Rockford, February 14, 1947

"For some reason or other at a meeting over a year ago the Board turned the question of conversion over to the county home committee and they never really have adopted it. They seem to be very much scared about whether they would lose control of the home. The county home has gone along and done a good job. They have made many improvements and are considering the building of a disposal station. We have been approved by the Fire Marshal . . .

"A great many people, as long as they are able to get around and care for themselves to a certain degree, can be taken in private homes and boarding houses. But as soon as they become a care, they are turned out again and there is no place we have to put them, and the only thing we can do is put pressure on the county home.

"We have met with a good many committees on the plan, and many are afraid that if we say we will accept, we will lose the county farm. During the last six or seven months we have done a good many of the things that have been recommended and we are going to continue to do them. I will say that there are a great many things we could do if

we received some assistance from the State. I am not hostile to the program as long as the operating authority is being left with the Board of Supervisors."

Mr. L. E. Modglin, Ava
Overseer of the Poor, Town of Ora, Jackson County
Public Hearing, Rockford, February 14, 1947

"I am on the committee which has started to reconvert our county home, a splendid fire-proof building that does credit to the State of Illinois. But it had been poorly kept, and until recently had been just a home for 'paupers,' as we called them.

"When I came here the institution cared for five, shall I say 'paupers'? You would, if you saw the institution as I saw it when I first came on the Board. Well, it wasn't kept up-to-date. It wasn't kept well. It had been neglected. We redecorated and painted. It still lacks a few of the comforts and services which we hope to provide. If you could see the home at its best, it is a very inviting place. If we couldn't make it so, I should worry about my old age, about having a decent and beautiful place to go . . ."

Representative W. R. Walker, Danville
State Representative, District 22
Public Hearing, Danville, May 9, 1946

"I think the County Board of Supervisors feel a little independent. They don't want any help from the State or Federal Governments unless they are going to retain control of the operation. There might be a time to come when they would need some help. I think it would be received only if there wasn't any supervision by the State or Federal Government and they would still maintain control over the operation of the institution."

Mr. N. T. Paulson, Chicago
County Home Consultant
Illinois Public Aid Commission
Public Hearing, Urbana, May 8, 1946

"In rural areas we have found exceptionally active interest in the county homes on the part of community organizations. For example, in Menard County, the County Farm Bureau has undertaken the complete furnishing of two rooms. The various Kiwanis, Rotary, and church clubs have also furnished rooms completely or have supplied other essential equipment and furnishings. Every doctor in the county has visited the institution and all have a keen interest in the development of the program. One doctor who visited the Home for the first time to examine a patient was so favorably impressed that he made

arrangements for one of his regular patients to be accepted for care. On a later visit he brought out a wheel chair which he had bought for his patient.

"One of the local newspapers sponsored a contest to get a name for the institution as remote as possible from anything which might suggest a 'poor farm' or an almshouse. They offered a small prize of $5.00 and ran the contest for two weeks. In that time 200 names were submitted by residents of Menard County and by former residents of the county in ten other states besides Illinois. The woman who selected the winning name 'Sunny Acres,' was from Ohio. She returned her $5.00 prize with the request that it be used to buy something for the home."

Mrs. Margaret Tobin, Urbana
Champaign County Family Service Bureau
Public Hearing, Urbana, May 8, 1946

"As a family social worker, I look at the program of changing over the county homes with mixed feelings. Because of the severe housing shortage our organization has been endeavoring to find homes for people. We tried to secure space in the county hospital but were told it was full of chronically ill. That is how severe our housing shortage is.

"Several of the people who have come to our agency regarding resources for care are not necessarily on old age pension. They ask, 'May I go to that county nursing home for care at the same rate as an old age assistance recipient'? There are many who are not 65 years of age but who need such a resource.

"I think this whole conversion program is something to be watched very closely because I think the approach is easy but the continued surveillance of the community will be necessary if the program is to be successful.

"Another point I would like to mention is that brought out by Dr. Lindstrom that there are many people who still look at these homes as almshouses and 'poor farms.' I am glad to see some effort has been made to eliminate this connotation.

"Another point which Mr. Hilliard mentioned is the matter of licensing nursing homes. This seems to be very important to me. There are many places needed—and they should be good—to help the old age recipient or similar needful persons by taking him in and giving him care. There are many families unhappy because of an elderly person who is chronically ill and in need of such care. Their recourse to such homes is certainly growing.

"I don't have any questions about what has been done. I only want to say that the efforts being made here are grand but we must

keep on practicing these things. It is not enough that the program is good; it must keep up that way."

Nursing Problems

Mrs. Madeline Roessler, Chicago
Chairman, Cook County Health Department
Consultant's Meeting, Chicago, September 7, 1946

"... Out of the classifications of chronic illness the involuntary case is the most difficult to manage. These sick people are helpless and need more nursing care than other types of chronically ill. The untidy case is also difficult and needs close supervision. These patients have very careless personal habits and create problems of nursing care, hospital personnel and equipment.

"As I have listened to the discussion on providing nursing home and hospital care in the community, I have been thinking that if more of these types of patients could be cared for adequately in their own homes, the problem would be less serious.

"Of course, in the nursing home some care is provided by graduate nurses and the care of this type of patient is a real challenge to the nursing profession. I do not understand how these persons in charge of operating nursing homes can profit with the cost of personnel and care of patient. They are not making money and I do not see how they can give adequate standard care or are financially able to provide the necessary needs to patients.

"The nurse in the community has a challenge also. I believe that if provisions were made for more adequate personnel to the health departments, a plan could be devised to provide supervision of care in the patients' own homes. Provisions have been made for child care, tuberculosis, communicable disease and crippled children. The chronic invalid is always the last to be given consideration and the problem has not been met in any way to date.

"My suggestion would be to meet with representatives from the various nursing organizations, State and local, the hospitals and the Public Aid Commission to plan a solution."

Miss Ann Trutter, R.N., Springfield
Director
Public Health Nursing and Tuberculosis
Association of Sangamon County
Public Hearing, Springfiield, October 10, 1946

"Every nursing association usually carries a long list of chronically ill patients whom it tries to care for in their own homes. That is the

situation here. We have many such cases. Some of them have been under our care for a period of eight years and some a little longer.

"Now, the care of these people does not necessarily require skilled nursing service; neither does it require any definite plan for health education. It does, however, require a little feeling of sympathy and understanding on the part of the nurses who perform this feat day after day. We find too often that there is a feeling of insecurity on the part of some of these people into whose homes we go. This may be due to a crowded situation or the economic condition or of older adults living with younger people where there is a conflict of ideas, etc.

"Aside from the nursing care we are very often baffled as to what to do in some cases where the chronic illness extends over a long period of time. We feel definitely that we would welcome any plan that would help us to be able to give these individuals the type of care and service that would make their remaining years comfortable. At the present time we have 32 patients, all in their own homes. The person who has been cared for the longest is one who has been paralyzed for six years."

Mrs. Florence Tait, Rockford
Manager, Tait Nursing Home
Public Hearing, Rockford, February 14, 1947

"I have both trained and practical nurses in my nursing home, and while I think it is well to have a trained nurse at the head, the practical nurses are quite capable. They are usually middle-aged experienced people and better qualified to do the work than the younger nurses because they can use their judgment . . ."

Comments by Welfare Workers

Mr. John F. Ardner, Urbana
Executive Secretary
Champaign Council of Social Agencies
Public Hearing, Urbana, May 8, 1946

"From 1918 to 1938, as a nation, we shelved the aged. With the war we placed them back into industry and into agriculture. Now that the war is over, what are we going to do with them? I am referring to persons over 50, both men and women. If they can live socially useful lives, if we can gear them into our peace economy, the number of hospital beds required for their care will not be as great as if we again shelve them. Already there is a trend for our personnel departments to be concerned in the main with employment of persons under 45. What we do with the aged from now on will largely determine, in my opinion, the need for facilities for the chronically ill."

Dr. Marietta Stevenson, Urbana
Director of Graduate Curriculum in
Social Welfare Administration
University of Illinois
Public Hearing, Urbana, May 8, 1946

"It seems to me very proper that the State have supervision and control over the standards and fiscal set-up of county homes and that adequate supervision be exercised over all types of service available to those in the institutions . . .

"In New York, the New York City Welfare Committee concluded that at least one third of the group requiring hospital care are chronically ill. They emphasize the fact that there is great need for more intensive study of this problem to provide care for chronically ill elsewhere in order to make room in hospitals for those emergency cases and acutely ill, most of whom need major operations.

"They point out that chronic illness is on the increase partly because our resistance is low because there is more strain in living. Over half of the people who needed care were under 45, which is rather surprising, and seventy per cent were under 55—so that chronic illness isn't simply a disease of old age.

"Another authority is the Texas Survey which pointed out that most chronic illness occurs in low income groups. Naturally that would be the case, and it is more difficult to provide care for these groups."

Mrs. Florence I. Hosch, Urbana
Associate Professor in Social Welfare
Administration, University of Illinois
Public Hearing, Urbana, May 8, 1946

"What I have to say may seem academic but I think maybe the doctors here will agree. We have been very enthusiastic about the possibility of institutions for the chronically ill and are holding very high hopes for the development of this new program. The illustration of Menard County shows what can be done. The important thing is that we keep it up. All too often after the first glamour of the undertaking wears off we sink into a routine and let it deteriorate. I would like to see the Commission and the State of Illinois do something in the way of research in this field of the chronically ill. We are going to meet this problem more and more in the future and we are going to have more and more people applying for care. I think prevention is the key word.

"There is one other thing I should like to mention and that is the problem of eligibility. We have to determine at what level of income persons can afford to pay.

"I would like to stress for the record that I hope there will be

proper supervision in areas where the Illinois Public Aid Commission does not reach. I hope that we will be able to encourage such care in places not now under its jurisdiction for all persons including those under 65 years of age."

SECTION III

FROM A PATIENT'S VIEWPOINT

While it is assumed that health and welfare agencies, physicians, nurses, and hospital administrators must necessarily have major roles to play in the development of sound planning for the chronically ill, it has seldom occurred to students of the problem that persons who are themselves severely afflicted might have suggestions of particular applicability and significance.

In the November and December 1945 and the January 1946 issues of *The Modern Hospital* there appeared a series of three articles on chronic illness written "from the patient's viewpoint" by Miss Eleanor McClurkin of Aledo, Illinois (Mercer County). In a letter dated January 25, 1946 to Raymond M. Hilliard, Secretary of this Commission, Miss McClurkin, who helped organize the Illinois Wing of the National Shut-In Society, wrote:

"Ultimately I hope to acquire the skill necessary to make the public more aware of the present plight of the severely handicapped, and I feel that they should have a voice in the plans made for their care. So I am glad to have you use my articles, if the magazine gives its consent.

"I don't know what personal details will interest your readers. My life has been one of great contrasts: from the active life of a kindergarten teacher in a social settlement to a hospital ward to fight a losing battle with arthritis. Then from those crowded Chicago streets to a rural village, and several years on the farm. Thus I feel qualified to speak from personal knowledge on handicapped problems, both city and rural.

"Economically speaking I've had a view from both sides of the fence, too. For I paid up my college loans just in time and passed abruptly from social worker status to a charity patient—thanks to arthritis!

"After leaving the hospital I experimented with various home businesses, and finally succeeded in building up a mail-order business in hand-made greeting cards. I am not far up the financial ladder, but I am now able to pay my own bills.

"During the twenty-four years I have lived in a wheel chair both my parents died. Depression and bank failure wiped out my savings

and family illness often incapacitated those who cared for me. Being completely helpless, I have a personal stake in future plans for the handicapped."

Miss McClurkin has made available to this Commission the manuscript for her three articles in *The Modern Hospital*. Excerpts are quoted below by permission of Miss McClurkin and the Managing Editor of The Modern Hospital Publishing Company.

Facilities in Rural Counties

"Many rural counties have co-operative arrangements for sanitarium care of tuberculous patients. It seems that a practical method of caring for other chronic diseases could be planned on the same basis . . . Such a plan for the less spectacular and noncontagious chronic diseases would require more publicity on present needs. It also calls for proof that community health would benefit by establishing centers for care and study of crippling diseases . . . A rural health center of this type would serve many community needs. And if adequate grounds were provided many of the patients could help in its maintenance. I am thinking of the possibilities of gardening, poultry and dairy farming, small fruits and orchards, as therapeutic aids in rehabilitation. Many individuals have found these activities possible in spite of crippling conditions. There should be further experimentation and demonstration of these activities as a source of support for disabled rural citizens."

Rehabilitation

"Although actual life is not at stake in all chronic diseases, many serious complications and crippled conditions could be avoided by a new conception of the hospital as an educational institution. Planned primarily to study chronic disease, such a hospital would serve both medical research and the patient . . . Army hospitals are working out new techniques in rehabilitation of service men. They find it best to begin reorienting the patient at once. Light exercise, mental occupation, recreation, begin as soon as possible. All facilities are co-ordinated to re-educate the seriously disabled. Recovery and readjustment to life are greatly hastened by this plan. The civilian patient faces a similar shock and readjustment which frequently is overlooked in treating physical symptoms. Mental attitudes must also be considered. Adequate diagnosis is the first essential and the treatment must cover as long a period as necessary in the hospital. But if former living or working conditions are a contributing factor the patient should be prepared for different activities while undergoing treatment. This means a much broader conception of occupational therapy than the present general

hospital provides. New skills can be gained which have both therapeutic and educational value. But mental as well as physical needs must be considered. The patient will co-operate in the more tedious repetitive activities for muscle building, if they are fitting him for a useful job later. Co-operation with state employment and rehabilitation agencies will be part of the integrated program. With some of the insecurity and worry over loss of job and income removed, the patient should respond faster to treatment."

Use of Handicapped Persons in Serving the Chronically Ill

"In the hospital which is geared to longer periods of treatment, the staff undoubtedly will develop greater personal interest and a more informal attitude toward patients. It will miss a great opportunity if capable well-educated patients are not enlisted in research projects. Why not use former teachers, social service workers, nurses and their like, who have acquired physical handicaps, to assist busy staff members? They could aid in counseling, occupational therapy, compiling statistics, etc. If this seems visionary, consider the demonstrations which are arranged in veterans' facilities by amputees, the blind, and other handicapped persons, as morale builders. It would encourage the educated patient to feel that there were openings for his previous training. Frustrated problem patients might disclose their worries to one who had been 'through the mill' when they distrust an able-bodied counselor. 'Ward life' often discloses this tendency. I have seen uncooperative patients aroused by a 'bull session' or by thoughtful advice from a more experienced roommate."

Physiotherapy

"One of the crying needs of the homebound patient today is for information and guidance in the selection of appliances for home exercise. Few of us ever see a physiotherapist and must devise our own gadgets. Commercial appliances often need special adaptation or are financially out of reach. The physiotherapy department could render valuable aid in testing appliances and in adapting simple devices to home conditions. Clinical demonstrations for doctors and nurses would enlarge this service for slight injuries treated in the home."

Homes for the Ambulatory Handicapped

"... consider the more active section—the ambulatory who are now employed, or could be if transportation and living facilities permitted. Even during the present man power shortage there are many unemployed who could be usefully occupied. Employed handicaps living in rooming houses, students wishing further education in city schools and colleges, the newly rehabilitated waiting placement on jobs would

all welcome a location where their needs had been considered. Since nursing care and medical treatment are not required, the building and its location are most important . . . it must be near many employment opportunities where real estate values are high. On the the other hand, the individuals of this class pride themselves on their financial independence so that large maintenance endowments would be unnecessary. In fact, there is undoubtedly enough business and executive experience among them to run a co-operative establishment. Desires they have mentioned point to a combination hotel and club house with recreational opportunities for leisure hours . . . The setting need not be extravagant. Comfortable, sanitary rooms, or apartments with ramp entrances and elevator service to prohibit falls, community dining room, recreation rooms and library are essentials. Possibly some plan for group transportation could also be devised."

Homes for the Handicapped Needing Nursing Care

". . . the very nature of their own struggle for independence often makes the ambulatory person overconfident so that he misunderstands his more helpless contemporary. Our second group which really differs only in physical condition from the first has its own desire for independence. Each must work harder for it, in a more circumscribed area. Therefore, I think their need is for an institution developed to give physical care, useful employment, and the mental and spiritual and recreational life of normal people. Accepting this basic need for physical care such a home in either city or country surroundings will first provide conveniences for all possible self-help. Lifting devices for bedside and bathroom use, wide doorways and easily opened doors with no threshold for all rooms will make wheel chair navigation easier and also save work for attendants. The routine daily care which is essential to good health should not consume too much of the day. Therefore any aids which increase self-help should be utilized. Treatments or periodic checkups should be scheduled in advance not to interfere continually with the primary occupation of the resident of the home."

Need for Privacy

"It is assumed that cleanliness and balanced diets are part of any modern institutional plan. So I will not dwell on that aspect here. But let me emphasize the need for private rooms. Several consultants, in such homes or hoping for accommodations in a future one, have stressed the need for privacy in which I heartily concur. For short periods in a hospital the ward has definite advantages. How many normal persons would care to be constantly surrounded by roommates not of their own choosing? And no matter how congenial one's friends, or how

gregarious his nature, there is a need for periods of personal privacy. This is particularly true in a permanent location where the individual is encouraged to have a definite aim in life. My hypothetical Home would be permeated by this ideal. An immediate effort would be made to help each new resident find his talent and develop it. Perhaps some of the handicapped members of the home who show aptitudes for leadership could be trained as counselors. Many of the duties of the Home could be done by the more active members. Every possible position should be filled by a handicapped person."

The foregoing suggestions from a citizen of Illinois who knows first-hand what chronic invalidism means should be of wide interest, especially to local governments planning the development of facilities within the local communities.

SECTION IV

RESEARCH INSTITUTE FOR THE STUDY OF CHRONIC ILLNESS AND GERIATRICS

A Proposal

By Dr. Andrew C. Ivy, Vice President, University of Illinois

The Problem

Care of the chronically ill and aged is a vital problem in the State of Illinois. The Governor and General Assembly have officially recognized this fact by the appointment of a special commission to make a survey of present and future needs. This body is known as the Commission on the Care of Chronically Ill Persons. In addition, The Institute of Medicine of the City of Chicago has sponsored a Central Service for the Chronically Ill under the organization of the Council of Social Agencies of Chicago.

The Solution

Provision for Custodial Care

It is obviously necessary to provide custodial care to meet the existing emergency demand.

But this represents only one half of the solution of the problem. It constitutes the emotional and temporizing rather than the well-considered solution of the problem.

Provision for Research

Research on those diseases which cause chronic illness and premature aging obviously provides the only hope for:

1. Rendering old age more efficient and comfortable, and
2. Decreasing the future tax burden for the custodial care of chronically ill persons by:
   a. decreasing the number requiring custodial care, and
   b. decreasing the time that custodial care is required.

Relatively little is now known regarding the prevention and management of those diseases which cause prolonged illness. The same is true of factors which may retard aging and render old age more effi-

cient. And we cannot afford to ignore the fact that due to our increased knowledge regarding the prevention and management of acute diseases the percentage of the population above 45 years of age is rapidly increasing.

From the humanitarian viewpoint, time and money should be spent to decrease the incidence of those diseases which disable and which render old age less efficient and enjoyable.

From the material viewpoint, it appears to be ill-advised to build more and more institutions and to spend more and more money on the care of the chronically ill, and at the same time to devote nothing to research—to the study of how to prevent and better manage chronic illness. Knowledge regarding the prevention and treatment of chronic illness and how to delay the onset of disabling conditions associated with aging will decrease the need for custodial care and add to the income-producing activities of the individuals of the State and Nation.

A Specific Proposal

It is proposed to study how to prevent and improve the present methods of treatment of such diseases as arthritis, high blood pressure, hardening of the arteries, kidney diseases, chronic cardiorespiratory diseases, cirrhosis of the liver, and ulcerative colitis.

In addition to these diseases, assuming that a desirable co-operating working service could be made available to county homes and to private homes for the aged, the results of the research could be extended to these homes. For example, a co-operative study on senility might be made at Oak Forest, the county home for Cook County or the results of research be applied there.

Specifically, it is proposed to create a Research Institute for the Study of Chronic Illness and Geriatrics in the Medical Center Area on Chicago's Near West Side, to be operated by the University of Illinois College of Medicine in connection with the group of special hospitals now attached thereto (the Research and Educational Hospital, Eye and Ear Infirmary, Neuropsychiatric Institute, and Institute for Juvenile Research).

Creation of such an institute offers the hope that as many as 20 per cent of the causative factors leading to commitment to state institutions might be obviated.

Nowhere in the world is there such an institute. Illinois could well be proud to take the leadership in this field, not only for the sake of leadership, but because it offers the most constructive attack on an ever-increasing menace to the growing percentage of aged in our population.

Explanatory Details

A suitable Research Institute[1] would provide beds for 200 patients, an outpatient service for 15,000 patients a year, and suitable facilities for research. Forty patients would be hospitalized on each of five floors. Adjoining each bed area, research facilities in a particular specialty would be provided.

For example, 40 patients with essential hypertension or high blood pressure could be housed on one floor. A physician-scientist and two assistants would study methods for controlling this disease. They would work in the research laboratory adjoining their patients on the same floor. The same general arrangement would be followed on each of five floors.

The two upper floors would be devoted to research on animals. All the basic and important leads which have advanced medicine in the last century have come directly or indirectly from such studies. Information on the effect of diet, exercises, hormones, heredity, and other factors on the longevity of humans can be obtained best by studying, under controlled conditions, the effects of these factors on the longevity and health of animals.

Program

1. A Research Institute for Study of Chronic Illness and Geriatrics.
2. Beds for 200 patients.
3. Outpatient services for a maximum load of 15,000 patient visits per year (50 per day).
4. Adjunct services in Radiology, Physical Therapy, Occupational Therapy, and Nutrition.
5. Administrative offices.
6. Research space on each floor adjoining the patient space.
7. Provision for long-term studies of factors which prolong the life of animals.
8. Conference and classroom space.
9. Laundry and power to be secured from central plant not in this building. Other service areas will be included.

Expenditure Required

A suitable Research Institute to carry on the research and treatment described above would require an initial expenditure of $2,500,000 for land, buildings and equipment. Its operation would require an annual expenditure of $950,000.

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[1]See p. 18 of this report for architect's drawing of the proposed Research Institute.

SPACE REQUIRED

Ground Floor Area	16,600 S.F.	10 Ft.	166,000 C.F.
First Floor Area	16,600	13	215,800
2nd to 8th Floors			
7 floors at 12,600	88,200	11	970,200
	121,400 S.F.		1,352,000 C.F.

AREA OF LAND

16,600 S.F. x 4 (25% coverage) 66,400 S.F. equals 200'x332'

CAPITAL COSTS

Land	66,400 S.F. at $2.00	$ 132,800
Building	1,352,000 C.F. at $1.55	2,095.600
Equipment		271,600
		$2,500,000

ANNUAL COSTS

Patients Care (22 at $7.00 per day)	$500,000
Building Operation and Maintenance[1]	100,000
Academic Staff, Administration and Assistants	350,000
	$950,000

[1]Determined on the basis of 80c per square foot per year: 121,400 square feet totals cost of $100,000.

SECTION V

MEDICAL SUPERVISION AND CARE IN INSTITUTIONS FOR THE CHRONICALLY ILL

Report by

The Committee of the Illinois State Medical Society Consultant to the Commission on the Care of Chronically Ill Persons. Everett P. Coleman, M.D., Canton (Chairman); Robert S. Berghoff, M.D., Chicago; Harold M. Camp, M.D., Monmouth; Harlan A. English, M.D., Danville; Malcolm T. MacEachern, M.D., Chicago; John P. O'Neil, M.D., Chicago; and Walter Stevenson, M.D., Quincy.

Introduction

Institutions for the chronically ill vary in size and type from the chronic disease hospital to the small private nursing home. The chronic disease hospital should be as well equipped and staffed as the general hospital, and medical supervision and care in such hospitals should be subject to the same medical staff authority found in the general hospital.

Other chronic care institutions with which this report is concerned include nursing homes, both private and public, private homes for the aged with infirmary sections, and voluntary institutions for the chronically ill. This entire group of institutions provides custodial or nursing domiciliary care in homelike surroundings. The term "custodial" is used to describe a sheltered or protected environment in which patients may receive the type of nursing care required because of chronic illness, handicaps or infirmity caused by senescence. Medical supervision of the institution's treatment program and medical care of the individual patient in order that he may have the full benefit of modern medical science and receive the nursing care best suited to his needs must be provided by qualified physicians. This report outlines those areas in the administration of the institution's program and the care of the individual patient for which the medical profession should be responsible.

Institutions for the chronically ill in Illinois vary in size, progress in program development, proximity to adequate hospital facilities, availability of physicians, and management. Certain general requirements

for a medical care program in an institution can be described, however, which, with minor adaptations, would be generally suitable.

The committee in the following generally applicable recommendations has kept in mind the need for completeness and continuity of care of institutionalized chronically ill patients. The committee believes that the plan outlined provides *minimum* requirements for a medical care program in an institution for the chronically ill and that the physician or physicians responsible for the medical direction should enrich the program as time goes on for the purpose of rehabilitating the patients to the fullest extent possible. Such adjuvant services as occupational and recreational therapy, medical social service, and vocational rehabilitation would become part of this fuller program.

Medical Direction of Institutions for the Chronically Ill

The first responsibility of the institution's board and of the medical director, staff, or board is for the care of the patient because of whose needs the institution exists. Efficient business management of the institution, although important, is secondary to consideration of the patient's requirements. In this consideration the medical director of the home has a specialized focus on the patient and is responsible for the quality of the patient's day-by-day treatment through the formulation of the over-all medical policies of the institution.

General medical direction may be provided according to the size, program, and location of the institution by one or more of the following:

1. A full-or part-time paid medical director.
2. An organized medical staff.
3. A medical committee or board representing the local medical society; such board should, if possible, represent those specialties particularly related to care of the type of patients in the institution.

Medical Policies of the Institution

The medical director of the institution should establish and carry out general policies with regard to the following:

Admission of Patients

There should be a review of a patient's medical history before he is admitted. This may, in many instances, require diagnostic examination in a hospital to determine whether the patient has had the full benefit of active medical treatment or whether he should remain in the hospital for a time before admission. In other cases a full report by the attending physician or an examination by the medical director or a member of the board or staff may be sufficient to determine whether the institution can provide the type of care required by the patient. The

admission review should be used for classification of the patient with regard to treatment and nursing care and also with regard to his placement in the institution. Indiscriminate jumbling together of such patients as senile dements, arthritics, and terminal cancer patients would certainly not add to the comfort or happiness of any group. It should be determined by proper tests that patients to be admitted do not have tuberculosis, are not typhoid carriers, and do not have any other disease which can be transmitted to fellow patients or to the staff of the institution.

Periodic Re-examination of Patients

Each patient in the institution should have a complete physical examination not less often than once a year even though he is under regular medical care for a particular illness. This will permit a full inventory of his physical condition, and will lead to better and more individualized care of the patient. Even among the chronically ill who are so often considered by lay persons to be only "on the downgrade" there are peaks and valleys of physical fitness and sometimes marked and lasting improvement.

Medical Treatment of Patients

Whenever possible the patient should continue to be attended by his own physician who may call at regular intervals or may visit irregularly as needed. It is recognized, however, that some institutions may be located in a community distant from the patient's own home town so that the services of his personal physician are not available to him. Under these circumstances or when the institution is somewhat distant from any town so that all physicians are not able to call, the medical policy may provide for a staff physician to provide necessary treatment. Institutions for the chronically ill should be open to all qualified physicians who wish to care for patients there subject to whatever rules and regulations may be established as over-all medical policy.

It is not possible to establish standards with regard to the frequency of physicians' visits to chronically ill patients since their conditions vary so greatly. With suitable medical direction of the institution, however, and adequate and qualified nursing staff a patient in need of a visit from his physician will receive such care. There should be a well-established and understood procedure for obtaining the services of a physician in an emergency.

Discharge of Patients

The medical policies of the institution should provide through review of the medical record by the medical director, staff or board for discharge to other facilities of patients who no longer require the particular type of care provided by the institution. Such patients may

be found to need general hospital care, state hospital care, tuberculosis sanatorium care or may be able to return to their homes or other living arrangements in the community.

Record Keeping

An individual record of medical and nursing care should be maintained for each patient in the institution and should contain the admission report and examinations, periodic examination reports, the physician's orders, the nurse's record, and additional findings by the attending physician. The record system should be simple but complete. If a patient is hospitalized and is to be under the care of a physician other than the one attending him in the institution, a summary of his medical history should be provided the attending physician in the hospital.

Likewise, when the patient returns from the hospital the institution's medical record should have added to it a report concerning the hospital diagnosis and treatment.

Standing Orders and Drugs

General medical policy of the institution should provide for instructions to the nursing staff with regard to standing orders for certain kinds of routine treatment and administration of medication. Except as provided in standing orders, no treatments or medications should be given to patients by nurses except upon the physician's instructions.

Hospital Affiliations

Each institution should have an arrangement with one or more nearby hospitals that will accept patients when they require hospital care. Hospitalization should be arranged on the recommendation of a physician.

Registration by the American Medical Association

It is recommended that institutions for the chronically ill establish standards of medical care acceptable to the American Medical Association so that they may be registered by the American Medical Association as related medical institutions.

County Nursing Homes

The committee believes that it is particularly important for county nursing homes in Illinois operating under the provisions of the Rennick-Laughlin Bills to have competent medical direction of their medical programs. A county board which constitutes the governing board for the county nursing home is made up of elected officials, and is the governing body for all other county affairs. By law the county board is

responsible for the administration of the county home, but it must be recognized that members are not selected as are boards of private institutions solely because of their particular interest in and knowledge of the institution's program. Despite this fact many county boards have developed programs that show considerable understanding of the needs of chronically ill persons. This understanding, of itself, should encourage county boards to arrange for good medical direction. In most counties this could best be provided by an advisory committee representing the county medical society. Although county boards of supervisors are responsible for the creation, maintenance, and administration of county nursing homes, it is entirely within the law for responsibility for medical direction to be delegated to the medical profession, and such delegation assures both the county board and the patient that the best possible care is provided.

The committee is not including in this report detailed recommendations with regard to Oak Forest Infirmary, the county institution in Cook County, since its size precludes its consideration jointly with the very much smaller downstate county nursing homes. But the committee does wish to point out that Oak Forest's location near Chicago with its four Class A medical schools offers unlimited opportunity for development of this particular institution into an actual chronic disease hospital. The committee recommends strongly that the Cook County Board of Commissioners take necessary action to meet the requirements of the American Medical Association for intern and resident training so that this institution may affiliate with the Class A medical schools and thereby become able to offer suitable care and treatment to the patients in Oak Forest.

Privately Operated Nursing Homes

The committee is particularly concerned with medical care in nursing homes that are operated for profit. In such homes there is no one to take responsibility for medical supervision unless the proprietor retains a physician, which is done far too seldom, nor is there an administrative board to safeguard the patient from possible exploitation or neglect. While most nursing home proprietors give care to the best of their ability, there are some who require considerable supervision. The committee recognizes that the State Department of Public Health through its licensure program has done much to raise standards. The committee recommends, however, that as the licensure program continues, particular attention be given by the department in accordance with the principles outlined in this report to the quality of medical care in these homes.

Construction of New Institutions for the Chronically Ill

The great need for additional beds for the chronically ill has interested many philanthropic groups in planning for construction of new institutions for the chronically ill. The federal and state funds which will be available for hospital construction under the Hospital Survey and Construction Act (Public Law 725) have also stimulated interest. The committee recommends that in planning for new institutions every possible effort be made by planning groups, whether they be private or public, to provide for the closest possible affiliation between the institution and a well-staffed and equipped hospital. Wherever possible, consideration should be given to having a joint medical director for both medical institutions or an interlocking medical staff so that the services of specialists and technicians will be readily available.

Such affiliation with a general hospital will provide, in addition to better care for patients in institutions for the chronically ill, a greater possibility of screening patients for study as research material. If the State establishes a research institute for the study of chronic disease and geriatrics as has been proposed, plans should be made for referral of patients from institutions and the hospitals with which they are affiliated. It is only through study of chronic disease and the knowledge of prevention and control which will thereby result that the increasing burden of caring for the chronically ill can be lessened. The committee has approved, in principle, the proposal by Dr. Andrew C. Ivy for the development of a Research Institute.

SECTION VI

PRELIMINARY REPORT OF THE SPECIAL COMMITTEE ON MINIMUM STANDARDS FOR THE CARE OF THE CHRONICALLY ILL

By Malcolm T. MacEachern, M.D., (Chairman), Hugo Hullerman, M.D., Everett W. Jones, Leo M. Lyons, and Miss Edna Nicholson

General Statement

Medical facilities for the care of a particular segment of the population are usually provided when society recognizes that need. Many forward-looking physicians, sociologists, and social workers have been cognizant of the medical and social problems presented by the aging population and have been thinking for years in terms of provisions for the aged and the chronically ill. Recently these thoughts have crystallized into definite recommendations for the care of these people and still more recently the governing bodies of a few states have recognized the chronically ill patient as a definite social problem and one that must be met by the concerted action of the state. We believe that society is becoming more and more conscious of the problem in each community.

We are all aware that the economic structure of our society has changed. An agrarian society has given way to a highly industrialized society; the large home has been replaced by the small city apartment. Mechanized household equipment and cleaning service by the day or hour have replaced the family servant. There is no room to care for the bedridden chronically ill patient or even the wheel chair patient at home and even if there were, it would be difficult to obtain sufficient household help to carry the extra burden.

Along with the change in our economic structure has gone progress in medical science. At the same time that industrialization of society condemned to the past large dwellings and family servants, medical progress advanced the life expectancy from 40 to 65 years.

The population as a whole is familiar with the situation through inability to obtain admission for old people in homes for the aged and the difficulty in securing adequate care for the chronically ill patient, be he

young or old, either in the general hospital, the occasional home for the incurables or the nursing home.

Unless provision is made for the care of disorders which afflict the chronically ill, society will have failed in its responsibility for the well-being of a large segment of the population and in addition will have to bear a large financial burden due to lack of foresight in providing treatment which might have rendered many members of society self-supporting.

Society is ripe for the establishment of a co-ordinated state-wide system of all types of agencies for the care of the chronically ill. The fact that the Governor of this State has appointed a Commission to study provisions for the care of these patients in the State of Illinois is proof of this.

Summary of Current Opinions

In establishing standards for institutions caring for the chronically ill it is necessary to define our terms and to decide upon the type of care to be provided.

The thinking of current leaders in this field must be considered and factors which must be taken into account critically evaluated before formulating minimum standards for institutions caring for chronic disease patients. There seem to be two main schools of thought regarding hospitalization for the chronically ill patient.

Dr. Ernst P. Boas, formerly Director of Montefiore Hospital and at present a member of the staff of Mount Sinai Hospital, New York City, the leader of one school, separates the chronic disease patient into three categories:

1. Those in need of active medical care for diagnosis and treatment.
2. Those chiefly in need of skilled nursing care.
3. Those in need of custodial care.

He feels, and many agree with him, that the first two classes should be cared for in the chronic disease hospital while for the third class a custodial home affiliated with the chronic disease hospital is sufficient. The chronic disease hospital would provide facilities for diagnosis and treatment; the custodial home, domiciliary care.

Dr. E. M. Bluestone, Director of Montefiore Hospital, New York City, a voluntary hospital for the care of patients with chronic diseases, leader of the other school, contends that the chronic disease patient in need of active medical care should be cared for in the general hospital where all the diagnostic and therapeutic facilities are available. He feels, and again many agree with him, that a duplication of these facilities in a separate hospital for the chronically ill is an unjustifiable expense.

There is universal agreement regarding the chronically ill patient

in need of active medical care. It is felt that he should not be relegated to a custodial home and whether he is placed in a special hospital for chronic diseases or a general hospital, the same diagnostic and therapeutic facilities necessary for the care of the acutely ill patient in the general hospital should be available for his care.

The trend is away from the special hospital and back to the general hospital, and it would seem best to think of the care of the chronic disease patient as a part of the function of the general hospital. The advantages to this arrangement are well known to those in the hospital field. Briefly these are economy of operation and the services of a skilled and well-rounded staff. The disadvantages are few compared to the advantages if we consider that the chronic disease patient in need of active medical treatment is generally not in the hospital more than a few weeks or months at a time.

Recommendations of the Committee

The Committee on Standards recommends that the chronically ill person in need of active medical care be placed in the general hospital and affiliation with a nursing home arranged for patients in need of nursing care only. This institution should be in close proximity to the general hospital although there are already many institutions in existence today that could meet minimum requirements for institutions of this type by affiliation with a general hospital. Location in a suburban or country district should not serve as a deterrent to their approval.

Reference here should be made to the situation in the State of Illinois. Many county homes throughout the State have been or are in the process of being converted into nursing homes for the infirm and the chronically ill. This would appear to be a simple solution to the problem of caring for the chronically ill. However, a good many of the county homes will require extensive alterations as well as changes in equipment, personnel, and management before they can meet the minimum requirements for nursing homes for the care of chronically ill patients.

The Committee recommends that if a survey of county homes establishes the fact that a sufficient number of them could meet minimum requirements as hereinafter laid down, these institutions should be of the nursing home type and the State divided into sections, two or three nursing homes serving a centrally located, approved community or county hospital prepared to care for the chronically ill patient in need of active medical care.

Pay or part-pay patients as well as the medically indigent should be admitted to these nursing homes and the proper state-supported

agency asked to underwrite the care of the indigent chronically ill in need of active medical care in the voluntary general hospital. Such payment should be based on cost and patterned after the Emergency Maternity and Infant Welfare Care Plan.

The Commission on the Care of Chronically Ill Persons has under consideration a proposal for the erection of A Research Institute for the Study of Chronic Illness and Geriatrics in conjunction with the Research and Educational Hospitals of the University of Illinois College of Medicine. This is most commendable. Such an institution would stimulate interest in the prevention of chronic disease and in the chronic disease patient. All voluntary and county hospitals should have the privilege of referring interesting and problem cases of chronic illness to the research center.

Minimum Standards for Institutions Caring for Chronically Ill Patients

1. *Physical Plant*—a physical plant adequate in size, construction, and equipment to meet the needs of the patients accepted for care.
   a. A building free from fire and sanitation hazards with safety and self-help devices to meet the needs peculiar to chronically ill patients. These shall include facilities available to all patients for easily summoning an attendant at any time; handrailings in the corridors; grip bars in the bathrooms, and other rooms used by patients; hanging wash basins for the accommodations of wheel chair patients; water closets with curtains in place of doors; wide doorways without thresholds; wide corridors; elevators large enough to accommodate stretchers and equipped with wide doors and handrailings; ramps leading from the first floor to the ground; etc.
   b. A sufficient number of solaria, balconies or porches, small day rooms, dining rooms for ambulant and wheel chair patients together with a large hall for recreation, a library, and a storage room for patients' trunks.
   c. Space sufficient to afford adequate light, ventilation, and reasonable privacy for patients. There should be private, semiprivate, and ward accommodations, the latter not to exceed six beds. These accommodations should include easily accessible storage facilities for patients' clothing and personal possessions in bureaus, closets, lockers or other suitable form.
   d. Decorations and furnishings of a type consistent with physical needs of the patients and with a homelike, cheerful atmosphere.
   e. Allotted space, plumbing, and equipment necessary for house-

keeping, maintenance, and nursing activities. These should include on each patient floor a serving pantry, a nurses' station, bathrooms, one or more utility rooms equipped with bedpan flushers and other nursing equipment, janitor closets, and space for storing wheel chairs, walkers, crutches, and other appliances.

2. *Location*—a location readily accessible to the patients it is to serve and to their families and friends; and to the specialized staff and facilities needed in their care, especially physicians, nurses, and general hospital facilities. Efforts should be made also to provide an attractive neighborhood and pleasant surroundings.
3. *Governing Board*—a carefully selected governing board having complete authority and final responsibility for the operation of the institution.
   a. Board members should be selected to include representative, responsible persons in the community with sincere interest in the care of chronically ill people.
   b. Provision for including, in the formulation of policy and in other activities of the governing board, the particular knowledge of the various specialists directly concerned in the problems of chronic illness and the management of institutions for the care of the sick including medicine, nursing, law, hospital administration, business and finance, public health, social welfare, government, etc. This provision may take the form of membership on the governing board of persons competent in the specialties or of advisory committees working with the board on the special problems. In no instance, however, should physicians, nurses, social workers or other persons employed or practicing in the institution or in agencies or professional practice working directly with the institution or in competition with it serve as members of the governing board.
4. *Organization*—clearly stated written constitution, charter, law or similar document setting forth the purpose, scope, duties, responsibilities, form of organization, financing, and administrative relationships of the institution.
   a. If the institution is not operated as an integral part of a general hospital, reciprocal relations with a general hospital should be established in order to provide patients with the services of a skilled medical staff and hospital facilities in case of acute illness or in case of the return of an active phase of a chronic disorder.
   b. Clearly defined, written policies covering the operation of the institution. These policies should be formulated by or with the help of persons competent in the various specialized fields and should be officially defined and adopted by the governing board. They

should include, among others, policies governing admission and discharge of patients; medical attention; standing orders and other aspects of nursing care; control of drugs and medications; business management and financing including charges for the care of patients; relationships with the general hospital and other institutions, agencies, and governmental units.

c. Admission policies should be developed in conference with representatives of the affiliated general hospital, and of other medical, public health, and welfare agencies in the community.

5. *Financing*—financing adequate to provide and maintain on a stable basis the plant, furnishing, equipment, supplies, and services needed to meet the standards outlined in this statement.

a. Fees charged for care should be maintained at a level which, when added to the institution's other sources of income, if any, are sufficient to cover the cost of maintaining and operating the institution. Welfare agencies and government agencies referring indigent patients to the institution should be charged the minimum rates established for other low-income patients in the institution.

6. *Administration*—a competent, well-trained executive officer or administrator with authority and responsibility to carry out the policies of the institution as authorized by the governing board.

a. The administrator must possess executive ability; a knowledge of the fundamentals of institution management including business procedures, administrative organization and relationships; and at least a superficial acquaintance with the problems and general methods of caring for the sick including an ability to work effectively with physicians, nurses, and other professional staff.

b. In addition to the above qualities the administrator must possess sympathy and understanding of sick and helpless people and must be able to instill the same feeling in those associated with him in the care of such patients.

7. *Medical Staff*—a medical staff adequate in its numbers, qualifications, and organization to assure that there will be good medical supervision of all aspects of patient care and that all patients will receive competent medical attention at regularly scheduled times and promptly in emergencies.

a. Responsibility for participation in the formulation of medical policy and of other policies of the institution directly affecting the care of the patient should be clearly placed upon an individual physician or a designated committee of physicians. This physician should also be responsible for the application of medical policies

and for the quality of medical care provided within the institution. This responsibility may be placed on designated officers of an organized medical staff or on a competent medical director employed by the institution. He should work closely with the medical staffs of the hospital or hospitals referring patients to the institution, preferably through a co-ordinating or advisory committee composed of representatives of these staffs.

b. There should be provision for a sufficient number of competent physicians to meet the needs of all patients accepted for care. These needs include, in addition to emergency medical attention, physical examination of all patients at regularly scheduled intervals in accordance with a clearly defined policy and procedure.

c. The medical staff should include a dentist, a pathologist, a radiologist, and a psychiatrist in addition to general practitioners and other recognized specialists. Services of the various specialists may be obtained through the affiliated general hospital; on a part-time or consulting basis; or by special arrangement with approved hospitals, laboratories or practitioners. An inter-locking medical staff with the affiliated general hospital is highly desirable.

d. There should be definite provision for obtaining these services of the physician promptly in emergencies. Large institutions or those located in rural areas should have one or more resident physicians. Smaller institutions in more favorable locations may arrange with medical staff members in the immediate vicinity of the institution to handle emergency calls.

e. All physicians serving on the medical staff should be graduates of approved medical schools and have served internships and residencies or have equivalent experience.

f. Physicians serving on the staff, particularly the medical director or resident physician, should be selected not only on the basis of medical training but also for understanding of the psychic and emotional problems of long-term illness.

8. *Adjunct Medical Facilities*—adjunct medical facilities sufficient to make available at all times, as needed, laboratory service, physical therapy, occupational therapy, dental care, and emergency treatment. An emergency treatment room should be provided in every institution. In large institutions space, equipment, and personnel should be provided in the institution for all of these adjunct services. Smaller institutions may provide them through the affiliated general hospital or by arrangement with approved hospitals, laboratories or practitioners in the community. Provision should be included, under any of these arrangements, for bringing each of these adjunct serv-

ices to the bedside when the patient cannot easily be transported to the facilities provided.

a. Laboratory facilities should be equipped to do routine urine examinations, blood counts, sedimentation rate determinations, and simple cultures and smears.

b. The treatment room should be equipped for superficial physical examinations, dressings, and minor outpatient procedures. All patients acutely ill should be transferred to the affiliated general hospital.

c. A physical therapy department should have adequate equipment to carry out treatments prescribed by the medical staff, both residents and consulting.

d. The occupational therapy department should be equipped and supplied to provide services for the mental and emotional health of the patients as well as for the restoration of physical function. These might include facilities for music therapy, etc.

9. *Auxiliary Facilities*—auxiliary facilities, including a dietary department, a social service department, and a recreation department.

a. The dietary facilities should include space and equipment for refrigeration and storage of food; a modern kitchen; serving pantries for the preparation of trays for bedridden patients; space allotted and equipped for preparation and serving of special diets; dining rooms for ambulatory and wheel chair patients; and dining rooms for employees.

b. The social service department should be easily accessible to patients and their families and to the members of the medical staff.

c. The recreation department should be so located and equipped that it can provide services to bedridden patients as well as to those who are ambulant; and should provide regularly scheduled activities in which there is active participation by the patients as well as passive entertainment such as movies, concerts, etc.

10. *Personnel*—an adequate number of efficient personnel, properly organized and under competent supervision should be provided.

a. The nursing personnel and service should be in charge of a registered nurse who has had supervisory experience. The nursing personnel must be of sufficient number and ability to meet the patients' requirements and to maintain standards of good nursing care. From 25 to 30 per cent of the total nursing staff should consist of graduate nurses in order to provide sufficient supervision for the attendants and in order to care for medications, temperatures, and treatments requiring nursing skill. Attendants giving personal care or nursing service to patients must be suf-

ficiently trained and experienced and should work under supervision of graduate nurses at all times.

b. Laboratory service should be under the supervision of a competent pathologist.

c. If drugs are compounded and prescriptions filled in the institution, the drug room should be under the supervision of a registered pharmacist.

d. The dietary, physical therapy, occupational therapy, social service, and recreation departments should be staffed by qualified personnel. Staff in these departments should be supervised by persons with recognized training and experience in their respective fields. Small institutions may obtain the services of dietitians, physical therapists, occupational therapists, social workers, etc., through the affiiliated general hospital or on a part-time or visiting basis if arrangements for full-time trained staff are not practicable.

11. *Medical Records*—accurate and complete medical records and nursing notes must be maintained and filed in an accessible manner, available for follow-up, for study, and for reference.

a. An adequate resume should accompany the patient in his passage from and to the general hospital and should include a social service report on the pertinent environmental and psychosomatic factors.

SECTION VII

NURSING SERVICE FOR THE CHRONICALLY ILL

Report by

The Committee of the Illinois State Nurses' Association Consultant to the Commission on the Care of Chronically Ill Persons. Mrs. Madeline Roessler, R.N., Chicago (Chairman); Miss Helen Frederick, R.N., Joliet; Miss Margery MacLachlan, R.N., Chicago; and Miss Lorna May, R.N., Chicago.

Home Nursing Service

A survey of home nursing service (visiting nurse service) in Illinois indicates that such care is available from voluntary nursing agencies in only 23 communities in Illinois:

Alton (Madison County)
- Alton Associated Charities
- Alton Catholic Charities

Aurora (Kane County)
- Aurora Public Health Association

Chicago (Cook County)
- Chicago Infant Welfare Society
- Chicago Visiting Nurse Association

Danville (Vermilion County)
- Danville Visiting Nurse Association

Decatur (Macon County)
- Decatur Visiting Nurse Association

East St. Louis (St. Clair County)
- East St. Louis Visiting Nurse Association

Elgin (Kane County)
- Elgin Health Center

Evanston (Cook County)
- Evanston Visiting Nurse Association

Freeport (Stephenson County)
- Freeport Child Welfare Association

Galesburg (Knox County)
- Galesburg Visiting Nurse Association

Joliet (Will County)
- Joliet Public Health Council

Kewanee (Henry County)
- Kewanee Visiting Nurse Association

La Grange (Cook County)
- La Grange Community Nurse and Service Association

Marseilles (La Salle County)
- Marseilles Public Health Center

Oak Park (Cook County)
Infant Welfare Society
Family Welfare Visiting Nurse Service
Ottawa (La Salle County)
Ottawa Public Health Nursing Association
Peoria (Peoria County)
Peoria Visiting Nurse Association
Quincy (Adams County)
Quincy Visiting Nurse Association
Rockford (Winnebago County)
Rockford Visiting Nurse Association
Rock Island (Rock Island County)
Rock Island Visiting Nurse Association
Upper Rock Island Visiting Nurse Association
Springfield (Sangamon County)
Public Health Nursing and Tuberculosis Association
Waukegan (Lake County)
Barwell Settlement House
Wilmette (Cook County)
Wilmette Health Center

The Metropolitan Life Insurance Nursing Service provides service to insured persons in three of the above communities and nine additional ones.

In all other parts of Illinois patients requiring nursing care in their homes are dependent, if friends or relatives can not care for them, on nursing service from whatever professional or nonprofessional personnel may be available. Visiting nurse service can not be supplied by official health agencies because of limited staff and funds. These facts illustrate the great need for extension of home nursing service for the acutely ill and the chronically ill patient alike.

The manner in which home nursing service may be extended varies with the community and the existing services, public or private. A basic principle in any plan should be that "each nurse, in her home visits, combine the principle functions of health teaching, prevention and control of disease, and care of the sick whether in a given situation she works under the direction of a private physician or a health officer. This is important to provide a complete nursing service that is most satisfactory for the family."[1] Possible patterns of nursing organization are:

1. In rural communities all visiting nurse service including care of the sick at home is best administered and supported by the health department. The United States Public Health Service in a letter addressed to the Commission on the Care of Chronically Ill Persons on December 17, 1946 stated:

"While it is true that many official health agencies do not

[1]Desirable Organization of Public Health Nursing for Family Service, Public Health Nursing, August 1946.

provide this type of nursing service, the Public Health Service is recommending that as soon as sufficient staff is available, Health Departments should provide this type of service."

2. Small cities have had some success with a combination nursing service jointly administered and financed by public and voluntary agencies with service given by a single group of nurses.
3. In large cities preventive services in the nursing field are frequently the responsibility of the health department while a voluntary nursing organization does the bedside nursing usually, although not always, in close co-operation with the health department.

Recommendation: The committee recommends to the Commission that further study be given during the next biennium to the manner in which home nursing service may be extended and integrated throughout the State of Illinois.

Study of the Problem

Factors to be considered in studying the extension of home nursing service involve not only consideration of the above-mentioned variations of a basic plan but such considerations as:

1. whether existing voluntary nursing agencies can extend the area in which they give service;
2. how the nursing service, if not to be administered by the official health agency, is to integrate its services with those of the health department;
3. what sources of funds are available such as payment from the patient's own resources or from assistance funds and to what extent these need to be supplemented by private and community contributions or by local or state subsidies;
4. whether public agencies can accept service contracts from insurance companies.

Recommendation: Because of these factors and the complexity of the problem the committee recommends to the Commission that a qualified graduate registered public health nurse be retained to study and report on this entire question. The committee recommends further that an advisory committee of nurses be appointed to work with the above-mentioned nurse, and that the Illinois Department of Public Health, Division of Public Health Nursing, be represented on the advisory committee.

Supervision of Nursing Personnel

Since the nursing care of chronically ill patients in nursing homes and in their own homes in the community is often provided by persons

known as practical nurses, nursing assistants or nursing aides, provisions should be made for the supervision of these persons by a professional registered nurse. Supervision by a professional nurse would insure that persons giving the nursing care would have adequate supervision; this would also be a protection to the chronically ill patient. Supervision of the nursing staff of the nursing home, if there is no registered nurse in the home, might be provided through local or state health agencies who are responsible for the inspection of these homes for licensing. In the community the nursing supervision of the private home might be provided by the local health agency. Provisions for nursing supervision to the chronically ill patient should be under the general direction of the Illinois Department of Public Health.

Recommendation: The committee recommends to the Commission that the nurse whose appointment was recommended above include in her study the problem of providing nursing supervision to the chronically ill, whether they are cared for in their own homes or in public or private institutions.

Training of Nursing Personnel

Nursing service is dependent upon leadership of the medical profession and the type of treatment recommended by physicians. Similarly, interest in nursing care of any particular group of patients or diseases can best be stimulated by physicians who are working with such patients and diseases.

Recommendation: The committee recommends to the Commission that research in the prevention, control, and treatment of chronic disease be undertaken at the earliest possible moment. Such research would benefit the patient group and would provide training for physicians and nurses interested in the care of the chronically ill.

Licensing of Nursing Personnel

The Illinois Nurses' Practice Act, until this time, has licensed only the professional or graduate nurse. A new act which has been prepared and is to be introduced at the Sixty-fifth General Assembly will provide for the licensing of all nursing personnel including the group known by such titles as practical nurses, nursing assistants or nurses' aides. Licensing of this type would insure that persons giving nursing care for compensation would have had suitable training under supervision and would constitute a protection not only to chronically ill persons but to all other persons who are dependent upon this group for nursing service.

Recommendation: The committee recommends to the Commission that it endorse the passage of the new Nurses' Practice Act.

Standards Relating to the Duties of Nursing Personnel

The American Nurses' Association has already studied the nursing needs, standards for nursing care, and analysis of time required for the care of the obstetrical, surgical, and other specialized types of patients. The nursing care of the chronically ill patient is a major national problem, one in which there has been widespread interest. It is the opinion of the committee that standards should be established.

Recommendation: The committee recommends to the Commission that it be suggested to the American Nurses' Association that a study of the nursing needs of the chronically ill patient, similar to their other studies, be initiated.

Licensing of Nursing Homes

Much of the nursing care of chronically ill persons is given in private nursing homes which are now subject to licensing. Certain changes are needed in the law licensing nursing homes. At present the Illinois Department of Public Health does not have jurisidiction in those communities where there is local provision for licensing nursing homes. While the state law requires that such local provision be comparable to the state law, there are some communities in Illinois where the local licensing procedures do not operate effectively.

Recommendation: The committee recommends to the Commission that action be taken so that the Illinois Department of Public Health has jurisdiction with regard to licensing in all communities in the State, superseding all local licensing authority. The Illinois Department of Public Health should be commended for the excellent job which has been done in licensing nursing homes and should be given all support in continuing this much needed program.

SECTION VIII

CHRONIC ILLNESS IN METROPOLITAN CHICAGO

A preliminary report on the nature and extent of the problem of chronic illness in the Chicago metropolitan area and the general type of community program which should be developed to meet it, including some specific recommendations.

April 1947

Prepared by

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Foreword

The Institute of Medicine of Chicago, through its Central Service for the Chronically Ill, hopes to make available within the coming year a detailed report on the extent and nature of the problems of chronic illness in the Chicago area; facilities and services now available to meet these problems; changes and additional services needed; and recommendations for developing them. In the meantime, at the request of the Illinois Legislative Commission on the Care of Chronically Ill Persons, this preliminary report is presented. It constitutes a preliminary statement of the steps which the Central Service for the Chronically Ill believes should be taken in the Chicago area and outlines the plan which the Service will follow in its work directed toward meeting the problems of chronic illness in this community.

For the past three years The Institute of Medicine of Chicago through its Central Service for the Chronically Ill has given intensive study to the problems of chronic illness. In the course of this study it has had the help of national and local leaders in the various professional fields directly concerned in the different aspects of these problems. These have included physicians; hospital administrators; nurses; public health personnel; voluntary health agencies; social workers; di-

etitians; administrators of homes for the aged; persons experienced in community organization and financing of community groups; church organizations; and others. In addition to its other duties the staff of The Central Service has worked intensively in assembling factual information on such points as:

1. The approximate number of persons affected; their age; sex; financial status; diagnosis; degree of disability; and amount and type of care needed.
2. The total facilities needed in the community for the prevention and control of the chronic diseases; for the rehabilitation of patients handicapped by them; and for the long-term care of persons for whom prevention, control, and rehabilitation are no longer possible, including the number, type, quality, and approximate costs of the various services and institutions needed.
3. The total facilities now available in the Chicago metropolitan area, including the number, type, quality, and current costs.
4. The general characteristics of the additional facilities and services which can and should be developed in the Chicago area, taking into consideration the importance of the most effective use of existing facilities and the ideas and preferences of community leaders with respect particularly to such points as methods of financing; relationship between government, voluntary philanthropy, and private initiative; specialization of services, etc.

In assembling this information the staff has investigated the methods in use in other communities and states throughout the United States and Canada. Various aspects of the problem have been discussed, also, with persons working with it in England, Sweden, and Brazil. There is marked similarity between the problems facing Chicago and the State of Illinois and those confronting other communities throughout the United States and other nations.

It is not possible to include in this report complete statistical and other detailed information relating to the various points outlined above. This information is, however, on file in the office of The Institute of Medicine, The Central Service for the Chronically Ill. It forms the basis for the proposals presented in this report.

Extent and Nature of the Problems of Chronic Illness in Metropolitan Chicago

Chicago and the State of Illinois are facing serious problems as a result of the rapidly increasing numbers of people disabled for long periods of time by chronic illness. These problems are shared by other communities throughout the United States, and other nations. They are serious everywhere.

Medical science and practice have made rapid progress in the past half century. Advances are continuing. They have occurred, however, almost entirely within the field of prevention and control of the acute diseases, chiefly those which are infectious in origin. As a result the nature of the diseases which predominate as causes of illness and death has shifted. The diseases which strike quickly and terminate rapidly are no longer the chief health hazards. Their place has been taken by the chronic diseases which characteristically are insidious in onset and bring slowly progressive invalidism over long periods of time. For the majority of people who die each year the length of time during which they are ill and require care is no longer a week or ten days. For more than half of all people who died in 1946 this period of illness lasted weeks, months or years. During 1946 heart disease caused more than ten times as many deaths in Illinois as were caused by pneumonia and influenza combined. The four leading chronic diseases—heart disease, cancer, cerebral hemorrhage, and nephritis—accounted for two thirds of all deaths which occurred in the Chicago metropolitan area during 1946. This experience was consistent with that of the State and the nation as a whole.[1]

The chronic diseases are serious in the extent to which they cause death. From the point of view of human suffering and economic loss, they are equally serious in the long-continued illness and disability which precede death. Some of the chronic diseases—notably rheumatoid arthritis—frequently strike during the young adult years of life. They rarely cause death; but they leave their victims crippled and helpless for years. In this group should be included also some of the neurological disorders such as paralysis agitans, multiple sclerosis, muscular dystrophy, and others.

Estimated Number of Persons Affected

It is estimated that there are in Chicago and Cook County more than 750,000 people who suffer from chronic diseases sufficiently serious to be recognized as constituting some degree of handicap in normal living. Of these, more than 50,000 are so seriously disabled that they are unable to carry on normal activities and may be described as invalids. The remaining 700,000 people have some chronic disease but are still able to continue fairly normal activity and to care for themselves.[2] Most of the 700,000 people who are still "on their feet" are in the early stages of heart disease, circulatory disorders, cancer or

[1]See Health Statistics Bulletin, Division of Vital Statistics and Records, Illinois State Department of Public Health, 1946 series, number 3.

[2]Estimate based on rates established in National Health Survey, United States Public Health Service, applied to population figures for Cook County.

other conditions which, unless checked, will progress with steadily increasing seriousness until the patient reaches the stage of complete invalidism. These 700,000 people constitute the chief source from which the invalids of the immediate future will develop.

Among the 50,000 persons who are already invalids the seriousness of their conditions and the amounts of care which they require show considerable variation. Some of the patients are still able to move around and care for most of their own personal needs provided there is someone available to look after their homes, prepare meals, and be available in case help is needed. For the entire group of 50,000 invalids the degree of care required ranges all the way from this group which requires the minimum of service to those whose illness and disability are increasingly severe to a point where death is imminent. In general, it may be said that with respect to the amount of care required all invalids move along a course which begins with a need for minor care and proceeds through gradually increasing helplessness to the terminal period of illness and death.

The immediate aspect of the problem of chronic illness which is pressing so heavily upon the public consciousness at the present time is the lack of services and facilities to care for patients who are already invalids as a result of chronic disease. There is desperate need for more and better services and facilities of this type. The need must be met. The immediate urgency of this need, however, must not be permitted to overshadow the equal need for constructive efforts to prevent and control the particular chronic diseases and to rehabilitate patients handicapped by them.

Advances in the control of the acute, infectious diseases during the past half century have provided dramatic illustrations of what can be accomplished when the full powers of medical research, professional education, public health education, and preventive medicine are focused upon particular diseases. Until recently, comparatively little had been done to direct forces of this kind at diseases of the heart, circulatory disorders, arthritis, kidney disorders, and the other chronic diseases. The surface has barely been scratched in efforts at prevention and control of these conditions. Enough has been accomplished, however, to demonstrate tremendous opportunities which have not previously been recognized nor used. It has demonstrated, also, the importance of approaching the problems of chronic illness with a constructive attitude. It is true that, in the present stage of medical knowledge, there are many cases of circulatory disorders, disease of the nervous system, cancer, and other chronic conditions which can not be cured or markedly relieved. Progress is being made, however. More can be fore-

seen. Many patients whose condition seemed hopeless in the past are being cured today. Many of those who seem hopeless now may be cured in the future.

Advances of this kind can not be expected as a result of fortunate scientific accidents, however. If they are achieved it will be as the result of well-planned, practical steps which make them possible. Large amounts of money will be needed to support the work. Good physical facilities will be needed for research in the basic medical sciences and at the bedside. Adequate numbers of competent personnel will be needed for research, for professional education, and for care of patients.

Chronic illness has been described as "the Nation's Number One Health Problem." It is almost overwhelming, both in its size and in its seriousness. Constructive efforts to deal with it have been too long delayed. As a result the need for effective action is extreme. The amount of money which will be required and the number and quality of personnel and facilities needed are tremendous. This is not a problem which can be met by patching up old buildings no longer suitable for other uses. Nor can it be conquered by piecing together the scraps left over from other health, medical, and welfare services regarded as of greater immediate importance. The problems of chronic illness must be faced squarely. The community must be realistic in accepting the fact that they will not be solved easily nor cheaply. The costs will be large. The costs of any further delay in dealing with these problems, however, will be even larger. The steadily and rapidly increasing invalidism resulting from chronic disease has already brought appalling financial burdens to patients, to their families, and to the tax-paying public. Money and effort intelligently spent in prevention and control of the chronic diseases and in rehabilitation of patients disabled by them offers the only hope of stemming the increasing burdens of invalidism. The expenditures required, therefore, great as they are, will constitute a sound investment. Any further delay in providing them can result only in continued increases in the number of helpless people in the population requiring long-continued and expensive care. Failure to meet these problems realistically represents, at best, a tragic example of a "penny-wise and pound-foolish" policy.

Constructive action for prevention, control, and rehabilitation must be undertaken. The immediate pressure for adequate care of the thousands of patients who are already "hopeless" invalids must also be met. Adequate provision for long-continued care of those patients who have little hope of recovery is essential. It is vitally important, however, that provisions for care of these patients be an integral part of a comprehensive community program which includes provisions for

prevention and control of the particular chronic diseases and rehabilitation of patients in all possible cases as well as continuing care of "hopeless" patients. The hospital facilities, nursing homes, rest homes, and infirmaries needed for long-term care of patients should be developed with full consideration of the part which they can play in medical research, professional education, general health education, and rehabilitation as well as in the daily care of long-term patients.

Essential Elements of a Comprehensive Community Program

A complete program designed to meet the problems of chronic illness must include well co-ordinated activities in three broad fields:

1. The prevention and control of the chronic diseases and of the invalidism associated with them.
2. Rehabilitation.
3. Long-term care of patients.

Specifically, an effective community program must include at least the following activities:

1. *Medical research* into the causes and methods of prevention and treatment of the particular chronic diseases including diseases of the heart; arteriosclerosis and hypertension; cancer; neurological disorders including paralysis agitans, multiple sclerosis, etc; nephritis and other kidney disorders; and other chronic conditions. Research should include efforts to clarify and deal with the currently ill-defined condition commonly described as "senility," especially as it may result from circulatory disorders and as it may be related to nutrition. Provision should be included for research in the basic sciences as well as for clinical research.
2. *Social and economic research* into the causes and methods of prevention and relief of factors other than physical damage which contribute to invalidism. This should include investigation into the effect of emotional factors, the possibilities of rehabilitation, selective placement of handicapped people in industry, etc.
3. *Professional education* which will assure a supply of professional personnel competent to meet the problems of prevention and control of the chronic diseases and the rehabilitation and care of patients disabled by them. This should include physicians, nurses, public health personnel, nutritionists and dietitians, occupational therapists, physical therapists, social workers, hospital administrators, and other professional persons needed to provide the various services required.
4. *Health education* directed toward educating people on nutrition and other aspects of health promotion, and including information which will promote early recognition of disease symptoms and prompt seeking of competent medical attention.

5. *Public health services* including good vital statistics; well-balanced administration of public health services to take into account the chronic diseases as well as the control of communicable disease, infant welfare services, etc. These should include consistent activities which will keep the public intelligently informed on the nature and type of health problems in the community including the chronic diseases. They should also include effective licensing, registration, and other means of control over the quality of professional personnel offering services to the sick; and of institutions including hospitals, nursing homes, sanatoria, homes for the aged, and other places offering shelter and care.
6. *Provisions for meeting the costs of care for persons unable to do so from their own resources.* Public assistance programs, voluntary welfare agencies, "free" and "part pay" medical services, should be adequate to assure that no one in the community will, for want of funds, be unable to obtain promptly and whenever needed the medical services, hospitalization, care through protracted or terminal illness and other attention necessary for:
   a. Prevention or early detection of disease.
   b. Diagnosis and treatment of existing illness.
   c. Rehabilitation including partial or complete restoration of physical function which may have been lost or damaged.
   d. Control of the progress of disease and prevention of further disability.
   e. Relief of pain.
7. *Personnel and facilities adequate in quality and amount to meet the needs of all persons in the community for diagnosis, treatment, rehabilitation, and care.* These should include all professional services and hospital and other institutional facilities needed for early detection of disease and for prompt diagnosis and treatment. Specifically, they should include adequate numbers of well-qualified:
   a. Physicians including the specialists.
   b. Nurses including competent practical nurses as well as registered nurses.
   c. Hospitals.
   d. Laboratory and X-ray personnel and equipment.
   e. Dentists.
   f. Nutritionists and dietitians for instruction of patients as well as management of diets in hospitals and institutions.
   g. Occupational therapy technicians.
   h. Physical therapy technicians.
   i. Social workers.

j. Sources of medications and prosthetic and therapeutic appliances.

8. *Rehabilitation services comprehensive in scope and constructive in approach.* They should include well co-ordinated services for:
   a. Physical restoration.
   b. Education of the patient in how to care for his personal needs and live intelligently with his handicap.
   c. Instruction in performance of useful work.
   d. Vocational guidance.
   e. Selective placement in industry.

   The services should be available to all who can profit from them and should not be limited to persons who can become fully self-supporting. They should include such services as instruction of handicapped women in the performance of household duties and education of parents of handicapped children in how to meet their needs constructively.

9. *Facilities and services for long-term care of patients.* These should include services to help families caring for patients in their own homes; and community facilities for care of patients who can not remain in homes of their own. Adequate provision should be made in both groups for all patients needing care regardless of economic status. It is usually preferable for the same agencies and institutions to serve both rich and poor. The costs of care for the poor can be met from public funds while payment is made from their own resources by patients able to pay for their care. Services for patients in their own homes should include adequate provision for:
   a. Physicians.
   b. Nurses including visiting nurses and also registries and other means by which families can obtain part-time or full-time service from both registered and competent practical nurses.
   c. Services of other specialists on a visiting or part-time basis including nutritionists and dietitians.
   d. Housekeepers.
   e. Occupational therapy.
   f. Physical therapy.
   g. Social case work.
   h. Religious activities.
   i. Rehabilitation, particularly instruction of patients in how to live with their handicaps.
   j. Recreation.

   Facilities for the care of patients outside their own homes will include units for long-term care affiliated with general hospitals; nursing homes; infirmary units in homes for the aged; etc.

10. *Co-ordination of facilities and services.* This should include adequate provision for maintaining accurate information on the nature and extent of community needs; gaps and overlapping in services; and community attitudes. Provision should be included, also, for a central place where persons needing care can obtain reliable information on how and where to obtain it.

Some Basic Considerations Which Should Guide the Development of Facilities and Services

The Central Service for the Chronically Ill believes that the following basic considerations should guide the development of additional facilities and services to meet the problems of chronic illness in the Chicago metropolitan area. This belief is based upon extensive study of the problems and possible methods for meeting them including an analysis of opinions expressed by approximately 200 leading persons in the community with particular competence and experience in dealing with various aspects of chronic illness. These persons included physicians; public officials; hospital administrators; representatives of civic organizations and church groups; nurses; social workers; business men; persons experienced in management and financing of community health and welfare agencies; managers of homes for the aged; superintendents of institutions now caring for chronically ill patients; and a selected number of chronically ill patients.

The Service believes that the following statements are sound; are workable in practice; and are consistent with the desires of the community. They are not all now being met in practice. Considerable time may be required to bring existing facilities into conformity with some of these statements of principle. Consistent efforts should be made in this direction, however, and each new development in the community should be in the directions indicated by these statements.

1. *There should be a comprehensive program of well-integrated services directed toward prevention, control, and rehabilitation as well as long-term care of patients.* No one segment of this program should be developed apart from the total plan and without full consideration of its relationship to other elements in the program and of the part which it is to play in meeting the community's total need.
2. *Facilities and services in the community should provide care to patients without economic barriers.* There should not be established nor maintained separate personnel, community services, and institutions to provide care for the poor apart from those which serve financially independent people. The same professional personnel, hospitals, and other services and institutions should serve both rich and

poor. Persons financially able to pay for their own care should do so. For those financially unable to pay for the care which they need, including "part-pay" patients, costs which they are unable to meet should be met through public assistance payments or similar methods of distribution of public funds on a fee-for-service basis.

3. *Voluntary philanthropy, private initiative, and government should work together on a partnership basis in meeting the problems of chronic illness.* There is a need for joint efforts of all these groups. Methods of dealing with the various aspects of chronic illness have not yet been fully tested. Experimentation and flexibility in programs are essential. A wide variety of facilities and services are needed. In general, government's part in meeting the problem should lie chiefly in its established responsibilities for regulation and licensing; in providing financial assistance to meet the costs of care for patients unable to do so for themselves; and in providing funds for construction of institutions under the general plan outlined in the Hospital Construction Act of 1946. Voluntary philanthropy and private initiative should establish and operate the new institutions and other facilities needed, collecting reasonable fees for service.

   These fees should be adequate to cover operating costs and would include both those paid by financially independent patients and those paid by or on behalf of patients dependent upon public assistance for part or all of the costs of their care.

4. *The problems of chronic illness, including long-term care of chronically ill people, are primarily medical problems.* They should be approached in the best tradition of medical practice and should have as their constant objective the greatest possible restoration of the patient to health and well-being. It is recognized that the nature of the problem is such that there may be a high percentage of failure to restore patients to full health. Recent experience has demonstrated, however, that for some patients cure is possible; for many there is a possibility of control of the progress of the disease and of improvement in physical function; for many more medical science can do much to relieve suffering; and from all these patients, physicians and others can learn much which may help to prevent other patients from suffering similar helplessness and pain. Institutions caring for these patients should therefore emphasize treatment and rehabilitation. They should not be regarded as "shelters," "infirmaries," or "custodial institutions."

5. *All chronically ill patients, wherever they may be and in whatever stage their need for treatment may be, should have competent and continuous medical supervision and should have easy access to all*

of the specialized services and facilities needed in the prevention, diagnosis, and treatment of disease of any type. The amount of medical attention required will vary between patients and for the same patient at different times. Some patients during some periods of their illness may need only occasional visits from the physician. Others or the same patient at different times may require daily attention. The quality of care which the patient needs, however, does not vary. And his need for having constantly accessible all types of specialized facilities and services is constant since his condition may change at any time. Facilities through which the patient receives medical supervision should be such that the continuity of his care will not need to be interrupted as his condition may grow better or worse or as he moves from his home to an institution or back again. The patient who has been bedridden and has improved to a point where he can be up and about should continue under the same medical supervision. It should not be necessary to transfer him to new doctors and new institutions, breaking the continuity of his care each time he improves to the point of becoming ambulant or grows worse and is bedridden.

6. *Institutions for the long-term care of patients should be so developed, located, and administered that they will provide opportunity and encouragement for:*
   a. The best possible care and rehabilitation of the patients, including provisions for continuity of medical care.
   b. Medical research.
   c. Research into social and economic factors related to invalidism and to the possibilities of rehabilitation.
   d. Professional education especially of physicians; nurses; nutritionists and dietitians; physical therapists; occupational therapists; social workers; and other personnel needed in the prevention and control of the chronic diseases and the rehabilitation and care of patients.

   Institutions should be so located that they are easily accessible to the patients they are to serve and to the professional personnel, specialized medical facilities, and other staff and facilities needed in the daily operation of the institution. Rural surroundings usually offer the advantage of cheaper land values and quieter surroundings. These can rarely compensate, however, for the disadvantages of an isolated location in terms of the possibility of getting and keeping good staff to operate the institution; having the patients easily accessible for visiting by their families and relatives; making use of

specialized facilities and utilities more readily accessible in urban locations; and being available for teaching and research.

7. *Specialized institutions are rarely desirable though specialized units, wards, or whole buildings operated as part of a general hospital or medical center may be.* This is true with respect to specialized "chronic disease hospitals" apart from general hospitals or medical centers. It is also true of independent institutions for particular diagnostic groups such as cancer, orthopedics, etc. It is particularly true of the chronic diseases that they frequently occur in combinations. The patient suffering from cancer may also have heart disease, hypertension or arthritis. The diabetic may also have arteriosclerosis or any number of other conditions. The patient suffering from a chronic disease may develop an intercurrent acute illness or an acute exacerbation of his chronic disease. For these reasons all of these patients must have access at all times to all of the facilities and services which are included in a good general hospital or medical center. A specialized hospital, operating independently of any general hospital or medical center, will have to duplicate all of these facilities within its own organization. This is expensive and unnecessary.

   Separate, specialized hospitals present an added disadvantage and expense in administrative difficulties particularly in the admission process. Admission to the specialized hospital makes it necessary to determine not only that the patient is ill and requires hospital care but also to determine the diagnosis in advance and eliminate those patients who do not fall within the specific category served by the particular hospital. If this can not be done in advance and is accomplished only after admission, it may mean transfer of the patient to another institution with consequent administrative difficulty and expense as well as delay and inconvenience for the patient.

   It is sometimes assumed that specialized, independent hospitals have advantages with respect to the possibility of obtaining public and professional interest and support. Such advantages as there may be in this respect, however, usually can be retained and many of the disadvantages avoided if the necessary facilities are established as specialized units or services within the general hospital or as specialized units which are integral parts of a complete medical center.

8. *In general, facilities for the long-term care of patients during periods when they do not require intensive treatment should be developed through a series of relatively small institutions spread throughout the community rather than in one or two large centralized units.* Facilities for long-term care of patients during periods when they do

not require intensive treatment can operate efficiently with 25 patients and with even fewer if the facility is an integral part of a general hospital. The optimum size of facilities of this type varies with a number of factors. In most instances, however, such facilities should not be less than 20 beds in size nor more than 300. If it is essential that institutions larger than 300 beds be operated, they should be broken down into a series of smaller units or subdivisions.

9. *Adequate financing is the foundation on which good care for patients must rest.* Money alone will not assure good care. Without adequate funds, however, good care is impossible. This fact must be faced clearly both in evaluating existing facilities and in planning new ones. It is unwise to attempt to develop facilities for care of long-term patients on the premise that this is to be an immediate money-saving device.

Good care for long-term patients can be provided at a little lower operating cost and with less expensive equipment than can care in a general hospital serving acutely ill patients. If complete care of good quality is provided, however, the costs are not as much lower as is usually supposed. Dr. E. M. Bluestone of Montefiore Hospital for Chronic Diseases in New York City, has estimated the cost of care for the long-term patient at about two thirds of that of caring for the acutely ill patient. This can be regarded as a minimum figure. As better techniques and equipment are developing for the care and rehabilitation of long-term patients, they are being reflected in increased costs. It must be kept in mind that the very considerable differences in costs of care in many so-called infirmaries for long-term patients now operating as compared with general hospitals are usually related to incomplete and low-quality care of patients. It is not safe to assume that good care can be provided for these patients at less than two thirds to three fourths of the cost of general hospital care.

With respect to construction costs of new buildings or the remodeling of existing buildings for this purpose, there is little basis for assuming that they will be significantly lower than the costs of constructing new buildings or remodeling old ones for general hospital use. Equipment costs will be lower. But actual construction costs will not be markedly different since with respect to size, safety, and similar construction factors the needs are essentially the same.

Inadequacies in Existing Facilities and Services in the Chicago Metropolitan Area and Recommendations for Meeting Them

It is not possible in this preliminary report to mention, by name, all of the work which is now being done in the Chicago area to meet

the various aspects of the problems related to chronic illness. In addition to the services being provided by individual professional persons practicing in the community there are more than 400 agencies and institutions in the Chicago metropolitan area now providing services essential in meeting the problems of chronic illness. Many of these individuals, agencies, and institutions are at the present time engaged in the effort to develop more and better facilities and services to meet these problems. Institutions offering professional education, charitable foundations and trusts, hospitals, health agencies, social agencies, homes for the aged, public assistance agencies, physicians, nurses, professional organizations, public officials, church groups, civic organizations, and women's clubs are actively participating in planning and developing the necessary additional services needed in the community.

Significant progress is being made. New and more adequately supported research projects are being undertaken in medical schools and hospitals. Increasing interest is being shown by the various professional personnel involved and by educators in the different professional fields. Health education services relating to particular chronic diseases are expanding. Rehabilitation services are receiving intensified practical interest and support and planning for some additional service is well under way. Public assistance agencies are giving intelligent study to ways in which they can meet their responsibilities more adequately and are taking definite steps toward doing so. The confusion surrounding the licensing of nursing homes and institutions has been clarified though the problems in the City of Chicago, Oak Park, and some smaller municipalities in the metropolitan area have not yet been eliminated. There is increasing interest and some progress in strengthening and expanding the services needed in caring for patients in their own homes. Development of additional facilities for long-term care of patients in hospitals, nursing homes, homes for the aged, and other institutions necessarily requires considerable time for planning, fund-raising, and construction of buildings. Significant developments are occurring in this direction. A number of hospitals and homes for the aged are actively planning new facilities for long-term care and expansions in existing ones. Some of them have completed their fund-raising campaigns and have money available for construction of buildings in the immediate future. There have been noticeable improvements in the quality of care being provided in privately operated nursing homes.

Significant progress has been made in public understanding of the problems and in the development of intelligent public support for good services. Reliable technical information is now available on such matters as staff needs, reasonable costs of construction and operation of

facilities, and other practical problems involved in building and operating institutional facilities. The needs of the community are known and possible methods of meeting them have been explored. In the current emergency period of extreme lack of facilities in the community, social agencies, visiting nurse associations, and other community services are continuing to stretch their facilities to the utmost in helping patients and their families to the best compromise possible between their urgent immediate need for care and the tragic lack of adequate facilities to provide it. The community can not rely on these agencies to continue the struggle against this overwhelming need indefinitely. Their services are an extremely valuable asset, however, in the present emergency period until facilities can be developed more nearly equal to the need.

The Central Service for the Chronically Ill regrets exceedingly that it is not possible in this report to mention by name the many individuals, agencies, and institutions now providing these highly important services. These existing facilities and services are of fundamental importance because they are now bearing the burden of caring for patients in the community and must continue to do so until sufficient additional ones can be brought into existence. They are equally important because they form the nucleus from which additional facilities and services can be developed. Practical limitations, however, make it impossible to include individual mention of them and the good work which is being done. This final section of this preliminary report, therefore, is limited to a summary of inadequacies in the community and some recommendations regarding ways in which the inadequacies can be met.

PREVENTION AND CONTROL OF THE PARTICULAR CHRONIC DISEASES

1. *Medical Research.* Chicago is fortunate in having four medical schools of excellent quality; a large and representative group of outstanding physicians and related scientists; and a number of well-operated, progressive hospitals. There are now in process in these medical schools and hospitals many individual research projects on the particular chronic diseases. These include, among others, cancer, circulatory disorders, diseases of the heart, rheumatic fever, arthritis, metabolic disorders, and orthopedic conditions. There are research projects, also, on nutrition in relation to the various diseases. Work is already being done both in the basic sciences and in clinical research. Too many of these individual research projects, however, are handicapped by lack of sufficient funds, staff, equipment, and clinical material.

Recommendations: Definite efforts should be made to strengthen, co-ordinate, and expand this research on the various chronic

diseases and on the relationship between nutrition and disease and invalidism. These efforts should include such activities as those listed below.

a. Work now in process (in The Institute of Medicine of Chicago, The Central Service for the Chronically Ill) should be continued and expanded in an effort to maintain centralized information regarding research now being done, gaps and overlapping in the work, and areas in which new developments are needed; to facilitate co-ordination of activities; and to promote effective use of facilities needed in research work.

b. Continued efforts should be made to publicize the importance of prevention and control of the chronic diseases in an effort to:
   (1) stimulate the interest of competent professional personnel in undertaking research of this type; and
   (2) develop a broader base of public interest and support for such work.

c. Efforts should be made to encourage foundations, government, and individuals to provide funds for the support of research projects on subjects not now adequately covered.

d. Additional clinical facilities should be made available by:
   (1) arranging affiliations between medical schools and the hospitals and other institutions caring for chronically ill patients; and
   (2) promoting the development of new facilities for care of patients under such auspices and in such locations that research can be an active part of their programs.

e. Plans are already under consideration for the establishment of a co-ordinated program of research in chronic diseases at the University of Illinois Research and Educational Hospitals. An adequate research program including the necessary physical facilities and provisions for continued maintenance should be established as a part of the program of the University of Illinois Medical School and the Research and Educational Hospitals. The program should cover all phases of the chronic diseases and should not be limited to any one age group. Similar programs might well be established in one or more of the other approved medical schools in the city.

2. *Social and Economic Research.* Some work is being done in isolated places in Chicago and Cook County on investigation of the possibilities for rehabilitation of handicapped people in industry and in methods and possibilities for rehabilitation of handicapped patients. Some large industrial firms are experimenting in this area and at least one

large general hospital has begun work on rehabilitation directed toward teaching patients with chronic disabilities to live with their handicaps. There is no co-ordinated research program in this field at the present time, however.

Recommendations: Research in this field should be undertaken as follows:

a. Definite efforts should be made to bring into reality the proposed rehabilitation center for which plans have recently been developed through a committee of the Council of Social Agencies of Chicago and to encourage research on various aspects of rehabilitation, vocational guidance, and selective placement in industry of patients handicapped by chronic disabilities.
b. Provision for research of this kind including publication of reports should also be included in the program and appropriations for the Illinois Hospital School.
c. Experimental work on the possibilities of rehabilitation should be encouraged in all institutions caring for chronically ill patients.

3. *Professional Education.* Chicago is unusually fortunate in the number and quality of its educational facilities. There are in Chicago and Cook County approved schools of good quality for the training of physicians, graduate nurses, nutritionists and dietitians, social workers, occupational therapy technicians, physical therapy technicians, medical record librarians, and hospital administrators. There are no schools of public health and no approved facilities for the training of practical nurses in the Chicago area. So far as can be ascertained at this time there are no schools anywhere for training persons skilled in rehabilitation as a special field of service. Nor are there any specialized facilities for the training of personnel competent to administer homes and institutions for long-term care of chronically ill patients. As expansions occur in facilities and services in both these fields the need for training will be more definitely recognized and the possibilities for practical training of personnel will expand.

In the facilities which now exist in the Chicago area for training of professional personnel there is an almost universal lack of sufficient emphasis upon the chronic diseases, their importance, and methods for prevention, control, and rehabilitation. The lack of satisfactory facilities for training practical nurses and practical nurse-housekeepers is an immediately serious obstacle to providing adequate care for patients.

Recommendations: Immediate efforts should be made to increase the emphasis on chronic diseases in the curricula of existing

professional schools and to develop the additional educational facilities needed in the community. Such steps as the following should be taken:

a. Efforts should be made through national professional organizations and directly with local schools to provide more adequate training of students in the various professional schools now in existence. These efforts should include, among others:
   (1) promoting understanding of the importance of this subject matter;
   (2) assisting in the development of teaching material; and
   (3) facilitating teaching affiliations between agencies and institutions caring for long-term patients and the educational institutions.

b. Immediate efforts should be made to develop adequate training courses for practical nurses and practical nurse-housekeepers.

c. Efforts should be made to develop facilities for the training of personnel competent to administer homes and institutions for long-term care of chronically ill patients. These facilities probably should be developed in connection with existing courses for the training of hospital administrators.

4. *Health Education.* Well-established voluntary health agencies exist in the Chicago area in the specialized fields of heart disease, cancer, tuberculosis, prevention of blindness, promotion of hearing, cerebral palsy, mental hygiene, and infantile paralysis. Agencies have recently been established in the fields of nutrition, the control of epilepsy, and the treatment and control of alcoholism. All of these agencies maintain health education services within their own fields and in most of these fields health education material emanating from national organizations is also available in Chicago. With the exception of infantile paralysis, however, and possibly tuberculosis and cancer all of these agencies are now handicapped in their health education efforts by insufficient funds and personnel. The same factors handicap the work which should be done in health education in the public schools and through the public health departments in the Chicago area.

The chief source of hope in controlling most of the chronic diseases at the present time lies in early detection of symptoms and prompt, competent treatment. These can not be achieved unless the public is educated to the importance of regular, competent medical attention.

Recommendations: Health education services of existing agencies should be strengthened and expanded and new services should

be developed in areas not now covered. Health education services should be more widely diffused through other education, health, and medical activities including hospitals. Specifically, there should be such steps as the following:

a. Voluntary health agencies now in the field should be encouraged to develop their health education services to the fullest possible degree.
b. Health education services in the schools should be greatly strengthened particularly on such points as the importance of healthful living, good nutrition, periodic physical examinations, and prompt seeking of competent medical advice in the early stages of illness.
c. More emphasis should be given to health education in relation to chronic diseases through public health departments.
d. Services should be developed through voluntary health agencies or public health departments or both to cover the particular diseases and subject matter not now covered. These should include, particularly, emphasis on the importance of recognizing disease entities in older people; dealing with them as definite disease rather than accepting them as inevitable concomitants of advancing age; and clarifying the nature of so-called "senility."
e. General hospitals should be encouraged to develop their services as true health centers including health education services.

Basic Community Provisions Affecting the Quality and Quantity of Services in the Community

1. *Licensing, Registration, and Other Means of Control Over the Quality of Professional Services and Institutions.* Present provisions for licensing and registration of most of the professional personnel concerned with chronic illness appear to be relatively satisfactory. There are no controls at present, however, over schools purporting to train practical nurses and there are no provisions for regulating the practice of persons serving as practical nurses.

Present legal provisions for licensing of nursing homes in the City of Chicago are unrealistic and unworkable. This fact plus the division of authority and responsibility for interpretation and enforcement of the requirements constitute a serious obstacle in the way of improving services of this kind in the community. The solution of this problem will not be easy. It is important, however, that persistent efforts be made to improve both the legal requirements and the way in which they are enforced.

The chief points on which problems arise are zoning, requirements related to fire prevention, and the detailed nature of the re-

quirements in the building code. Since all of these are points on which the municipality must have certain regulatory powers, there is some doubt as to whether the present difficulties could be significantly relieved by making the State licensing law applicable within the City of Chicago. Work is now in progress on a revision of the Chicago Building Code. This should result in considerable improvement in relation to licensing of nursing homes. Efforts are also being made to bring about better co-ordination between city departments in the formulation and enforcement of licensing requirements.

Recommendations: Continued efforts should be made to find adequate solutions for the current problems related to licensing and registration especially as they relate to schools for training of practical nurses, to regulation of the practice of "practical nursing," and to licensing of nursing homes in the City of Chicago.

a. The proposals made by the Illinois State Nurses' Association in the current session of the State General Assembly regarding changes in the requirements affecting graduate nurses should be adopted.
b. Provisions should be adopted as soon as possible for regulation by the State of schools for practical nurses.
c. Provision should be made as soon as possible for voluntary State registration or licensing of practical nurses. Plans should be made for compulsory registration or licensing in the future. Provisions of this kind should not be adopted at the present time, however.
d. Revisions now in process on the Chicago Building Code should take into account the importance of sound, realistic requirements affecting nursing homes.
e. Efforts of the Metropolitan Housing Council and other organizations to promote centralization of city inspection services and to strengthen them by more and better staff should be supported.

2. *Public Assistance as It Relates to Chronic Illness.* The adequacy of services received by financially dependent people can never be any better than the adequacy of public assistance programs including standards governing the amount of financial assistance which can be provided; the flexibility of policies and procedures under which assistance is given; and the adequacy of case work services provided to persons dependent upon public assistance for support. This is true of people suffering from chronic illness as well as others in the population. Adequate amounts of assistance and sound, flexible administrative policy and procedure are essential if the necessary services and supplies are to be provided for the prevention and control of the chronic diseases and the rehabilitation or continuing care of

patients disabled by them. There have been marked improvements in recent years in the administration of public assistance in Illinois and there have been some improvements in the adequacy of assistance payments. There are, however, serious inadequacies still existing from the point of view of prevention and control of the chronic diseases and of care for patients permanently disabled by them.

Persons dependent upon Aid to Dependent Children, Aid to the Blind, and Old Age Pension are financially unable to purchase many of the services essential for health promotion and early detection of disease. As a result it frequently happens that their chronic diseases have reached an advanced stage before medical attention is obtained. In spite of recent revisions in the amount of assistance provided to Old Age Pensioners who are invalids, the increases over the past three years have little, if any, more than kept pace with increases in the costs of living and the costs of providing care for them. Consequently, such increases as have been made do not support significantly better care than was available to these patients five years ago. The amount of assistance now being paid to Old Age Pensioners who are invalids is not sufficient to cover the actual cost of providing adequate care. Large numbers of invalids who are dependent upon Old Age Pension are receiving seriously inadequate care and are unable to obtain care which can by any reasonable standard be regarded as satisfactory.

There have been significant improvements in the past three years in the public aid policies and procedures affecting the care of chronically ill patients. Regulations have recently been adopted permitting greatly improved flexibility in adjusting the amount of the assistance payment to the amount of care needed by the individual patient. These regulations have not yet been made fully effective by the adoption of realistic standards for determining the amount of money needed to cover the cost of the varying amounts of care. The adoption of this method, however, represents a significant improvement in procedure.

Case work services, particularly for recipients of Old Age Pension, are seriously inadequate. Case loads are so high that many pensioners rarely see a case worker. The serious physical, social, and emotional problems which they and their families face in connection with the chronic illness and care rarely receive adequate attention. Their case workers are so burdened with unreasonably large case loads that it is impossible for them to deal with problems in their early stages when something might be done to prevent family breakdowns. There are many times when patients are unable to get in

touch with their case workers promptly even in emergencies such as sudden illness of a family member who has been responsible for the care of the invalid pensioner.

Recommendations: The Illinois Public Aid Commission is to be commended for improvements which have already been made in relation to the provision of assistance for chronically ill patients dependent upon them for support. Consistent efforts should be made, however, to bring about further improvements:

a. Realistic standards to replace those now in operation should be adopted as soon as possible to govern the amount of assistance which can be paid to invalids requiring personal care and nursing services.

b. Present case loads, particularly in Old Age Pension cases, should be decreased as soon as possible to a point where adequate individual attention can be given to chronically ill patients and to other recipients whose problems may contribute to the development of disability and invalidism.

Services and Facilities Needed for Continuing Care of Chronically Ill Patients in Their Own Homes

It is estimated that there are in Chicago and Cook County at least 35,000 invalids being cared for by their families in their own homes. A high proportion of these patients remain in their homes because they and their families prefer this arrangement. Some of the 35,000 patients now living in their homes, however, could pay for the necessary care and would prefer to be in nursing homes if enough good facilities of this kind were available. There may be as many as 5,000 such patients among the 35,000 invalids now living with their families in their own homes. This number is at least partially offset, however, by the considerable numbers of patients now in nursing homes and institutions who could and would prefer to be in homes of their own if they could obtain the household and professional help needed to care for them there.

Considering both of these groups of patients it is estimated that approximately two thirds of all invalids are now in their own homes and that well over half of all invalids can and will probably always prefer to remain in homes of their own. These persons would not make use of nursing homes and institutions, even if plenty of such facilities were available. In planning community services and facilities for long-term care of chronically ill patients, therefore, it is important to provide for the needs of these persons as well as those who are in institutions.

The visiting nurse associations in Chicago, Evanston, and other communities are the chief sources of help now available for families caring for invalids in their own homes in the Chicago metropolitan area. They are giving excellent service. Because of limitations in finances and staff, however, they have not been able to meet the full needs of all patients requiring care, even within the communities which they serve, and there are some areas in Cook County in which little or no service of this type is available from any source. Services of visiting nurses are now available almost exclusively to the low-income families and to those who are dependent upon public assistance for support. Large numbers of families in the middle-income groups also need services of this kind and are able and willing to pay reasonable fees for them. There are practically no sources now available in the community, however, from which they can obtain them.

There is an almost total lack of sources from which any patients, rich or poor, can obtain professional services of dietitians, occupational therapists or physical therapists in their homes. There is an urgent need among patients in all economic groups for sources from which they can obtain competent practical nurse-housekeepers to help in household management and the care of patients in their homes. There are no schools in the Chicago area for the training of persons competent to perform this combination of services. There are practically no community organizations nor privately operated employment agencies to which chronically ill patients and their families can turn for help in obtaining such personnel even though they may be able to pay for it.

There has been very little help available to families and patients needing rehabilitation services in their homes. The "Home-Bound" services provided by the Illinois Association for the Crippled give excellent help to some patients in learning to live with their handicaps and carry on useful activities in spite of them. Limitations of the agency's staff and finances, however, have made it impossible for more than a very small number of patients to obtain these services.

Illness of all kinds may be aggravated by physical surroundings, living conditions, fear or worry, lack of understanding or unsympathetic attitudes on the part of the patient's family, and other social problems. This is especially true of such diseases as heart conditions, high blood pressure, diabetes, and other chronic diseases. Not only do social problems aggravate the illness. The illness and the burdens placed on the family in caring for the patient create new and serious social and economic difficulties. Families previously living happily may suffer serious strain, even to the point of complete breakdowns in the form of separation or divorce, when confronted with months or years

of caring for a "difficult" invalid in the home. Serious problems of readjustment of the family's way of living and serious emotional problems on the part of both the patient and his family are common. These problems are not limited to families who are financially dependent. They occur with equal seriousness in families of all economic groups. Good social case work can go far toward relieving these strains and helping patients and families through the difficult personal adjustments which must be made.

Social case work service is being used in slowly increasing amounts by financially independent people in the Chicago area. There is still widespread lack of understanding of its value, however, and many families suffer through very difficult and sometimes disastrous efforts to "muddle through" their problems without help because of the mistaken idea that social case work is useful only for "paupers" and social misfits.

Recommendations: Services and facilities in the homes of chronically ill patients should be extended by such steps as the following:

1. *Consistent efforts should be made to increase the financial resources and staff of existing organizations providing visiting nurse services to a point where it is possible to meet the full needs of all long-term patients including those able to pay for their care.* Areas in which such service is not now available should be encouraged and helped to develop it through voluntary agencies whenever this is possible. In some areas service might be developed through extension of existing agencies now working in adjacent communities. In areas where services can not be developed satisfactorily through voluntary agencies the need should be met by expansion of the rural nursing service of the Cook County Department of Public Health.

   Fees covering the costs of the services should be collected by the nursing agencies from patients and families able to pay for them, and from public assistance agencies to meet the costs of care for patients who are dependent upon public assistance for support.

2. *Steps should be taken as rapidly as possible to develop agencies or centers in the community from which families in need of such service can obtain competent practical nurse-housekeepers.* Development of such centers will necessarily go hand in hand with the development of the educational facilities mentioned above for training of such personnel. Service should be available on both

part-time and full-time arrangements to meet varying needs of the patients and families to be served. Preferably the same agencies or centers should serve all economic groups. Patients able to pay for service should do so. For patients unable to pay for necessary service, costs should be met by public assistance agencies and voluntary welfare agencies.

The possibility should be investigated of developing these new services in connection with existing community agencies such as Visiting Nurse Associations. If this is not feasible, they might be developed in connection with the educational institutions for the training of personnel or as independent agencies. They should, however, be operated on a not-for-profit basis similar to the voluntary hospitals which serve all economic groups.

3. *The services of competent nutritionists and dietitians should be made available as soon as possible for consultant service on a visiting basis to patients and their families in their own homes.* These services should include help to families in meal planning and management of good normal diets and special help in the planning and management of therapeutic diets as needed.

   Like other services related to care and treatment of the patient, the services of the nutritionists and dietitians should be carried out in accordance with the directions of the patient's attending physician.

   Services of this type should be available to patients in all economic groups, preferably through a single agency. Fees should be collected from patients able to pay and from assistance agencies to cover the costs of services to patients dependent upon such agencies.

   These services might be developed in connection with existing organizations such as visiting nursing associations; or they might be developed as a part of the agency providing practical nurse-housekeeper service. Some services of this type might be developed as extensions of diet therapy departments in hospitals, particularly those in which there are training courses for dietitians. In whatever particular form the necessary organization may be developed, it should be operated on a not-for-profit basis and should include affiliation with educational institutions responsible for training of nutritionists and dietitians.

4. *Consistent efforts should be made to provide adequate occupational therapy and physical therapy services on a visiting basis to patients in their own homes.* In general, occupational therapy and physical therapy services should be provided by the same agency

with close correlation between them. Like the services mentioned above these services should be provided through a not-for-profit agency serving all economic groups and collecting fees from patients and assistance agencies. The services should, of course, be provided under the direction of the attending physician in all cases.

Such services should be developed, if possible, as an expansion of the existing services provided by the Visiting Nurse Association and the Illinois Association for the Crippled. Arrangements should be included for affiliation with the training courses for occupational and physical therapy technicians.

5. *Rehabilitation services should be made available to patients in their own homes as rapidly as possible.* These should include educational services for patients and their families designed to help patients to learn to live with their handicaps and perform useful activities in caring for their own personal needs as well as those activities designed to help them become self-supporting.

Consistent efforts should be made to increase the financial resources and staff of the Illinois Association for the Crippled to a point where the type of services now being provided in their homes for cerebral palsied children and a few other patients can be made available to all patients in need of them.

Such services might be developed also as an extension of the proposed new Rehabilitation Center in Chicago and other not-for-profit agencies; the State Division of Rehabilitation; the Division of Services for Crippled Children; and the Illinois Children's Hospital-School; or similar agencies or organizations.

Wherever such services are developed they should be in agencies which also provide physical and occupational therapy and social case work and should be closely correlated with these services. They should, like other specialized services, be provided in all instances in accordance with the directions of the patient's physician.

Services of this kind are needed by patients able to pay as well as those in the lower financial brackets and should be equally accessible to all economic groups on a reasonable fee-for-service basis. Fees for such service for recipients of public assistance should be recognized as constructive and appropriate expenditures of public assistance funds.

There should be provision for affiliation between agencies providing these services and schools for training of occupational and physical therapy technicians and those offering training for

social workers, especially child welfare, psychiatric, and medical social work.

6. *Efforts should be made to develop more social case work service for financially independent families and wider public understanding and more intelligent use of such service by these families.* Services now being provided to financially independent families through voluntary social agencies should be more widely publicized and made more easily available to financially independent people. Provision should be made for making good social case work service available on a fee basis in attractive surroundings where financially independent families will find the atmosphere less suggestive of social failure and stigma. If possible, this should be accomplished by extension of services of existing agencies. If it can not be done in this way, an experimental service should be established entirely independent of those serving the poor and should be operated until such time as the value of its service has been demonstrated to the general public.

Long-term Care of Patients in Hospitals, Nursing Homes, and Other Institutional Facilities

Approximately two thirds of all invalids are cared for by their families in their own homes. The remaining one third, however, can not be cared for in homes of their own either because they are single or widowed people with no relatives to care for them, or because the only relatives they have are, themselves, ill or for other reasons unable to give them the nursing and other care they need. It is estimated that there is a total need in Chicago and Cook County for at least 15,000 beds for patients of this kind. In addition there are significant numbers of patients, now in their own homes, who would like to have care in good nursing homes and are able to pay for it but can not obtain it because of the lack of sufficient good facilities in the community.

Characteristics of Patients Requiring Long-term Care in Nursing Homes, Hospitals, and Other Institutional Facilities. The 15,000 people who require care outside their own homes include people in all age and economic groups. There are variations, also, in the amounts of care they require and the illnesses from which they suffer.

Reliable estimates indicate that a majority of all invalids are people in the middle and young age groups. Less than one third of the total number of invalids are 65 years of age or older. There are definite variations, however, between the total group of invalids and the smaller group which includes only those requiring care outside of their own homes. A high proportion of children and young adult invalids remain

in their own homes. The ability of families to care for an invalid at home, however, decreases as the age of the patient increases. Consequently a relatively high proportion of invalids in the younger age remain in their own homes; and comparatively fewer of them need care in other facilities. The situation is reversed, however, among invalids in the older age group. A recent analysis of approximately 4,000 cases handled by The Central Service for the Chronically Ill showed that 66 per cent of all the patients needing care outside their own homes were 65 years of age or older. Twenty-seven per cent were between 35 and 65 years of age; 5 per cent from 15 to 35 years; and 2 per cent were under 15 years of age.

A review of the same records indicated that more than half of all these patients are fully able to pay for their care; less than 10 per cent are unable to pay anything toward the cost of their care; and the remaining 40 per cent can pay part but not all of the costs of the care they need. The amounts these "part-pay" patients could pay ranged from as little as $10.00 to as much as $75.00 per month.

Approximately one fourth of this entire group of patients were invalids as a result of hardening of the arteries, high blood pressure, and "strokes" with resulting paralysis. Fourteen per cent of the total number of patients were reported to be "senile" or suffering from the mild mental confusions commonly attributed to "old age." In actual

Diagnoses	Percentage of Total Cases
TOTAL	100.0
Arteriosclerosis and hypertension including cerebral hemorrhage and resulting paralysis	24.8
"Senility" and "mild mental confusion"	14.3
Orthopedic impairments, blindness, and deafness including old fractures and injuries	11.9
Diseases of the heart	10.0
Cancer and other malignancies	8.7
Diseases of the nervous system including Parkinson's Disease, multiple sclerosis, cerebral palsy, etc	7.1
Rheumatism and arthritis	6.3
Mental illness	2.4
Diabetes	2.4
Ulcers of the stomach and duodenum, and other nonmalignant diseases of the gastro-intestinal tract	1.2
Vague and ill-defined disorders	4.7
Other miscellaneous conditions	6.2

fact, in a very high proportion of these cases the mental confusion is not due to the number of years the patient has lived but to hardening of the arteries. In others, severe nutritional deficiencies are contributing in large measure to these symptoms which are mistakenly regarded as inevitable results of advancing age. These deficiencies, incidentally, are not limited to poor people. They probably result at least as much from poor food habits and lack of good health education for the entire population as they do from poverty.

The distribution of the various diagnoses among the 4,000 cases studied is shown below.

Existing Facilities. The 15,000 invalids in the Chicago area who can not receive care in homes of their own are now scattered through a variety of places in the community. Some of these facilities are well equipped and offer good services. Others are not intended for the care of patients of this type; they object to the presence of such patients in their institutions and, while giving them adequate care, are constantly trying to "unload" them. These include, particularly, the general hospitals and some homes for the aged. Some privately operated nursing homes and "boarding homes," are giving the best service possible within the limits of the low fees being paid them but are nevertheless far from adequate. In general, services in these homes can not be markedly improved until realistic provisions are made to meet the costs of satisfactory care for financially dependent people. Many Old Age Pensioners are in homes of this kind and can not obtain better services because they do not receive sufficient money to cover the cost of them. An extremely small number of homes offer low-quality care because of lack of conscience or bad intentions on the part of the operator. Of the 15,000 patients now in need of care, approximately 1,500 are in the Cook County Infirmary at Oak Forest; about 4,000 are being cared for in not-for-profit institutions including the infirmary sections of homes for the aged; about 2,000 are in recognized nursing homes or "boarding homes;" 1,500 to 2,000 are backed up in general hospitals against the wishes of the hospitals which need their beds for acutely ill patients; and the remaining 5,000 to 6,000 are scattered through hotels, rooming houses, and other places not equipped to care for the sick. Exclusive of the beds needed for treatment of tuberculosis and of mental illness, the Chicago area needs at least 6,000 new beds for long-term care in addition to the total number now in existence. Many of those now available are in buildings which are not safe nor well adapted to this purpose. These beds should be replaced as rapidly as possible. Including additional beds and replacements the Chicago area needs a total of at least 10,000 new beds for long-term

care of patients now disabled. Unless effective efforts are made to prevent and control the chronic diseases, this number can be expected to rise steadily in the future.

Recommendations: The Central Service for the Chronically Ill believes that these beds should be developed in accordance with the following plan.

1. *Consistent emphasis should be placed upon treatment and rehabilitation of patients. To this end efforts should be made to develop in connection with every approved general hospital a unit for long-term treatment and rehabilitation.* Each hospital should have in its unit for long-term patients, roughly, two beds for every five beds in its section caring for the acutely ill. The research and educational functions of the hospital should be fully extended into the unit for long-term patients.
2. *Privately operated nursing homes and institutional homes for the aged should be regarded as substitutes for or extensions of the care of patients in their own homes.* Adequate provisions should be made in these institutions for the same type of care and service as is carried on in patients' own homes. Intensive treatment, such as can best be given in hospitals, should not be attempted in institutions of this type.

   These institutions should have close working relationships with hospitals, preferably administrative affiliations or actual management by the hospital. Efforts should be made to bring about such affiliations between existing homes for the aged and hospitals as rapidly as possible.
3. *The total number of privately operated nursing homes should not be significantly increased, but the level of quality should be raised by fostering improvements in existing homes and encouraging the development of good new ones to replace those whose quality of care can not be maintained at an adequate level.* Efforts to improve quality of care must include better financing of services and development and use of more practical educational material for the use of persons operating nursing homes or planning to open them.
4. *Efforts should be made to remove present restrictions which limit the facilities of the Convalescent Home operated by the City of Chicago Welfare Department to patients dependent upon the city or county for support.* The high quality of care available in this institution should be made available to the greatest possible number of patients.
5. *The character of the County Infirmary at Oak Forest should be*

changed to make it primarily a medical institution. The size of the institution should be reduced and the quality improved. Staff should be added, sufficient in number and qualifications to provide constructive medical attention and rehabilitation. At least half of its total bed capacity should be converted into a general hospital serving the southern section of the county. Efforts should then be made to arrange affiliation with a teaching institution.

SECTION IX

EXCERPTS FROM THE ILLINOIS HOSPITAL SURVEY AND PLAN[1] CONCERNING CARE OF THE CHRONIC AND CONVALESCENT

By Henrietta Herbolsheimer, M.D., Director of Study,
Illinois Hospital Survey

Facilities for Chronic and Long-term Convalescent Patients in General Hospitals[2]

Modern medical science has shortened the convalescence of a great many diseases. There are, however, some notable conditions which require long periods of care with varying degrees of medical, nursing, and custodial services. With the gradual aging of our population and the growing relative importance of chronic illness of varying grades of disability and seriousness, the medical, social, and economic aspects of this problem merit all the consideration which they are obtaining at this time.

Ever increasing demands are being made of the general hospital in many institutions to the extent of 20 per cent of all beds for care of this group of long-term cases whose stay frequently runs into years. This is a critical problem for the general hospital, the purpose and destiny of which is to provide care and early rehabilitation for the acutely ill.

The provision of elaborate equipment and highly trained personnel and the architecture peculiar to general hospitals make for expensive cost of operation. This high cost of care is especially noteworthy because the medical and surgical sections of the general hospital building are not designed to really meet the physical and emotional needs of long-term cases. When full and dispassionate considerations are given to the fact that general hospitals as we understand them today have plants which are attuned to the care of acute illness with large staffs of highly trained nurses and other personnel required for care of pa-

[1]Reproduced by permission from draft copy as submitted to the Executive Committee of the Advisory Council on Hospitals, February 25, 1947.

[2]Ibid, page 10, Section I, "Principle Concepts of Hospital Planning," Chapter I, Subtopic 5.

tients whose condition may change decisively hour by hour and have preventive medical responsibilities, it seems unwise to permit the misuse of these highly expert facilities by cases which do not have immediate need for such equipment and personnel. To be sure, there is a shortage of beds for the chronic and long-term convalescent and temporary expedients will have to be arranged. But vision should not be turned from the fact that the acute units of general hospitals in communities of all sizes are constituted both to care for short-term cases amenable to treatment and to afford the principles of prevention to the challenges of chronic illness. These are equal needs of the people.

In the past general hospitals have been reluctant to admit long-term patients because of the shortage of hospital beds, the length of stay of these cases, the nonemergent nature of their disease, and the frequent additional obstacle of "no funds." Today pensions and various grants have come to the aid of the chronically ill, but the cost of general hospital care is rising to the point where it is almost as much above the amount the average chronically ill patient can pay as it was before the grants were available.

General hospitals as the facility to serve community health needs have a responsibility for the long-term convalescent patient whose recovery is delayed because the disease with which he is afflicted is not responsive to current methods of therapy. Both the inpatient and outpatient facilities of the general hospital should be available to patients with chronic illness for diagnosis and for treatment of any intercurrent acute illness or exacerbation of the chronic condition. Beds should be available in accordance with such needs, and provisions should be made for temporary care of cases pending transference to a nonacute facility. In addition, serious consideration must be given to the provision of suitable facilities for the care of the long-term cases in wings or separate buildings of the general hospital unit. These facilities should include buildings and grounds, furniture and equipment designed for semiambulant patients and should lend themselves to the development of recreational and occupational therapy and rehabilitation programs.

Chronic and Convalescent Hospitals[1]

The problem of providing care for persons chronically ill or needing a long-term convalescence seems inextricably interwoven with that of the furnishing of custodial and domiciliary care for incurables, geriatric cases, and boarding home care for children. Progress toward a solution of the facilities aspect of the problem can follow only upon clarification of the nature of the problem. The many conferences with

[1]Ibid, page 18, Section I, "Principle Concepts of Hospital Planning," Chapter I, Topic D.

excellent agenda on this subject have, notwithstanding, served to a certain extent to enlarge upon the confusion by including in the category of the chronic the heretofore segregated and well-defined problems of tuberculosis and mental illness. These latter two conditions have long been provided for to varying extents in separate institutions and are clearly recognized as specialty fields of medicine. It is true that both tuberculosis and neuromental care are long-continuing processes which label the diseases as chronic in distinction to acute conditions. But the large issue of the long-term cases suffering from degenerative diseases, either inherited or acquired, is worthy of consideration separate from the medical and hospital aspects of tuberculosis and nervous and mental illness.

The consensus seems to be that there are the following groups of patients in the chronically ill category:

a. Patients requiring diagnosis, intensive medical care, and treatment.
b. Patients requiring chiefly skilled nursing care under medical supervision.
c. Patients requiring only custodial or attendant care.

Optimum facilities for care of these long-term cases would vary in accordance with the needs of the category into which the patient falls. The patients who require intensive care and are amenable to treatment have real need for the full provisions of the general hospital. The group requiring chiefly nursing care may obtain this service in a special wing of the general hospital or in a separate institution especially designed for nonacute cases. Such separate institutions should be near general hospitals or have a close liaison with a complete general hospital. They would afford: (1) Suitable facilities for patients such as low beds, ramps, solaria, dining rooms, grounds, etc.; (2) lower operating cost than general hospitals, per se; (3) opportunity for occupational and recreational therapy and vocational rehabilitation programs; and (4) economical use of the time of physicians and nurses.

A special hospital of not over 200 beds designed particularly for the purpose should be provided in affiliation with a teaching institution in order to emphasize both education of physicians and research into the fundamentals of this heterogeneous group of incapacitating diseases. Such an institution should provide for all age groups of the chronically ill and should furnish ample specialized services for ambulatory cases.

The plants of county homes should in so far as possible be converted to desirable facilities for the care of the chronically ill according to the provisions of the Rennick-Laughlin Bills. These public facilities originally constructed for care of the destitute had, by virtue of

the Social Security and Illinois Public Aid programs, rapidly become depopulated. The physical plant, though old, can in most instances be modernized to serve for care of the semi-invalid and invalid patients. In view of the pressing needs of the chronically ill who can not be self-maintaining or who can not obtain care in their own home, these county homes should be utilized fully to this very practical end.

Chronic and Convalescent Institutions[1]

There were at the time of the survey 362 institutions for the care of chronic and convalescent patients having a total bed capacity of 11,513 beds. None of these institutions meets the minimum requirements of the Federal Hospital Advisory Council for a Chronic and Convalescent Hospital; they are for the most part nursing homes. Of the 11,513 beds, 574 were in the tuberculosis unit at Oak Forest and 374 were in rest homes licensed by the Department of Public Welfare for the care of neuropsychiatric cases.

CHRONIC AND CONVALESCENT INSTITUTIONS AND BEDS, BY CONTROL, ILLINOIS, 1945

Control	Institutions		Beds			
			Number		Per Cent of Total	
	Number	Per Cent of Total	Normal	Complement	Normal	Complement
All Institutions	362	100.0	11,521	11,513	100.0	100.0
Nonprofit	68	18.8	4,540	4,379	39.4	38.0
Proprietary	274	75.7	4,187	4,206	36.3	36.5
Governmental	20	5.5	2,794	2,928	24.3	25.4

SELECTED STATISTICS FOR CHRONIC AND CONVALESCENT, BY CONTROL, ILLINOIS, 1945

Control	Number of Institutions	Bed Complement	Admissions	Patient Days	Average Census	Per Cent Occupancy
All Institutions	362	11,513	7,639	2,352,048	6,444.0	56.0
Nonprofit	68	4,379	4,199	1,161,075	3,181.0	72.6
Proprietary	274	4,206	2,927	935,050	2,561.8	60.9
Governmental	20	2,928	513	255,923	701.2	23.9

While the per cent occupancy for this entire group is low we should realize that for the most part they are small institutions and consequently would have a low rate. In this type of institution the

[1]Ibid, page 39, Section II, "Health Service Personnel and Facilities in Illinois," Chapter II, Topic D.

death rate is quite high due to the large percentage of terminal illness cases and aged in the institutions. The institutions had 3,395 workers, 84.5 per cent of whom were full-time employees. The average per diem cost of operation among these institutions was $1.81 which figure was based on incomplete reporting and for the most part was based on estimates furnished by the owner.

Recommendations Concerning Chronic and Convalescent Facilities[1]

The Illinois Hospital Survey has had the advantage of and has relied heavily upon the findings of the Committee to Investigate Chronic Disease Among Indigents established by the Sixty-third General Assembly in considering the care of the chronically ill. The data of the Hospital Survey is incomplete both in the number of chronically ill patients cared for in present facilities and the number of beds available for this kind of care in present facilities. Very few of the Illinois hospitals completing schedules indicate that chronically ill patients are admitted for care and no census of chronically ill patients was obtained from the hospitals.

In testimony before the Public Hearing in Springfield on April 10, 1945 the conservative estimate was made that, in addition to family-provided care in homes, facilities are needed in nursing homes and institutions to provide care for 35,000 to 40,000 invalids in Illinois, 25,000 of whom are now in need of financial assistance or will be if the levels of employment and wages decline. This problem has the enormity of that of providing for the care of tuberculosis and mentally ill patients with the additional complexity that no state facilities to provide care are available to the large group unable to earn and finance care. This difficult problem will become further accentuated as the average life expectancy increases.

Additional general hospital beds will palliate the present acute condition but will not be the final answer to the problem. Conversely, the seemingly great need for acute beds in general hospitals would become more in focus of the actual needs if adequate facilities for the care of the chronically ill were otherwise provided. The co-operation of two well-managed, above-average general hospitals was obtained in the consideration of this problem. An analysis of the patient census of these two hospitals considered the age of the patient, the diagnosis, and the date of admission to the hospital. This study significantly revealed that approximately 20 per cent of the patient census is chronically ill. No one will question that the exacerbation of chronic illness are cases only for the general hospitals with therapeutic equipment, laboratory facili-

[1]Ibid, page 54, Section IV, "The Illinois State Plan," Topic D.

ties, and geared-up nursing and trained personnel. No one can deny that the chronically ill patients in general hospitals are utilizing beds and personnel needed for acute illness care at costs that are extravagant and resources depleting in the light of their illnesses.

The information that is available in Illinois concerning facilities for care of the chronically ill and convalescent indicates that studies should be directed toward the following possibilities:

1. Use of general hospitals for diagnosis and intensive treatment only.
2. That the nonacute chronically ill and convalescent patient be provided for in special wings of general hospitals or in separate institutions having a liaison relationship with the general hospital. The appointments of such wing or institution should conform to the type of illness being cared for with emphasis on occupational, rehabilitative, and recreational therapy.
3. A special hospital in affiliation with a teaching institution in order to emphasize both education of physicians and research in the incapacitating diseases.
4. State payment for care of residents afflicted with chronic disease or permanent impairment who are financially unable to pay for such care.
5. Conversion of county homes to desirable facilities for care of the chronically ill with a liaison relationship with a general hospital as provided in the Rennick-Laughlin Bills.
6. Raising standards for licensing nursing homes with close supervision of such homes and strengthening the educational and consultation aspects of the licensure program.
7. Extension of visiting nurse services to each county of the State in order to facilitate home care of the chronically ill or long-term care convalescent.

Public Law 725, the Hospital Survey and Construction Act, provides for construction of Chronic Disease Hospitals to the extent of 2 beds per 1,000 population. On the basis of the 1945 estimated civilian population (7,548,109) the Illinois State Plan, therefore, may allocate a total of 15,096 beds for the long-term convalescent and chronically ill patient. These facilities must be hospital facilities where intensive medical and nursing supervision are carried out in distinction to nursing homes where the domiciliary aspect of care predominates and medical treatment furnished is only incidental.

Of the facilities analyzed in the Survey there were 388 acceptable hospital beds for chronic and long-term convalescent patients. The deficit is 14,708 hospital beds; of this number the State Plan allocates 3,724

as chronic units of existing general hospitals and 200 are allocated to the research and educational institutions in Chicago.

In view of the fact that the federal grants-in-aid for hospital construction are limited to an amount that will scarcely permit substantial progress toward construction of needed general hospitals, especially in rural areas, and in view of the fact that few communities are ready to assume their full responsibility in medical, nursing, medical social, and physical rehabilitation programs for persons afflicted with long-term illness, the Illinois Hospital Plan at the time of the 1946-47 analysis does not recommend a pattern for state-wide distribution of the total number of allowable beds and facilities for long-term patients. The plan holds as a book figure 10,784 chronic disease hospital beds, the allocation of which by geographical area awaits the accumulation of more evidence on the expected use for such facilities in local communities.

SECTION X

CHICAGO-COOK COUNTY HEALTH SURVEY REPORT ON THE CHRONICALLY ILL[1]

By Edward T. Thompson, M.D., Senior Surgeon, United States Public Health Service, Chief of Section on Hospitals, Clinics, and Medical Care, Chicago-Cook County Health Survey.

Introduction

Chronic illness has been designated by the Surgeon General of the United States Public Health Service as the number one health problem of the nation. Unfortunately the full import of the seriousness of the problem is not generally recognized. The urgency of the situation lies in the fact that the ratio of the number of chronic invalids to the able-bodied in the population is continually increasing. Through advances in medical science the span of human life is being steadily lengthened with the result that each year finds a larger proportion of the people living to those ages when chronic diseases take a heavy toll.

In general chronic diseases begin insidiously and progress slowly. With the passing of time the disabling affects of the disease gradually increase in severity until the patient becomes permanently incapacitated. All ages are affected although the incidence of chronic illness is highest among the aged.

Almost invariably chronic disease brings in its train economic and social complications. During long-term illnesses financial resources may be rapidly dissipated. Even in families in comfortable circumstances under ordinary conditions serious economic problems may arise when some member of the family becomes chronically ill. With the number of permanent invalids increasing every year the problems of the chronically ill can no longer be considered as individual or family matters. They must be recognized as a community responsibility and must be dealt with in terms of prevention and rehabilitation as well as of adequate care.

Advances in medicine have contributed greatly in the control of some chronic diseases, notably in diabetes and pernicious anemia, and

[1]Reproduced by permission. The Survey was made in 1946

future research holds the hope of alleviation and control of other forms. To this end the medical profession should devote more time to study and research in the cause and control of various forms of these diseases.

Adequate provision for the chronically ill is an essential part of any general community program of public health. In constructive planning for medical care in the Chicago-Cook County area this problem should be given major emphasis. Ways and means must be found to provide competent care for all persons suffering from long-term illnesses regardless of their age, sex, funds, race or creed. The need in this area is urgent.

Extent of Chronic Illness in Chicago and Cook County

A comprehensive study of the prevalence of chronic illness among the population of Chicago and Cook County was beyond the scope of this Survey. Sufficient information is available, however, from which the magnitude of the problem in this area may be reasonably accurately determined for purposes of practical planning. On the basis of the frequency of occurrence of chronic ill health among specific age groups as reported in the National Health Survey of 1935-1937,[1] estimates of the number of persons disabled from chronic disease have been derived separately for Chicago and for Cook County exclusive of Chicago. These estimates are given in Table 1. It will be noted from the table that in Cook County including Chicago it is estimated there are approximately 758,000 persons suffering from chronic diseases or permanent impairments which keep the individual away from his work or usual pursuits to the extent that the disorder is considered handicapping. Of this number at least 49,000 are disabled for such long periods of time that they constitute an invalid population although they are not necessarily helpless or bedridden. The term "chronically ill" refers to these permanently disabled persons and it is with the problems of their care that this section deals.

Estimates for the City of Chicago alone indicate that 635,000 persons have some chronic disease or serious impairment and that by reason of these disorders approximately 41,000 of them are chronically ill. In Cook County exclusive of Chicago it is estimated that more than 123,000 persons are suffering from chronic diseases or permanent impairments of whom about 8,000 are chronically ill.

Chronic diseases are not confined to any specific age group. They affect all ages but place a heavy burden upon the productive years of

[1]The National Health Survey: 1935-1936, The Magnitude of the Chronic Disease Problem in the United States, Division of Public Health Methods National Institute of Health, United States Public Health Service, 1938, Bulletin No. 6.

life. In the Chicago-Cook County area 60 per cent of the number estimated to be permanently disabled from chronic diseases are between 25 and 64 years of age. Even in the young age groups the incidence of chronic invalidism is not negligible but after the age of 40 it increases markedly and shows a close relationship with the coming of old age. Since the elderly are constituting a larger and larger proportion of the general population, it is evident that the volume of chronic invalidism is year by year becoming greater.

TABLE 1. ESTIMATED NUMBER OF PERSONS IN SPECIFIED AGE GROUPS (1) WITH CHRONIC DISEASE OR PERMANENT IMPAIRMENT AND (2) CHRONICALLY ILL*

AGE GROUPS (in years)	Persons with Some Chronic Disease or Permanent Impairment		Chronically Ill	
	Number	Per Cent	Number	Per Cent
Cook County, including Chicago	757,916		49,066	
Chicago				
All ages	634,226	100.0	40,951	100.0
Under 5	7,289	1.1	405	1.0
5-14	31,207	4.9	1,416	3.4
15-24	48,145	7.6	2,613	6.4
25-34	99,060	15.6	3,485	8.5
35-44	123,217	19.4	5,798	14.1
45-54	133,068	21.0	7,641	18.7
55-64	97,242	15.3	7,852	19.2
65-74	67,644	10.7	7,748	18.9
75-84	23,877	3.8	3,380	8.3
85 and over	3,477	0.6	613	1.5
Cook County, excluding Chicago				
All ages	123,690	100.0	8,115	100.0
Under 5	1,510	1.2	84	1.0
5-14	6,888	5.6	313	3.9
15-24	9,301	7.5	505	6.2
25-34	17,645	14.3	621	7.6
35-44	24,298	19.6	1,143	14.1
45-54	25,401	20.5	1,459	18.0
55-64	18,834	15.2	1,521	18.7
65-74	13,455	10.9	1,541	19.0
75-84	5,550	4.5	786	9.7
85 and over	808	0.7	142	1.8

*Based on prevalence rates reported by National Health Survey for specific ages, 1935-1937, as applied to Chicago and Cook County population, 1940.

The magnitude of this problem comes into clearer focus when it is viewed against the progressive aging of the population. On the basis of estimates reported by the National Industrial Conference Board[1] it is anticipated that by 1980 the percentage of the population in the Cook County area living to the age of 65 years and older will have more than doubled that in 1940. Projections for the period 1940-1980 for the country as a whole and for Chicago-Cook County are as follows:

	Per Cent of Population 65 Years and Over	
	U. S. A.	Cook County Including Chicago
1940	6.8	5.8
1950	7.9	6.8
1960	10.2	8.6
1970	11.9	10.8
1980	14.4	12.3

For the City of Chicago it is possible to convert these percentage projections into estimates of the number of chronically ill persons to be expected among this older age group. Predictions of the number disabled from some form of chronic disease and the number of permanently disabled invalids among them are given in Table 2 for the years

TABLE 2. ESTIMATES OF NUMBER OF PERSONS 65 YEARS OF AGE AND OVER IN POPULATION PROJECTIONS 1950-1965 (1) WITH CHRONIC DISEASES OR PERMANENT IMPAIRMENTS AND (2) CHRONICALLY ILL, CHICAGO

	Population 65 Years and Over*	Number with Some Chronic Disease or Permanent Impairment†	Number Chronically Ill†
1940	197,079‡	94,998	11,741
1950	278,860	134,411	16,592
1960	338,250	163,037	20,126
1965	363,660	175,284	21,638

*The percentage distribution of age groups 65 years and over as estimated for the United States (Statistical Abstract of U.S.A., 1944-1945 page 25) was applied to population projections for Chicago (The Chicago Plan Commission, 1944) to determine the aged population for specified years.

†Based on prevalence rates reported by National Health Survey (1935-1937) for persons 65 years and over as applied to Chicago population in 1940 and the projections to 1965.

‡United States Bureau of the Census 1940.

[1]National Industrial Conference Board, Economic Almanac for 1943-1944.

1950, 1960, and 1965. Reference to the table shows that by 1960 it is anticipated that the population of Chicago will include 338,250 aged persons of whom more than 20,000 will be chronic invalids. This is an increase of 8,300 invalids in these older age groups during this twenty-year period. These predictions are based on the prevalence of chronic diseases and invalidism reported at the time of the National Health Survey (1935-1937). They do not take into account the fact that in the future the incidence of these diseases may be raised or that advances may be made by medical science in their control and treatment.

The seriousness of the problem is further emphasized by the fact that the chief causes of death among the middle-aged and elderly are chronic diseases. A study of the mortality statistics for Chicago for the years 1940-1944 (comparable data for Cook County exclusive of Chicago were not available for analysis at the time of this Survey) showed that of the 36,569 annual deaths during these years 25,526 were due to conditions ordinarily classified as chronic. The average number of deaths per year in various age groups from certain chronic diseases is given in Table 3. Statistics presented in the table indicate that approximately two out of every three deaths in Chicago during this five-year period occurred as a result of chronic illness in persons over 40 years of age.

The number of chronically ill persons in the Chicago-Cook County area as here estimated includes patients who are suffering from all forms of diseases commonly classified as chronic. Among the 49,000 chronically ill there are 8,900 cases of mental and nervous diseases that are in the general population or have only recently been hospitalized, and at least 2,600 tuberculosis cases that are either not in institutions or have been there for relatively short periods of time. Special facilities for the care of these two forms of chronic illness are considered separately in other sections of this Survey.[1] When these facilities are also used to provide care for other chronically ill patients they will be reviewed in this section but it is with the needs of the remaining 37,500 chronic invalids that this report is primarily concerned.

In the interest of these individual patients and of the general community it is important that the facilities for their care be progressively expanded to keep pace with the increasing numbers incapacitated by diseases and that the type of services provided be the type that the patient's condition requires.

[1]Reference is to Chapter XXIX, Mental Hygiene, and Chapter XXV, Tuberculosis, of the Chicago-Cook County Health Survey.

TABLE 3. AVERAGE NUMBER OF DEATHS ANNUALLY FROM SPECIFIED CHRONIC DISEASES ACCORDING TO AGE, CHICAGO, 1940-1944*

Cause of Death	All Ages	Age in Years					
		Under 1	1-4	5-19	20-39	40-59	60 & Over
All Causes	36,569	1,779	390	817	3,340	11,290	18,953
Certain chronic diseases: Total	25,526	9	30	184	1,255	8,088	15,960
Disease of the heart	13,501	3	6	103	657	4,105	8,627
Cancer	5,409	1	15	36	290	2,087	2,980
Nephritis	2,763	1	7	28	167	698	1,862
Cerebral hemorrhage	1,940	2	2	4	52	582	1,298
Diabetes	1,182	....	....	10	39	352	781
Cirrhosis of the liver	466	2	....	3	49	239	173
Arteriosclerosis	265	....	....	....	1	25	239

*Data from unpublished records of Chicago Health Department.

Facilities for the Care of the Chronically Ill

About a third of the chronically ill need some form of institutional care. The total number in the Chicago-Cook County area is estimated to be 12,500 persons. At the time of this Survey the combined facilities for the care of these chronically ill patients, exclusive of facilities for persons with mental diseases or tuberculosis, consisted of 207 homes and institutions and a number of hospitals in which accommodations are made available to patients suffering from chronic diseases. Included in this number are 39 homes for the aged which provide some care for chronically ill patients. Institutional facilities which are operated solely for the chronically ill, convalescents, and the handicapped are summarized in Table 4 according to the controlling auspices, the type of patients served, and bed capacity.

TABLE 4. TYPE AND NUMBER OF AGENCIES PROVIDING CARE FOR THE CHRONICALLY ILL, CONVALESCENT, AND HANDICAPPED AND THEIR BED CAPACITIES, COOK COUNTY AND CHICAGO*

Controlling Auspices and Location	Number of Agencies Providing Care for Specified Types of Patients					Number of Beds
	Total	Chronically Ill		Convalescent	Handicapped	
		Ambulant	Other			
TOTAL	168	55	89	8	16	4,420
Governmental Institutions	4	1	1	1	1	1,453
Nonprofit homes	21	2	3	7	9	990
Proprietary homes	143	52	85	....	6	1,977
Chicago	137	54	64	6	13	2,716
Governmental Institutions	3	1	....	1	1	354
Nonprofit homes	18	2	3	5	8	900
Proprietary homes	116	51	61	....	4	1,462
Cook County						
Excluding Chicago	31	1	25	2	3	1,704
Governmental Institutions	1	....	1†	....	....	1,099†
Nonprofit homes	3	....	....	2	1	90
Proprietary homes	27	1	24	....	2	515

*Exclusive of institutions for patients with mental diseases and tuberculosis and 39 homes for the aged having a total capacity of 5,692 beds of which 1,296 are available for the chronically ill.
†Cook County Infirmary at Oak Forest, chronic disease section.

It will be noted from the table that the majority of the facilities are operated for profit as proprietary nursing homes and that most of these offer care to nonambulant patients. There are 143 proprietary homes with a total bed capacity of 1,977 or an average of about 13

beds per home. Capacities of these homes vary from a few beds to over 100, the average of the 60 smallest being less than 10 beds per home.

Under the control of private voluntary agencies there are 21 homes, 16 of which are primarily for convalescents or handicapped persons. The total bed capacity of these nonprofit homes is 990 beds with an average of 47 beds in each institution.

The four tax-supported institutions have a capacity of 1,453 beds, each institution providing care for a different type of patient—the ambulant chronically ill, the nonambulant, the convalescent, and the handicapped. These beds are exclusive of those in the institutions which are for the care of tuberculosis cases.

In the homes for the aged it is estimated that not more than 20 per cent of their bed capacity is available to the chronically ill. Most of the homes for the aged refuse admission to an applicant who is sick or suffering from a chronic disease which is likely to incapacitate him, but many of them provide care for residents who become disabled after admission. Of the 5,692 beds in homes for the aged including the Cook County Infirmary at Oak Forest, it is estimated that about 1,300 are available for the care of the chronically ill. Homes for the aged in this area are, in general, maintained through the support of fraternal and religious groups. There is evidence of an increasing tendency for those in control of these institutions to recognize the importance of their part in a community plan for adequate care for the chronically ill, and it is confidently expected that in the future these homes will assume a greater share in the responsibility for the care of chronic patients.

No information was gathered from hospitals regarding the number of beds allotted to patients having chronic diseases. On the basis of findings from surveys in other communities it is estimated that at the time of this review at least 10 per cent of the beds in general and special hospitals were occupied by chronically ill patients. It is not unlikely that this ratio may be as high as 14 per cent. The hospital survey conducted by the United Hospital Fund in the New York Metropolitan area (1935-1936)[1] found 14 per cent of the total beds in voluntary and governmental hospitals were available for chronic patients. Estimates based on the 10 per cent ratio indicate that there is provision in hospitals in Cook County for the care of approximately 1,350 patients with chronic diseases excluding the tuberculosis cases.

Under the present conditions in Chicago-Cook County the combined facilities of special institutions, nursing and boarding homes,

[1]Report of the Hospital Survey for New York (New York, United Hospital Fund, 1937), p. 657.

and hospitals can provide care for 7,060 chronically ill persons—1,453 beds in governmental institutions, 990 in nonprofit homes, 1,977 in proprietary homes, 1,297 in homes for the aged, and 1,343 in general and special hospitals.

Facilities for Chronically Ill Negroes

Among the 12,500 chronic invalids in the Cook County area who require care away from their homes it is estimated that at least 1,200 of them are Negroes. At the time of the survey facilities in actual use for the chronically ill Negroes consisted of a total of 352 beds scattered through eight proprietary nursing homes, two homes for the aged, and the Cook County Infirmary at Oak Forest. The census of the Infirmary on the day of visitation showed 15 per cent of the residents were Negroes which would indicate that approximately 165 beds for the chronic sick in this institution were occupied by Negroes. The remaining 187 available beds were all located in the City of Chicago and were distributed as follows: 178 in proprietary nursing homes and 9 in homes for the aged.

Cook County Infirmary, Oak Forest

As the Cook County Infirmary at Oak Forest is the largest "home" in Chicago-Cook County it merits special attention in this Survey of facilities. The Infirmary was established in 1910 as a county poor farm, but through the years it has gradually undergone a change of function and today operates mainly as a home for the chronically ill. It has a bed capacity of 3,145 of which 1,099 beds are in the chronic disease hospital section, 576 beds in the tuberculosis hospital section, and 1,470 beds in the wards designed for domiciliary care only.

The chronic disease section operates at full capacity at all times and as of July 1, 1946 had a waiting list of 83. The occupancy rate in the tuberculosis division is generally around 50 per cent, the census on July 15, 1946 being 252. In the general section on this date there were 1,043 residents, an occupancy rate of 71 per cent.

Conditions under which the chronically ill patients are cared for are not satisfactory. The wards are large and greatly overcrowded, many of them failing to provide enough space to move around the beds. Facilities for the patients' personal belongings are conspicuously absent. From a physical standpoint the buildings are generally well maintained with the exception of insufficient and unsatisfactory arrangements for the removal of bed patients in case of fire. Painting of the institution was in process at the time of visitation. From even

casual observation it was evident that the standard of housekeeping left much to be desired. Flies were prevalent, particularly in the butcher shop, the kitchen, and the dining room. Food did not appear appetizing and the serving of it was poor. For example, bread to be eaten at the evening meal was already on the patients' trays at 3 P. M. and uncovered.

Lack of trained help is everywhere apparent. On the day of visitation the woeful shortage of professional personnel, both medical and nursing, was particularly impressive. Chronically ill patients require a large amount of personal care. Many can neither feed themselves nor take care of their bodily needs. According to reports it has been frequently necessary to assign ambulatory patients to assist the bedridden. Such care is inefficient, insufficient, and often harmful.

Seven resident physicians are employed by the institution for the daily care of the patients. This is equivalent to an average of 200 patients for each physician which is a patient load beyond both his professional ability and the time permitted. Consulting physicians are available for weekly consultations except in one or two medical specialties.

The shortage of graduate nurses in the institution is critical. In the tuberculosis section at the time of the Survey there were eight graduate nurses, four of them acting as supervisors. This permits less than three graduate nurses for each eight-hour shift and provides one professional nurse for the care of 84 patients. In the infirmary hospital section there were 14 graduate nurses, nine of whom serve as supervisors. During each eight-hour shift, therefore, there are less than five professional nurses on duty or one graduate nurse to 220 patients.

The nursing staff is augmented by 114 nonprofessional nurses' aides. Of this number 33 are assigned to the tuberculosis section which is an average of one aide to assist in the care of 7.6 patients. The remaining 81 serve in the infirmary section, an average of one nurse's aide to 13 patients.

Shortage of personnel is not due to insufficient funds. The institution reports funds available to employ at least 45 additional nurses and much more nonprofessional help. The total budget, however, is still small. Even if all the positions were filled, the number of employees would be insufficient to render the care necessary to meet the requirements of an approved, well-managed institution.

The Infirmary is provisionally approved by the American College of Surgeons. It is also on the register of the American Medical Association but it has not been approved for either interne or residency training. It has not been approved by the Illinois Public Aid Commis-

sion for the care of the dependent chronically ill. Raising standards to warrant these approvals would certainly result in better care of the patients and at the same time would permit training for internes and residents and research in the field of geriatrics. Under present conditions only slight use is being made of the wealth of material available for research. In the course of a year approximately 75 medical undergraduates serve clerkships at the institution. The unique opportunity of the Cook County Infirmary for group studies, teaching, and training in geriatrics should be extended to medical students, both undergraduates and graduates, through affiliation of the institution with medical schools and through further expansion of staff privileges.

The present salary scale compares very favorably with the scale elsewhere but the location of the institution is not attractive to prospective employees. They feel that they will be too far away from Chicago activities. The lack of approval by the national professional associations also militates against obtaining professional help. A further deterrent is the fact that the nature of the cases hospitalized does not appeal to many persons, neither professional nor nonprofessional. Association with chronic invalids is depressing to many people, and as employment in more desirable institutions is easily obtainable applicants for work in the Infirmary are few.

The Need for Beds for the Chronically Ill

To meet the needs of the chronically ill in Chicago-Cook County this survey of existing facilities has shown that about 7,060 beds are available. On the assumption that approximately a third of the 37,500 chronic invalids in this area or 12,500 persons require some form of institutional care, it is evident that there is at this time a deficiency of 5,500 beds.

This estimate is considered to be very conservative. If the needs were determined on the basis of 3.3 beds per 1,000 population, which is the rate recently established by the Wilder Charities[1] of St. Paul, Minnesota, as the minimum for the care of the chronically ill, the estimated number of beds required for this area would be raised to 13,409. The deficiency of beds would thus be increased by 1,500 to a total of 7,000 beds. The current report (1947) of the Hospital Council of Greater New York establishes a rate of 3 beds per 1,000 population for the chronically ill. A similar study made in Cleveland in 1944 established a ratio of 4 beds per thousand.

In addition to the beds needed to care for the chronically ill, at

[1]Allen Stone, *Problems of Chronically Ill Patients* (St. Paul, Minnesota, Wilder Charities, October 1945).

least 3,500 beds are required for the mentally ill exclusive of those already in institutions. As previously mentioned, according to the prevalence rates for disabling nervous and mental diseases reported in the National Health Survey it is estimated that there are at least 8,900 mentally ill persons in this area who are in the general population and not yet hospitalized or have only recently entered an institution. Of this number approximately half or 4,450 cases are assumed to need institutional care. The need for beds for these patients was not considered in the estimate of additional beds required in mental institutions discussed in Chapter XXIX of this Survey (Mental Hygiene). The combined facilities of the community, exclusive of the overcrowded tax-supported institutions, can provide for less than 800 patients. These available beds are distributed as follows: 274 in nonprofit and proprietary homes and about 520 in general hospitals.

The requirement for tuberculosis beds would be 4,915. This figure is based upon the National Tuberculosis Association figures of 2.5 beds per death and gross deaths of 1,966 from tuberculosis for Chicago and Cook County in 1944. The following beds for tuberculosis are now available: in local governmental hospitals, 2,259; in federal governmental hospitals, 294; and in voluntary hospitals, 87. These available beds total 2,640 or 2,275 beds less than the 4,915 needed.

The total deficiency of beds for the care of chronically ill adults and children, exclusive of tuberculous and mentally ill patients already hospitalized, is estimated to be at least 12,000 beds.

Although the potential demand for beds for the chronically ill among the Negroes is included in the estimated over-all need, the serious shortage of facilities for the Negro under existing admitting policies of some institutions should be recognized. At the time of the survey only 352 beds were available for the 1,200 chronically ill Negroes requiring care outside of their homes, which is less than a third of the estimated number needed for them.

Quality of the Facilities and Their Services

Quality of service is so intangible that without a detailed investigation of each home it can not be adequately appraised. As time and personnel did not permit such inspection, appraisal of the facilities and their services for the chronically ill has been based on general interpretation of the physical conditions and specific acts of commission and of omission as observed by the United States Public Health Survey representatives or as reported to them.

The type of facility providing the service is in too many instances not suitable for the care of the chronically ill. Many of the proprietary homes have been converted from family dwellings into small nursing homes. Of the 143 proprietary homes 60 of them have an average capacity of less than 10 beds. Many of the homes lack adequate plumbing, have no isolation facilities, and present dangerous fire hazards due to the absence of adequate egress for bed patients. Many of them are unable to meet the requirements specified by the Municipal Building Code, the Board of Health, and/or the City Fire Department. At the time of the Survey only 19 of the proprietary homes were licensed to operate as nursing homes. The others continue to so function despite their inadequacies. Their failure to qualify for licensure, however, is not always due to deficiencies in the homes. Not infrequently it is the resultant of ambiguities and inadequacies in the Municipal Codes.

Overcrowding is common in all the homes, a condition which works to the detriment of the quality of the service rendered. Reports submitted to the Survey indicate that they operate at maximum capacity at all times and some of them have waiting lists so long that a delay of months is usual.

Lack of personnel, both trained and untrained, has also adversely affected the quality of care and is seriously retarding any efforts toward an improvement in the services offered. Figures show that a number of homes have been forced to discontinue operation because of their inability to obtain sufficient trained personnel to serve the essential needs of their residents.

From the professional viewpoint the medical care programs of the various homes and institutions leave much to be desired. Resident physicians are employed by seven of them. Attending physicians visit regularly in 42 institutions and are on call when medical service is needed in 125 others. No information regarding the frequency of visits by a physician was obtained from the remaining homes. Of the homes having an attending physician, 14 of them report daily visits, two of them three visits a week, one of them two visits a week, 14 a weekly visit, and the remaining 11 have visits at longer intervals.

Occupational therapy and physiotherapy are generally not provided by the institutions and little if any effort is made to restore impaired function. With rare exceptions these homes and institutions have no arrangements for keeping the residents active and interested in their daily life. Entertainment is almost entirely limited to social intercourse and the radio.

Standards and Licensure

The findings of this Survey have clearly indicated the urgent need in the Cook County area for raising the standards of care for the chronically ill. The community is not unaware of the situation and has made some material advances toward the promotion of good facilities. Through the co-operation of the Council of Social Agencies, The Institute of Medicine of Chicago, and the Community Fund of Chicago a special agency was established in 1944 for the specific purpose of fostering adequate care for the chronically ill. Since its organization this agency, known as The Central Service for the Chronically Ill, has directed its efforts toward an appraisal of existing facilities and the development of standard-setting materials. Long-range problems can not be solved in a few months but definite progress is being made by the agency. Through its educational activities with the general public and with various professional groups and its special educational programs for operators and prospective operators of nursing homes the agency is disseminating practical information and stimulating effective community planning for the care of the chronically ill. The work of this agency should be commended and heartily supported by the community.

No formulation of criteria for the proper care of the chronically ill in nursing homes and other institutions exists at the present time. At the request of the Illinois State Legislative Commission on the Care of Chronically Ill Persons a specific statement of standards is now being prepared by a joint committee which includes representatives of hospital organizations, the medical profession, and The Central Service for the Chronically Ill of The Institute of Medicine of Chicago.

A further approach to the problem in this area has been through licensure but thus far the results have not been satisfactory. Illinois has a law which requires licensure of homes providing care for the chronically ill and places the responsibility for inspection on the State Department of Public Health. The procedures prescribed by the statute seem to be satisfactory but the law applies only within a limited area in Cook County due to the fact that communities having their own licensing ordinances are permitted to operate under their individual ordinances. In Chicago, Evanston, and some smaller municipalities in Cook County licensure is administered according to the special legal requirements of these communities. Results in the Chicago area show a needlessly complicated and an exceedingly confused situation.

Nursing homes operated within the city limits of Chicago are subject to municipal licensure under ordinances adopted by the City Council. Before a license can be obtained inspection must satisfy the require-

ments of the Health Department, the Department of Buildings, the Fire Department, and the Departments of Streets and Electricity. Citations of the specific requirements for licensure are scattered through twelve[1] different chapters of the Municipal Code. It is consequently often difficult to ascertain just what are the requisites. The situation is further confused by the lack of co-ordination among the several departments in formulating and enforcing their requirements. With the procedures for qualifying for a license so numerous and involved the home operators frequently find they are unable to interpret them, to say nothing of meeting the requirements.

Confusion in interpretation of municipal requirements is a major stumbling block in the way of improving the exisiting facilities for the care of the chronically ill in Chicago. When events focus unfavorable public attention upon nursing homes and institutions, those that have applied for licenses and have made an earnest attempt to comply with all requirements have to bear the brunt of the charges. Under the present conditions such criticisms against the licensed homes are obviously unfair. A genuinely co-operative attitude on the part of the licensing and inspecting authorities in assisting home operators to interpret the complicated requirements would be a significant step toward improving the situation. As long as confusion in the licensing procedures and conflicts between departmental requirements continue, however, little hope for real improvement of conditions can be anticipated in Chicago.

In recent years the concentration of attention by both medical and lay groups upon the problems of the chronic invalid has served to emphasize the need for higher standards of care and facilities. Licensure through a state agency has been considered a likely means of attaining these objectives and in this area efforts have been made to establish a comprehensive state licensure law. Continued and continuous activity in this direction is advocated, but it will not provide the whole answer.

Economic Aspects of the Problem

Under the economic conditions existing in 1946 it is estimated that one third of the chronic invalids residing in the Cook County area are in need of financial assistance in meeting part or all of the cost of their care. The chronically ill who can meet the full cost of their care are limited in the purchase of services solely by the availability of facilities. Those who can pay only a part of the cost have the additional problem of financial resources. These patients include persons who have some funds of their own and persons who received financial assistance from relatives or friends and who in addition require some help from private

[1]For example, requirements are given in Chapters 8, 40, 43, 47, 48, 49, 66, 67, 81, 90, 101, 136

charity or public assistance. Invalids who can contribute nothing at all from their own or family resources toward the cost of care are usually provided for in governmental institutions or through public assistance payments, which are then used to pay for care in the patient's own home or in a proprietary nursing home.

The chronically ill who are recipients of public assistance grants to the blind, the aged, and dependent children may obtain care in any suitable institution, public or private, under the provisions of the Illinois Public Aid Commission. Provision for medical care for persons on the relief rolls in Chicago and Cicero is the responsibility of the relief authorities in these communities. For other invalids in Chicago and Cicero who are medically indigent but who are not eligible for the specified types of public assistance, the responsibility rests upon the Cook County authorities who make arrangements for their care in the Cook County Hospital or the Cook County Infirmary at Oak Forest. These residents of Chicago and Cicero can not be cared for at public expense in other institutions or nursing homes. As the Cook County Infirmary is occupied to capacity and has a long waiting list with a slow rate of turnover, a large group of the medically indigent chronically ill must depend for any care they may secure upon private charitable agencies and hospitals or upon relatives and friends.

Payment by public agencies to institutions providing care for the chronically ill is set at so low a level that a high quality of care can not be furnished for the amount received. Theoretically the public agencies increased the per capita payments in 1945 from $40 to $60 a month, but only recently has any change been effected and, in general, practice services are still paid for at the lower rate. Too frequently this low allowance has set the standard for the services offered by the institutions.

There is considerable variation in the amounts charged for care by the different homes and institutions. In 23 homes service is either provided without charge or the fee is adjusted to the patient's ability to pay for the service. Comparable information was not obtained from all of the 207 nursing homes and institutions, but the large majority of them operate on a more or less definitely established monthly rate. At the time of this Survey the range in these monthly rates was from less than $40 to over $200. These figures represent the minimal rates charged patients requiring the least expensive service. A distribution of the charges reported by 166 of the homes and institutions is shown in Table 5. It will be observed from the table that in most of the homes the charge for care did not exceed $100 per month and in a fourth of them it was not more than $60 a month.

In many instances the fees charged patients are not determined by the actual cost of the service. Many home managers not knowing their operating costs base their charges upon the patient's ability to pay. When the income received is inadequate to meet costs the quality of the care is correspondingly reduced.

In addition to the homes and institutions which furnish service on a monthly basis there are a number which have a lump-sum admission charge. These are homes for the aged where the management agrees to provide care for as long as the person lives. Some of these homes do not have a definite fee but require that accepted applicants sign over all their financial assets to the institution. The admission charges reported by 20 of the homes for aged are summarized in Table 6.

TABLE 5. MINIMAL MONTHLY CHARGES PER PATIENT REPORTED BY 166 HOMES AND INSTITUTIONS FOR CARE OF CHRONICALLY ILL, COOK COUNTY AREA, 1946

Minimal Monthly Charges	Number of Homes
TOTAL	166
$40 or less	11
41-60	31
61-75	27
76-100	28
101-125	26
126-150	10
151-200	28
Over 200	5

TABLE 6. LUMP-SUM PAYMENTS REQUIRED AS ADMISSION FEES BY 20 HOMES FOR THE AGED, COOK COUNTY AREA, 1946

Admission Charge	Number of Homes
TOTAL	20
$ 500 or less	8
500 plus any financial assets	2
1,000	8
1,500	1
5,000	1

Future planning for the chronically ill in Chicago-Cook County must provide opportunities for adequate care for an increasing number of chronic sufferers. The community must accept the responsibility for

care at public expense of those who are medically indigent by making full use of its combined resources of voluntary, private, and governmental agencies. More than half of all chronic invalids in the area are able to pay for the services they require. Increased bed capacity in the voluntary or proprietary institutions should be made available for them. Those financially unable to pay should be entitled to care in governmental institutions or in other institutions at government expense. Adherence to such a policy would help to maintain an even occupancy level in all institutions and homes at all times. Overcrowding in times of prosperity of the private and proprietary facilities with low occupancy of governmental institutions and the reverse in time of depression could thereby be avoided.

Home Care for the Chronically Ill

Many chronic invalids with the necessary assistance could remain in their homes and be given adequate care. It has been estimated that of those who have not been institutionalized 45 per cent of the chronically ill are living at home either alone or with spouse or parents, 40 per cent are living with their children, and the remaining 15 per cent reside in rooming houses, boarding homes, and hotels.

Regular medical care and nursing service are required for these patients. Some patients will need constant service in their homes, others who are ambulatory may require only occasional home care. Various organizations with field nurses render some service to chronic invalids if such persons reside in homes where these organizations happen to function but the main nursing load in this area is carried by the Visiting Nurses' Association. They report that their case load of chronic patients is at present so heavy that the Association has found it necessary to reduce the number of visits permitted to each invalid in order to spread the service more widely over the field. In 1945 approximately 75,000 home visits to chronic patients were made by the nurses of this agency, which was about 30 per cent of the total number of home visits made by their nurses. The Association reports that it can neither meet the requests nor the tremendous need for home nursing service to the chronically ill.

Housekeeping and nutritional services, occupational and physical therapy, and other adjuncts to care for chronic invalids in their homes are practically nonexistent in this area. Extension of visiting nurse, housekeeping, and other services must be depended upon as the most effective means of providing satisfactory care for the large number of chronic invalids who live in their own homes or are single boarders. Such services, particularly if associated with clinics or outpatient departments, will materially reduce the demand for institutional care.

The development of housing facilities for families with chronic invalids on the outlying borders of medical center areas such as is contemplated by the Illinois State Medical Center will make clinic services easily available and within the reach of the ambulatory chronically ill. The increase of facilities for custodial care of chronic invalids, while necessary and desirable, should not be considered as a replacement of home care but only as supplementary to it.

Rehabilitation

In any program for the care of the chronically ill consideration must be given to rehabilitation because of the contribution it can make toward improving the patient's condition. Rehabilitation refers to restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which such persons are capable. As a connecting link between medical care and the return of the patient to economic self-sufficiency it presents a tremendous challenge to the community and to all interested agencies. It is a fertile and almost untouched field in Chicago and Cook County. No rehabilitation center with workshops and similar types of equipment has been established in this area as has been done in a number of other cities, notably in Milwaukee, Cleveland, Boston, New York City, and Hartford, Connecticut. A few sporadic attempts have been made by some agencies in the area such as the Goodwill Industries. These, however, reach a very limited number of the large group of disabled persons who should have such an opportunity.

The State Division of Vocational Rehabilitation in joint participation with the Federal Government through the Federal Security Agency Office of Vocational Rehabilitation is at present functioning in this area with major emphasis upon vocational advice and counseling. No artificial or "made" work enters into this program. Employment is obtained in private business and industry and in government positions on the customary business basis. Training is provided in public and private schools through vocational courses and actual training on the job. The disabled person is not required to pay fees or contribute toward the cost of vocational guidance, counseling, psychological tests, and placement or for medical examination. For all other services including medical and surgical services or hospital care the client is expected to pay to the extent that his financial resources will permit. To be acceptable cases must be shown by medical examination to be remediable and relatively stable. Although the Federal Rehabilitation program calls for "early location of persons in need of rehabilitation to prevent effects of idleness and hopelessness," the local state office has not yet provided

case-finding facilities whereby the initiative can be taken in discovering persons eligible for the service.

Preliminary steps for the establishment of a rehabilitation center modeled after those in Milwaukee and Cleveland have been taken by the Committee for the Handicapped of the Council of Social Agencies of Chicago. Efforts will be centered upon providing prompt and competent treatment and the early return of disabled individuals to gainful employment. The plan calls for the establishment of curative, adjustment, and production workshops.

The place of industry in rehabilitation is more than one of sympathetic understanding. Its role should include active co-operation and participation for it is to industry that the chronic invalid must look for "on the job training" and for placement commensurate with his ability to perform.

During the war the demands of the armed forces for man power forced industry to employ persons with some form of physical handicap. Sufficient data from this experience have been gathered to demonstrate that such a procedure is advantageous as well as entirely practicable. Indeed, some employers have found that the work turned out by handicapped personnel is in many instances of such superior quality as to justify a definite employment policy in placing partially disabled applicants wherever possible. The proportion of the handicapped who can not be utilized or rehabilitated for employment is relatively small.

Chicago and Cook County comprise a great industrial center. Certainly in this area it is in the interest of the public that the employable among the physically handicapped be utilized to the greatest possible extent. Industry and society as a whole should realize that it is far more economical to rehabilitate and utilize a physically handicapped person than to support him in idleness.

Research and Teaching

Although it is an accepted scientific fact that much of the prevalent chronic illness could have been prevented by early diagnosis and treatment, yet needless invalidism is allowed to continue because of the lack of adequate diagnostic and therapeutic facilities. How many disabled persons could have been saved from chronic invalidism is not known and can not be estimated. Unquestionably from the economic standpoint alone a heavy burden is imposed upon the community by this failure to provide preventive facilities.

With the exception of a minimal amount of undergraduate medical teaching in the Cook County Infirmary at Oak Forest, no advantage is taken of the exceptional resources and opportunities for instruction

and research in this area. Practically no utilization for post- or undergraduate study is made of the many invalids who are residents of institutions and homes for the chronically ill and there is no program of clinic study or research in effect at any of these facilities. In view of the increasing public concern regarding the problems of the chronically ill, the medical and civic authorities must recognize their responsibility for initiating and encouraging extensive research and study in the fields of geriatrics and the various chronic diseases.

Summary and Recommendations

The findings of this Survey have indicated that chronic illness is one of the major problems confronting the private, voluntary, and public health and welfare authorities in the Greater Chicago area and that the problem is continuous and expanding. In future planning for the chronically ill special consideration should be given to provision for different types of care according to the medical needs of the patient. These should include facilities associated with medical centers where services are available for diagnosis and therapy and where research in chronic diseases may be carried on; facilities where care can be furnished to patients who do not need diagnosis or therapy, but who do require personal attention and nursing service with a small amount of medical care which should include supervision and periodic re-examinations by competent physicians; and facilities which provide for rehabilitation.

To lay the foundation for a comprehensive program for adequate care for the chronically ill it is recommended:

1. That 12,000 additional beds be provided for chronically ill patients, these to be distributed as follows:
   a. For chronic invalids, 5,500 beds.
   b. For the mentally ill who have not entered institutions, 3,500 beds. (For institutional requirements see Chapter XXIX of this Survey, Mental Hygiene.)
   c. For tuberculous patients, 3,000 beds.[1] (For details see Chapter XXV of this Survey, Tuberculosis.)
2. That 4,500 beds for the chronic invalids be secured by general expansion of facilities:
   a. In nursing homes.
   b. By converting the Oak Forest Infirmary into an institution for chronic invalids with the exception of the section to be reserved for a general hospital unit.
   c. By encouraging increased provision for the chronically ill in homes for the aged.

[1]This figure allows for replacement of about 800 obsolescent existing beds.

3. That beds for chronic diseases totaling approximately 1,000 be established as units in connection with modern hospitals; these hospital units to be affiliated with medical schools where both research and teaching in chronic diseases may be emphasized or near to and associated with hospital centers.
4. That beds for children with chronic diseases totaling approximately 125 be established as units in connection with modern hospitals either as a part of a unit for the chronically ill adult or as a separate unit for children; these hospital units to be affiliated with medical schools where both research and teaching in chronic diseases may be emphasized or near to and associated with hospital centers.
5. That a section of the Cook County Infirmary at Oak Forest be converted into a branch general hospital unit of Cook County Hospital to provide service for the southern section of Cook County (see Recommendations of Hospital Section).
6. That the Board of County Commissioners be urged to take the necessary steps to obtain full approval for the Oak Forest Infirmary by the American Medical Association and the American College of Surgeons; and that this Infirmary then be utilized to the maximum extent for both under and postgraduate medical education; and further, that a program for clinical research in chronic diseases be developed at the Infirmary.
7. That a thorough integration of the administrative functions and the medical service and organization of the Cook County Hospital and the Cook County Infirmary at Oak Forest be achieved under the auspices of the proposed Hospital Commission.
8. That immediate steps be taken by the Cook County Infirmary at Oak Forest to conform to the fullest extent to the building and fire protection requirements.
9. That institutions for the care of chronic invalids should provide recreational, occupational, and physical therapy facilities for their patients with emphasis upon the restoration of normal function.
10. That a comprehensive rehabilitation center with workshops and other appropriate equipment be provided in affiliation with existing medical centers.
11. That general hospitals be encouraged to accept chronically ill patients for diagnostic and therapeutic care.
12. That existing homes for the aged offering accommodations for chronic invalids co-operate with teaching institutions to the end

that full use can be made of all teaching and research materials available in these homes.

13. That the medical profession in collaboration with The Central Service for the Chronically Ill give consideration to a broader study of the needs of the chronically ill and that The Central Service continue with increased emphasis its institutes and seminars for operators of nursing homes.
14. That the Legislative Commission on the Care of Chronically Ill Persons:
    a. Be commended for its efforts on behalf of the chronically ill.
    b. Continue and extend its activities and investigations of chronic diseases.
    c. Secure the enactment of a uniform and comprehensive state licensure law to regulate institutions in the care of the chronically ill, the law to contain licensure provisions in lieu of local licensure and to be administered by a state agency preferably the State Department of Public Health.
    d. Establish and set standards of care for chronic invalids in governmental and nongovernmental homes and institutions.
15. That necessary legislative action be taken to make available to residents in Cook County state aid for medical care to persons not on relief but who are medically indigent on the same basis that such state aid is available to the rest of the State.

SECTION XI

SANGAMON COUNTY SURVEY ON EXTENT OF CHRONIC DISEASE AND OTHER LONG-TERM ILLNESS AS OF JANUARY 1947

Conducted at the Request of the
Commission on the Care of Chronically Ill Persons

By Robert Rosenbluth, Consultant, Illinois Public Aid Commission, with the Assistance of the Physicians of Sangamon County and Welfare and Health Agencies of the Springfield Community and Sangamon County.

Foreword

The findings of the Sangamon County study of chronic invalidism typify the current situation in downstate Illinois with respect to the whole problem of care of those afflicted with chronic illness. Obviously it is the number one challenge to our ability to solve current social, economic, and health problems.

In this typical county population totaling 117,912 (1940 Census), there were at the beginning of 1947 at least 1,749 chronic invalids,[1] that is, those whose affliction is such as to require care from others. Of these 1,749 chronic invalids, there are 649[2] for whom care should be provided outside their homes.

At the present time Sangamon County has 217 available beds in nursing homes as the sole special resource for care of chronic invalids. (These also must serve for convalescent care for cases recovering from acute illnesses.) A number of chronic invalids are now being cared for in the general hospitals. Such use of general hospital facilities (aside from the comparatively brief period in which chronic invalids require intensive treatment or thorough diagnosis in general hospitals) is not

[1]The 1,749 chronic invalids reported in Sangamon County constitute 1.5 per cent of the population. This contrasts with the figures of 1.23 per cent for Chicago and 1.25 per cent for Cook County outside Chicago reported in the Chicago-Cook County Survey. But there are 8.1 per cent of the total population of Sangamon County 65 years or older as contrasted with 5.8 per cent in Cook County. Both the Sangamon County Survey and the Chicago-Cook County Survey show results considerably higher than the 1.14 per cent reported by the National Health Survey in 1935-36.

[2]The need for 649 beds for chronic invalids for care outside their own homes constitutes 5.5 beds per thousand general population.

only unduly expensive, but it means that the beds occupied by chronic invalids are not available for acute cases.

The conclusion is inescapable, therefore, that extension of facilities specially designed for chronic invalids is essential for Sangamon County. The most immediate need would be for an institution located in connection with (preferably adjacent to) one of the existing general hospitals.[1] It is necessary also both to raise the standards prevailing in existing nursing homes and to increase the number of such homes. Needed also are extension of services, such as visiting nurse and visiting housekeeper services, to care adequately for as many as possible in their own homes.

The findings demonstrate clearly that the State should take the leadership in launching a program for research into the causes of chronic disease and improved methods of treatment. The importance of early diagnosis, prompt treatment, and facilities for care in the early stages of such diseases must be stressed to prevent a rapid increase in the total number of chronic invalids, particularly in view of the increasing percentage of the aged in the general population.

Finally, a program of rehabilitation is needed, not only in the early stages but for all chronic invalids so that as many as possible may be restored to useful life or self-sufficiency, and the remaining years of the others be lifted from the dull hopelessness generally surrounding their lives. This is important also for the other members of the families with whom the chronic invalids live.

Chronic invalidism is not a problem just for the individual sufferers, but constitutes a major social and economic problem for all. It has well been characterized as "the Nation's Number One Health Problem."

Purpose of Survey

To gather more current and detailed information concerning the extent and seriousness of the problem of chronic invalidism in Illinois than the figures estimated by the predecessor Committee to Investigate Chronic Diseases Among Indigents,[2] the Commission on the Care of Chronically Ill Persons determined to make a first-hand study in one county which might typify the situation in the state outside the Chi-

[1]The Federal Hospital Survey and Construction Act limits the number of hospital beds for care of chronic invalids to 2 per thousand population. This would amount to 236 hospital beds for chronic invalids in Sangamon County which would qualify for federal aid. On this basis 413 beds would be needed in nursing homes or in other facilities of less comprehensive standards than contemplated by the Federal Hospital Act. This figure corresponds closely with the independent findings (see page 244) that 428 beds are needed in nursing homes in Sangamon County.

[2]See p. 6, *Interim Report of the Committee to Investigate Chronic Diseases Among Indigents*, presented to the Sixty-fourth General Assembly of Illinois, June 7, 1945. The figures there given were projections of the 1935-36 National Health Survey figures.

cago-Cook County area. It was felt that the findings of such a study, supplementing the information gathered in 1946 by the Chicago-Cook County Health Survey[1] for the population of that area (over 50 per cent of the population of the State), would make available valuable current information for the State as a whole.

The Sangamon County Survey was launched at a public meeting held in Springfield on October 7, 1946 to secure local interest and support. It was evident from the outset that the problem of the chronic invalid was understood by those best acquainted with the needs and resources of the county to be a problem of major medical and social importance.

Participants

Credit for the Survey rests with the physicians, clergy, welfare, and health agencies of Springfield and Sangamon County without whose co-operative interest and help it would not have been possible to gather data and assemble other information vital to the analysis. Special appreciation must be expressed to Dr. Corwin Mayes, then President of the Sangamon County Medical Society, both for his personal and professional interest in the problem and likewise to the special committee named by Dr. Mayes to co-operate in this study. Members of that special committee were Drs. Harry Otten, Nelson H. Chesnut, and James E. Graham. Acknowledgment also is given to the staff of the Sangamon County Department of Public Assistance; to the township officials administering General Relief; and to the ministers and private welfare agencies whose reports were invaluable in disclosing conditions. Dr. Henrietta Herbolsheimer and the staff of the Illinois Hospital Survey were not only most helpful in offering suggestions for the survey as such, but the access given to data in the preliminary drafts of the Illinois Hospital Survey report saved time and aided in planning the areas of inquiry for the county survey.

Reasons for Selection of Sangamon County

Sangamon County was chosen because it was central in location; with one city, Springfield, the State Capitol of 75,503 population; and with small town and farm population constituting the remainder of the county population of 117,912.

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[1]See Section X of the Appendix beginning on p. 201, which prints in full the chronic illness section of the Chicago-Cook County Health Survey.

Central Location of Sangamon County

The Illinois Business Review published by the Bureau of Economic and Business Research, College of Commerce, University of Illinois, gives this description of Springfield:

"Springfield has a number of Federal offices as well as the offices of the State Government. It is the home of a number of insurance companies and regional government offices. Industrially, Springfield has a diversified list of concerns manufacturing road and earth-moving machinery, agricultural implements, machine tools, and boilers. It is also a center of coal mining and the processing of grain and soybeans."

The characteristics of the total population are therefore similar to the general population of the State; that is, the majority lives in cities and urban areas and the remainder, for the most part, on farms.

There is another significant factor with respect to the population of Sangamon County; namely, the distribution by major age groups corresponds closely with distribution for the State as a whole. The 1940 census gives for the State and for Sangamon County the following figures:

1940 Census Statistics

		Percentage					
			15-44				
	Total Population	Under 15	Total	Male	Female	45-64	65 and over
Illinois	7,906,514	21.6	49.1	48.5	49.7	22.0	7.2
Sangamon	118,146	21.4	48.4	46.9	49.8	22.0	8.1

Particular attention is called to the fact that even in 1940, 8.1 per cent of the Sangamon County population was in the group of those 65 years and over. This is particularly significant because it reflects the expected average for 1950 for the whole State population due to increasing proportion of the aged, and therefore gives perhaps a better picture of chronic invalidism than would otherwise obtain. The Sangamon County percentage (8.1) of those 65 and over approximates also the downstate average in 1940 of 8.7 per cent. In contrast, the percentage in 1940 of those 65 and over in Cook County was 5.8. The figures for Sangamon County therefore are conservative for downstate averages, using 1940 population as a base, and can be safely used also for the whole State average as of January 1947 since we have already progressed seven years towards the expected State average for 1950.[1]

Another important reason for choosing Sangamon County for study was the fact that this county is one of the few large counties of the State which has no county home. The question therefore of adequate facilities for the care of chronic invalids is currently of especial interest since the general hospitals have to provide care which could be better and more economically given elsewhere if the facilities were available.

[1]In the *Interim Report of the Committee to Investigate Chronic Diseases Among Indigents*, attention was called to the estimated increasing percentage of aged in the total population. On page 8 the Committee quoted the National Industrial Conference Board in its "Economic Almanac" for 1943-44 which estimated that the aged population for the entire United States would increase as follows:

Year	Population 65 and Over Per Cent of Total Population
1940	6.8
1950	8.0
1960	10.1
1970	11.9
1980	14.4

The *Interim Report* on page 6 also gave the 1935-36 National Health Survey findings as to the percentage of chronic invalids by age groups and applied them to Illinois as follows:

Estimated Number of Chronic Invalids in Illinois

Age Groups	Total Population	Chronic Invalids	
		Number	Per Cent of Age Group
All Ages	7,898,000	90,200	1.14
Under 5	547,000	900	.17
5-14	1,161,000	3,000	.26
15-24	1,361,000	5,200	.38
25-34	1,327,000	6,500	.49
35-44	1,193,000	11,200	.94
45-54	1,055,000	15,000	1.42
55-64	686,000	17,200	2.51
65-74	400,000	19,200	4.81
75 and over	168,000	12,000	7.20

Methods Used

The original plan was to have township supervisors, the County Department of Public Assistance, and other health and welfare agencies fill out individual reports on patients or families known to them to be indigent and to have the physicians fill out individual records for each patient with chronic disease not known to be assisted by a public assistance or welfare agency. Because of pressure on the physicians' time, it was necessary to substitute a more general summary for the individual patient report originally contemplated (see pp. 230 and 231 for form used by welfare agencies and pp. 232 and 233 for form used by the physicians). It remains one of the unfinished tasks of the Commission to undertake a more intensive survey, as originally planned, when more time and special staff will be available. Only then will exact facts be known.

When the work actually began, many unforeseen difficulties were encountered. Most surprising was the fact that many had failed to see the full significance of the effects of chronic disease and invalidism even though they were aware of the general nature of the problem. Many cases were discovered where previously there had been "acceptance" of the situation created by the presence of a chronic invalid in the home. This "acceptance" had been taken for granted even by social workers and doctors until they reviewed the cases with particular attention to the need for care of the invalid personally and the effect on others in the household who had to care for the chronic invalids. If for no other reason, the Survey was more than worthwhile.

A second factor of major significance was revealed by the reports from the doctors. A great "reservoir" of cases of chronic invalids was discovered for whom, in the doctors' professional judgment, care was needed outside their own homes yet for whom no place was available.

Chronic Illness in the Nonindigent Population

Analysis of returns showed so large a number of chronic invalids that even after several heavy "cuts" to eliminate every possible chance of duplication the figures established a need so much greater than the resources available that the results are both startling and tragic in their significance.

For the purposes of the Survey the doctors considered only those disease categories[1] in which care was required for a period of three months or longer. Their reports are summarized in the table on p. 234.

[1]Tuberculosis is not listed in this group because there are special laws and special facilities provided for sufferers from this disease. (See special section on this subject in the very excellent report of the State Hospital Survey.) For the same reason, committable mental defect and mental disease were not included since the State maintains a series of State institutions for such cases.

FORM USED BY WELFARE AGENCIES

CONFIDENTIAL

Survey of Chronic Disease and Other Long-Term Illness in Sangamon County, Illinois

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Name.....Address.....

a. Sex: 1. Male
2. Female

b. Race: 1. White
2. Negro
3. Other

c. Marital Status: 1. Single
2. Married
3. Widowed
4. Divorced
5. Separated

d. Year of Birth:
.....

e. Diagnosis.....

f. Type of care or service now received because of physical or mental condition

1. Supervision or custodial care
2. Housekeeping service
3. Help with bathing, dressing, or feeding
4. Special treatments by a nurse (dressings, injections, etc.)

g. Now receiving care in

1. Own home or home of relatives
2. Boarding home
3. Licensed nursing home
4. Unlicensed nursing home
5. Nursing home, license status unknown
6. Nursing home not subject to licensing (less than three patients
7. Hospital

h. Care in relation to the patient's needs appears to be

1. Satisfactory

Would be satisfactory if supplemented by

2. Housekeeping service
3. Visiting nurse service
4. More frequent physician's service

Unsatisfactory; requires institutional care in

5. Nursing home or infirmary
6. General hospital care
7. State hospital

Exceeding patient's requirements; should be in

8. Nursing home or infirmary
9. Boarding home
10. Own home

i. Financial status

1. Not receiving any form of assistance

Dependent, in part or whole, on public or private assistance

2. General Relief
3. Old Age Pension
4. Aid to Dependent Children
5. Blind Assistance
6. Other

j. When did patient first require present type of care.....
Month and Year

k. How much longer is it estimated care will be required?.....
Give in Terms of Months, Years, or Life

l. Prognosis

1. Will continue to need same kind of care
2. Will require more care
3. Will improve and be able to care for self
4. Will require some care but less than now received

Date form completed..... .....
Signature and Title or Agency

FORM USED BY PHYSICIANS

Dear Doctor:

The Commission on the Care of Chronically Ill Persons has been created by the Legislature to study the needs of chronically ill persons throughout the State and to make a report to the next General Assembly. The Sangamon County Medical Society is co-operating with the Commission in making a study of the problem of chronic disease and other long-term illness in this County. Each physician is being asked to complete this report with regard only to those of his patients, without regard to age, who are not receiving Aid to Dependent Children, Blind Assistance, Old Age Pension or General Relief, since the public agencies will report on these patients.

I. How many private patients do you have who have been receiving medical treatment for each of the following disease categories for at least three months? (Include only those who require supervision or custodial care, personal care or nursing service by another person.)

	(Number)		(Number)
Carcinoma	.....	Asthma	.....
Diabetes	.....	Chest conditions other than Tuberculosis	.....
Nephritis	.....	Epilepsy	.....
Heart	.....	Physical senility	.....
Blood dyscrasia	.....	Mental senility	.....
Hypertension	.....	Other mental disease and defects	.....
Arteriosclerosis	.....	Neurological conditions	.....
Rheumatism and arthritis	.....	Urological conditions	.....
Fractures	.....	Other conditions	.....
Other orthopedic and crippling conditions	.....		

II. If, in your opinion, some of these patients are not receiving the type of nursing or personal service they need, will you please indicate how many you believe should be receiving care in a

	(Number)
Nursing Home or Infirmary	.....
General Hospital (Include patients now in hospital)	.....
Specialized Hospital	.....
State Hospital	.....
Other Care (Specify)	.....

.....

.....

.....

.....

III. Please make whatever suggestions occur to you concerning additional services or facilities which should be developed in Sangamon County to care for chronically ill and other long-term patients.....

.....

.....

Thank you for your co-operation. Will you please return this by December 1st.

Very truly yours,

Committee: Harry Otten
Nelson H. Chesnut
James E. Graham

NONINDIGENTS WITH CHRONIC DISEASE, SANGAMON COUNTY

Disease	No. of Cases
TOTAL	3,296
Hypertension	587
Heart disease	520
Arteriosclerosis	295
Rheumatism and arthritis	275
Chest conditions other than tuberculosis	264
Fractures	187
Physical senility	169
Asthma	160
Urological conditions	129
Carcinoma	108
Diabetes	106
Nephritis	96
Orthopedic and crippling conditions other than fractures	93
Neurological conditions	73
Mental senility	58
Epilepsy	56
Blood dyscrasia	55
Mental disease and defects other than senility (noncommittable)	42
Other conditions	23

Out of these 3,296 persons with chronic disease reported by the physicians, 362 or 11 per cent of the total were chronic invalids and, in the professional judgment of the doctors, at least 315 were in need of care outside their own homes. These results are particularly surprising because, by definition of the Survey, these doctors' reports cover only nonrelief or nonpublic assistance cases. Once affliction by chronic disease sets in, far too many develop into chronic invalids, often because of lack of facilities for care in the early stage or initial onset, and as invalidism extends, financial resources tend to become depleted and indigency results.

THESE FINDINGS ESTABLISH THE FACT THAT CHRONIC INVALIDISM AFFECTS ADVERSELY ALL ECONOMIC GROUPS

They stress also the need for prevention, for early diagnosis, and for early treatment and rehabilitation. Otherwise the numbers will keep increasing. Another factor emphasized by the doctors is that knowledge concerning chronic disease lags far behind knowledge of other diseases and hence the importance of research.

The reports covering these 3,296 cases were furnished by 47 of 95 physicians in active practice. Another 15 reports were received showing that their practice did not include any chronic cases unless on relief rolls. (See below for report on indigent cases.) It was the opinion of Dr. Mayes that the experience of the 33 doctors not reporting would correspond with those who did, but in order to be ultraconservative, it was decided to include the findings only of those who reported.

As to type of care needed for these nonindigent cases representing the situation in the economic groups above the lowest, the doctors estimated that the type of care needed for the 315 invalided by chronic disease (outside those who could be cared for in their own homes) was:

General Hospital	154
Specialized Hospital	35
State Hospital	21
Nursing Home	105
Total	315

For the remainder, with the exception of 21 for whom State mental hospital care was indicated, the physicians felt that care could best be given in nursing homes. Typical of the comments of the doctors concerning these needs are the following:

R. Allyn, M.D. "A nursing home is needed for elderly people who are infirm but not otherwise ill in addition to one for the chronically ill bedridden elderly patient."

Nelson Chesnut, M.D. "Additional wing of 300 beds should be added to present hospital for care of these patients only."

Don Deal, M.D. "I feel that a nursing home is desirable."

Harold Ennis, M.D. "Hospital for the chronically ill."

Robert Flentje, M.D. "Believe agency should limit time in hospitals for all except severe sickness to conserve hospital space."

C. F. Harmon and T. F. Harmon, M.D. "A County, State, and Federal building to care for above type of patients including old age."

Harry Hart, M.D. "Hospital for care of chronically ill."

R. F. Herndon, M.D. "More nursing home or infirmary care is needed —especially better care. The service of this type now available is inadequate."

J. K. Mack, M.D. "Rheumatic fever program; polio program."

K. J. Malmberg, M.D. "Feel that there is a real need for a competent nursing home associated with one of the hospitals in the county."

Harry Otten, M.D. "In my opinion it would be most satisfactory if an addition could be made in a separate building or wing to each of our general hospitals for the care of the chronically ill. If these were connected with the general hospital by a tunnel patients could be transferred in case of an acute illness, X-ray, or any necessary treatments."

Robert Patton, M.D. "Subacute hospital."

M. E. Rolens, M.D. "Establish a convalescent hospital for care of those now in general hospitals—to give routine care at a reasonable rate."

W. Shriner, M.D. "A well-run nursing home of adequate size."

M. B. Weisbaum, M.D. "Drastic need for good nursing home where physician is in attendance at least daily."

O. L. Zelle, M.D. "Increased facilities for care of patients requiring more care than nursing home affords but less care than hospitalization."

Chronic Invalidism Among Public Assistance (Old Age Pension, Aid to Dependent Children, and Blind Assistance) and General Relief Cases

Recipients of Old Age Pension

On the rolls of the Sangamon County Department of Public Assistance in January 1947 there were 2,608 Old Age Pensioners (constituting 27.3 per cent of all persons 65 and over in the county). Of the 2,608, only 26 per cent or 678 had no record of chronic disease or permanent impairment. Seventy-four per cent or 1,930 had some history of chronic disease although more than half of these were able to take care of themselves adequately and hence were not to be classified as chronic invalids.

Classified with respect to the type of care needed the Survey showed the following with respect to recipients of Old Age Pension:

CARE REQUIRED BY OLD AGE PENSION RECIPIENTS

	Number of Persons	Per Cent
TOTAL	2,608	100.0
Able to care for themselves:		
With no record of chronic disease	678	26.0
With record of chronic disease	1,001	38.4
Total	1,679	64.4
Not able to care for themselves but can be cared for in private homes:		
Able to care for self most of time; need occasional or intermittent care available from others in household	344	13.2
Need considerable help from others in own household	271	10.4
Need considerable help (visiting nurse, visiting housekeeper, etc.) additional to help available in own homes	42	1.6
Total	657	25.2
Need care outside of own home:		
In private homes but need much help, additional to help available, *but do not get it*	63	2.4
Need care *outside own home* in hospital or nursing home	209	8.0
Total	272	10.4

RECIPIENTS OF AID TO DEPENDENT CHILDREN

On the rolls of the Sangamon County Department of Public Assistance in January 1947 there were 271 Aid to Dependent Children cases comprising 1,005 persons (743 children and 262 adults). First using the family case as the basis (since chronic disease even of one person in the family often affects the whole family situation) it was found that 65.2 per cent of the cases had no record of chronic disease for any individual in the family, but 34.8 per cent had some record of chronic disease for one or more individuals in the case.

Classifying the 1,005 individuals by type of care needed, it was found:

CARE REQUIRED BY AID TO DEPENDENT CHILDREN RECIPIENTS

	Number of Persons	Per Cent
TOTAL	1,005	100.0
Able to care for themselves:		
With no record of chronic disease	655	65.2
With record of chronic disease	293	29.2
Total	948	94.4
Not able to care for themselves entirely but can be cared for in private homes:		
Able to care for self most of time (referring only to disability because of chronic disease); need occasional or intermittent care available from others in the household	40	4.0
Need considerable help from others in the household	17	1.6
Total	57	5.6

Of the 57 persons classified as needing considerable help from others in the household, 42 are children, (only 12 needing considerable care because of chronic disease; presumably others are institutionalized) 7 are incapacitated fathers, 2 are chronically ill mothers, and 6 are other members in the household. The figures did not include several cases where the children in the family were believed to have mental defects. In general, the Sangamon County Aid to Dependent Children picture is ultra-conservative since there were found no permanently crippled children or absolutely bedridden adults. This is unusual and makes the figures from Sangamon County with respect to the Aid to Dependent Children load most conservative.

RECIPIENTS OF BLIND ASSISTANCE

In January 1947 there were 114 blind persons on the rolls of the Sangamon County Department of Public Assistance. From a medical standpoint these must all be classified as suffering from chronic disease. It is tragic to note that in addition to their blindness 63 per cent of the cases had some history of chronic disease other than blindness while only 33.4 per cent had no record of chronic disease.

Classified by type of care needed the Survey showed for the 114 blind persons:

CARE REQUIRED BY BLIND ASSISTANCE RECIPIENTS

	Number of Persons	Per Cent
TOTAL	114	100.0
Able to care for themselves:		
With no record of chronic disease	42	36.4
Total	42	36.4
Not able to care for themselves, but can be cared for in private homes:		
Able to care for self most of time; need occasional or intermittent care available from others in the household	20	18.2
Need considerable help from others in the household	42	36.4
Total	62	54.6
Need care outside own home in hospital or nursing home	10	9.0
Total	10	9.0

RECIPIENTS OF GENERAL RELIEF

In January 1947 there were 2,262 persons receiving General Relief in Sangamon County. General Relief is administered by the local authorities in the townships, the largest of which are Capital Township, Springfield Township, Woodside Township, Mechanicsburg Township, Chatham Township, and Clear Lake Township. The reports from these townships indicated that there were 313 chronic invalids or 13.8 per cent of all persons on the General Relief rolls. It is apparent from other information that this number is considerably less than a more thorough analysis of the case load would have revealed. It would appear that only the more serious and more obvious cases were reported. However, since it was the desire in the Survey to be as conservative as possible, the figure was accepted without further inquiry.

Classification of chronic invalids on the General Relief rolls cannot be made strictly comparable to those on the public assistance rolls. Only 70 cases are being cared for outside their homes. With respect to the others in their homes, they are all classified as far as care is concerned as "satisfactory." Of those not in the home, there were 12 listed as needing hospital care and the remainder needing nursing home care.

Sangamon County Chronic Invalids Not Included in Survey

In addition to the numbers reported from the Survey the State Department of Public Welfare reports that as of August 1, 1946 there were 771 cases in Sangamon County in the institutions of that Department. These really should be classified as chronic invalids, nervous or mental, requiring care outside the home. These figures are not included in the totals for Sangamon County because these persons already have care. Furthermore, figures generally used in reporting the extent of chronic invalidism are based on the National Health Survey figures taken in 1935-1936 which did not count patients already hospitalized for long periods because of nervous or mental conditions or tuberculosis.

Similarly, the figures for those cared for in the two tuberculosis institutions in Sangamon County and in the hospital schools for crippled children are not included. The numbers for these are respectively 78 tuberculous patients and 7 crippled children. Obviously these are "chronic invalids" and should be included in any over-all count.

Summary of Chronic Invalidism Among Persons Assisted by the Sangamon County Department of Public Assistance

Of the 3,727 persons on the rolls of the Sangamon County Department of Public Assistance in January 1947 we find that those who need care because of chronic invalidism (disregarding entirely those who are able to care for themselves) total 1,058 or 28.4 per cent of the total.

Looking at each category separately we find 35.6 per cent of the Old Age recipients, 5.6 per cent of the persons on Aid to Dependent Children rolls, and 63.6 per cent of the Blind recipients require care either from relatives in their own household, from outside help in their own household, or must be cared for outside their own homes.

Of the chronic invalids who do need care, we find:

37.0 per cent are able to take care of themselves most of the time and need only occasional or intermittent care available from others in the household.

29.2 per cent need considerable help from others in their own household.

4.5 per cent need considerable help (visiting nurse, visiting housekeeper, etc.) in addition to help available in own homes.

6.8 per cent are now in private homes and need much help in addition to help available but are not getting it; principally need care in nursing homes.

22.5 per cent need care outside own home, in hospital or nursing home.

Summary of Chronic Invalidism Among Indigents

If we consider all persons receiving either public assistance or General Relief in January 1947, there were 5,989 persons of whom 1,387 are chronic invalids or 23.2 per cent of all recipients. As noted previously, this is a minimum estimate of the numbers of persons forced onto or kept on public assistance rolls because of chronic invalidism.

Social Factors

Except for the first and last groups (namely, those who can care for themselves substantially all the time and those who definitely must be cared for outside their homes) there is a second major factor in the problem of chronic invalidism other than the physical care for the invalid person. This is the difficult social problem which arises because some other person in the home must forego a career or the amount of attention required by the invalid interferes with other family responsibilities or a number of other complex factors tend to make the presence of the invalid a very serious problem for the family as a whole. There were innumerable reports that this social problem was so great as to create a threat to normal family life for those in the home other than the invalid.

The importance of this factor has not been evaluated yet it is of outstanding importance.

Beyond any question, if there were suitable provisions for care outside the home, large numbers in the groups not counted as needing care other than that provided in the home would utilize such facilities.

That this is so, can be better understood by recalling the experience with general hospitals. Less than a generation ago people dreaded to go to a hospital, looking to it as a last resource. Because they generally did not go until the very last moment, death rates in hospitals were high, adding to the dread of going to the hospital. Today people understand that hospitals provide better care in most cases of serious illness and want to go to the hospital. Also, it should be pointed out that only a small percentage of babies used to be born in hospitals; today the overwhelming majority of children are delivered in hospitals.

There has been similar experience with respect to use of tuberculosis sanatoriums, schools for crippled children, mental institutions, etc.

The point here is to observe that there are undoubtedly large numbers in addition to those reported who should and would use satisfactory nursing homes or special wings attached to general hospitals if such facilities were available and if the cost were reasonable. This

point was emphasized in the reports from the physicians who recommended care outside the home for a greater percentage than did the reports submitted by the health and welfare agencies.

Economic Factors

By its very definition chronic invalidism implies long-term care. For the most part such care, if available, is expensive and at present generally not satisfactory. Where care is provided in a general hospital, it means that beds are occupied which ought to be available for acute, short-term cases. Thus a double problem is created of too expensive care for the chronic invalid where a satisfactory alternative could be provided at less expense, and at the same time the acutely ill person is deprived of the opportunity to secure care in the bed occupied by the chronic invalid.

The *Interim Report of the Committee to Investigate Chronic Diseases Among Indigents* quoted from findings of the study of chronic disease in the Eastern Health District of Baltimore which showed that 381 chronic disease families had 54 per cent of the total illness and received about 50 per cent of the medical care given to 13,800 families, and that persons from these few families also constituted almost 40 per cent of the persons hospitalized during the second year of the study.

Another factor reported in the *Interim Report* was that the percentage of chronic invalidism among those currently receiving public aid is 87 per cent greater than it is among those of economic self-sufficiency.

Reference may also be made to a recent report of the Illinois Public Aid Commission showing what a small income margin there is for approximately one half of all those 65 years of age and over who are not receiving Old Age Pension but are dependent on others in whole or in part. It is easy to understand that where long-continued chronic invalidism strikes, the ability to maintain one's self without recourse to public assistance is rapidly diminished. (See table on p. 243.)

There is another phase of the economic problem comparable to that of the social problem, namely, the effect on other persons in the home who must stay to care for the serious chronic invalid and hence cannot be gainfully employed themselves. This is also a major factor.

The Survey showed that 27.5 per cent of all the chronic invalids in private homes need care by other members of the household with slightly over half of this number (14.4 per cent) requiring very considerable help. This means that some adult in the home must be available and hence can not undertake outside work or must employ outside

SOURCES OF INCOME OR SUPPORT OF PERSONS IN ILLINOIS 65 YEARS OF AGE AND OVER, INDICATING ELIGIBILITY FOR OLD AGE PENSION, DECEMBER 1944

	Per Cent	Per Cent	Per Cent
TOTAL	100.0		
Persons self-supporting, income adequate, ineligible for Old Age Pension	54.0		
Current earnings, possibly also with other sources of income		30.0	
Other sources of income, no current earnings		24.0	
Persons dependent on others wholly or in part	46.0		
Old Age Pension recipients		21.8	
Supported by children or others; eligible for Old Age Pension if legal responsibility of children is removed		20.0	
Income inadequate but ineligible for Old Age Pension because:		4.2	
Supported in public institutions			1.6
Receiving other forms of aid			0.5
Other reasons			2.1

help or receive aid such as visiting nurse or visiting housekeeper service. In addition, there was considerable extra cost for medical services. Almost without exception the family plan has not included anything for rehabilitative treatments or services which are essential if any restoration to normal life is to be attained or the remaining years of life made happier both for the invalid and for the others in the household.

The Need for Beds

Sangamon County is particularly fortunate in having two large and excellent general hospitals with bed capacity of 891. These hospitals, however, also serve a considerable area outside the Sangamon County border. The Illinois Hospital Survey authorities report that bed capacity of the general hospitals is adequate for acute cases if only the Sangamon County population is considered. For Sangamon County population alone 547 beds are needed for acute cases.

There are 217 beds available in nursing homes, but these are used not only for chronic invalids but for canvalescent cases from general hospitals and for a number of special purposes. What the net capacity is for chronic invalids only can not be ascertained.

Sangamon County also is fortunate in that it has a bed capacity of 191 in its two tuberculosis sanatoria and 55 beds available in its

Crippled Children's Hospital School. For both these types of cases there are, according to the Illinois Hospital Survey, ample facilities for the Sangamon County population in present institutions.

This, however, is not the whole story. Because Sangamon County has no county home and existing nursing homes are not only inadequate in number but not equipped for adequate care, the use of beds in general hospitals must be resorted to for care of chronic invalids. The cost of beds in general hospitals under today's cost of construction exceeds $10,000 per bed (recent construction has cost as much as $13,000 per bed) as compared with facilities adequate to care for chronic invalids which cost approximately $3,000 to $7,000 per bed. Besides much greater construction costs, the cost of care in general hospitals is much more expensive than adequate care for chronic invalids in special facilities. It is obvious, therefore, that it is neither economical nor desirable to utilize general hospital beds for chronic invalids except for the relatively short period of time in which the chronic invalid needs extensive treatment, surgery or initial diagnosis and classifications as to care needed.

The Illinois Hospital Survey reports that approximately 20 per cent of the general hospital beds in Sangamon County were occupied by cases with chronic diseases and the majority of these could be cared for in nursing homes or in a wing adjacent or convenient to the general hospital.

There is still another factor, namely, that general hospital care being so costly and chronic invalidism by its very nature requiring long-term care, many who, in the professional judgment of the doctors ought to be cared for outside their homes, cannot afford care in the general hospital.[1] Nursing home capacity, even though unsatisfactory in its provisions, is presently inadequate. There is a minimum need for 428 beds in the nursing homes but only 217 beds available.[1]

It is evident that the greatest single need in Sangamon County is the expansion in bed capacity for chronic invalids. The most immediate and most effective improvement in the situation would result from construction of a new facility in connection with one of the general hospitals or adaptation of some present building convenient to a general hospital. If such facility were of at least 150-bed capacity, it would greatly improve the prevailing situation in Sangamon County. At least another 150 beds should be provided either in satisfactory nursing homes or a county home. If the addition to the general hospitals is not provided, then erection of a county home of 300-bed capacity might be considered to serve as a special center for chronic invalids.

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[1]See footnote 1, page 225.

Since the public assistance laws of Illinois provide for meeting from public funds the medical needs of the medically indigent as well as those of recipients of Old Age Pension, Aid to Dependent Children, Blind Assistance, and General Relief, payment of operating costs of the facilities for care of the chronic invalids who cannot afford their own care is assured. Others who could pay for their own care if costs were reasonable would of course also use such facility. If satisfactory places are provided, it is certain that use of such facilities will expand far beyond the present estimates because of the social and economic factors which are created by the presence of chronic invalids in their homes. For these conditions there is no solution until there are adequate facilities.

Comparison of Results With Other Surveys

NEW JERSEY

The Department of Institutions and Agencies of the State of New Jersey made an analysis of the total case load on its Old Age Assistance rolls as of October 1946 and found that 38.11 per cent of its Old Age Assistance recipients suffer from chronic disease. Of those with chronic disease, 74.55 per cent were cared for in their own homes, 21.39 per cent in institutional arrangements. The New Jersey figures are given in detail below:

REPORT FROM COUNTY WELFARE BOARDS ON LONG-TERM PATIENTS RECEIVING OLD AGE ASSISTANCE

(State of New Jersey Department of Institutions and Agencies)

	Number	Per Cent of Total Case Load	Per Cent of Chronics
October 1946 Total Case Load	21,044	.....	.....
Total Chronics in OAA Case Load	8,020	38.11	100.00
In Own Home			
With Visiting Nurse Service	419	.....	5.22
With Other Nursing Service	185	.....	2.31
Family Care Only	3,795	.....	47.32
Alone	1,580	.....	19.70
Total Cared for at Home			74.55
In Institutional Arrangements			
In Hospital	129	.....	1.61
In Nursing Home	540	.....	6.73
In Boarding Home	1,047	.....	13.06
Other	325	.....	4.05
Total Cared for in Institutional Arrangements			25.45

In addition there were 1,180 cases of chronic invalids over 65 in public institutions (New Jersey, unlike Illinois, does not continue Old Age Assistance grants to persons in public institutions). The total number of persons in public institutions was as follows:

IN PUBLIC INSTITUTIONS—NOT RECEIVING OAA

	Number	Per Cent of No. in Institutions
Institutions	1,894	.....
Receiving Medical Treatment	1,337	70.59
Over 65	1,180	62.30

The New Jersey results indicate a higher percentage of chronic invalidism than the 35.6 per cent indicated by the Sangamon County Survey for persons on the Illinois Old Age Pension rolls. Actually, however, other than indicating that the Sangamon County figures are conservative, the discrepancy could be explained in part by the greater restriction in requirements for Old Age Assistance in New Jersey and the corollary that where chronic invalidism is present it is an outstanding factor in compelling application for Old Age Assistance.

STATE OF WISCONSIN

A state-wide survey was made in October 1946 in Wisconsin by the Division of Public Assistance of the State Department of Public Welfare "to determine need in the fields of the totally disabled, the infirm and all persons requiring nursing home care." The Survey defined as a chronic invalid a "recipient unable to live alone or incapable of properly caring for himself if living alone. As used in the Survey it means a person who is unable to perform the most essential human functions without the assistance of another person because of chronic illness, long-term convalescence, old age or other disability of three or more months duration, or a person who is living alone under conditions likely to be detrimental to his health and well-being."

Comparison of the Wisconsin Survey findings with the findings of the Sangamon County Survey indicates that the findings of the latter are conservative. The State Department's Survey indicated the following percentages of each recipient group unable to live alone:

Old Age Assistance	27.7
Aid to Dependent Children	5.6
Aid to the Blind	100.0
Aid to the Disabled	100.0
General Relief	12.3

Four per cent of all adult recipients and 16 per cent of all persons reported in the survey were found to be so incapacitated physically that they cannot usually perform most of the essential functions of independent living. They comprise 4 per cent of all Old Age recipients, 9 per cent of Blind Aid recipients, and all aid to disabled beneficiaries (this group is not included in Illinois figures).

Although care of the completely disabled frequently involves a great deal of personal sacrifice on the part of persons charged with their care, 70 per cent of the completely disabled were living with relatives, many of whom assume this responsibility willingly. Nearly 25 per cent were cared for in hospitals, nursing homes, and private institutions for the aged.

With respect to persons of limited activity, the survey found that these include 17 per cent of all adult recipients and 72 per cent of all persons reported in the survey. They comprised 21 per cent of all Old Age Assistance recipients, 40 per cent of all Blind Aid recipients, and 8 per cent of all general relief beneficiaries. Seventy-one per cent lived with relatives, 7 per cent in unrelated family groups, and 12½ per cent in hospitals, nursing or boarding homes or private institutions for the aged. Nine per cent lived alone with some outside help.

The report of the Wisconsin Survey includes a great wealth of valuable information which is excellent source material for students of the problem of chronic illness or chronic invalidism. The most surprising result of this survey is the close similarity to the findings of the survey in Sangamon County, Illinois, showing that an analysis of the situation wherever made reveals a great extent of chronic illness and invalidism resulting therefrom.

Dane County, Wisconsin

An excellent detailed study was made in Dane County, Wisconsin, in 1946. This county, which includes the city of Madison, is in many ways comparable to Sangamon County. One of the most interesting findings of that survey was the fact that half of the adult persons found to be incapable of living by themselves because of chronic illness, long-term convalescence or otherwise who had to resort to public assistance for support were chronic invalids. In other words here, again, was independent proof of the fact that chronic invalidism is one of the major causes forcing people on to the public assistance rolls. Also, the Dane County Survey reveals a much higher ratio of beds needed for care outside of chronic invalid's own home than has generally been realized. While the findings are not strictly comparable, they do not differ materially from those reported in the Sangamon County Survey.

SECTION XII

PROGRESS REPORT ON LICENSURE OF PRIVATE NURSING HOMES[1]

By C. W. Klassen, Chief Sanitary Engineer,
State Department of Public Health

In accordance with the request of the Commission on the Care of Chronically Ill Persons, the Department of Public Health herewith submits a condensed report of its experience in the licensing of nursing homes.

General information and data obtained by the department in discharging its duties and responsibilities in this field are presented without attempting to give all of the details of the administrative procedures.

Comparison of Data with that of Illinois Hospital Survey

Coincidental with the initial phases of the department's contact with nursing homes, the Hospital Survey was being conducted by the department's Division of Maternal and Child Hygiene. This fact is mentioned because of the few differences in the listing of so-called nursing homes found in both activities. These differences are accounted for by the difference in approach under the two department responsibilities and the specific definition of nursing homes under the Nursing Home Law. The data given in this report refers to those homes coming under the definition as given in the Nursing Home Law.[2]

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[1]Summary of Enabling Legislation of 1945: The first provision in Illinois for State licensing of such homes was made in 1945 when the Sixty-fourth General Assembly passed House Bill 252 (Gibbs, Van der Vries, Wellinghoff, and Stransky). This Bill was signed by Governor Dwight H. Green on July 17, 1945 and became effective as of that date. The Bill provided for licensing and regulation by the Department of Public Health of all homes which undertake to provide maintenance, personal care or nursing for three or more persons who, by reason of illness or physical infirmity, are unable properly to care for themselves. Cities, villages or incorporated towns which have by ordinance provided for licensing and regulation in a manner which substantially complies with the minimum requirements set out in House Bill 252 were exempted from the provisions. Provision was also made to safeguard the rights of homes conducted for those who rely on treatment by prayer or spiritual means. The Act did not apply to homes maintained by county or municipal authorities such as the county homes for the infirm and chronically ill.

[2]A survey completed by the Illinois Public Aid Commission in September 1946 provides information concerning "boarding homes" in downstate counties in which aged and blind recipients were receiving care. The survey was originally made to determine whether some of the homes in which recipients lived and had their meals were subject to licensing under the Nursing Home Licensing Law.

(Footnote continued on page 249)

Table I on page 250 gives the status of these homes as of February 1, 1947 or twelve months after the first of the licensure inspections were made.

Table II on page 251 gives a summary of the specific defects found in the homes at the time of the pre-licensing inspections.

The information collected, however, is also of significance in the considerations of this Commission.

There were, at the time of the study, 189 homes in 61 downstate counties providing boarding home care to aged and blind recipients. Of 1,675 persons in these homes, 775 were recipients of Old Age Pension or Blind Assistance. In 109 homes of the total reported there were 63 bedfast recipients and 152 recipients in need of more assistance than the ordinary boarder although not confined to their beds. Thus, there were 215 persons in homes not equipped, even by the most elastic standards, to give them proper care. It was reported, at the time of the study, that some of the 109 homes giving nursing care or personal service had applied for nursing home licenses, but it is not known how many licenses were granted.

TABLE I. APPLICATIONS FOR NURSING HOME LICENSES RECEIVED AND ACTED UPON

Known homes	533
Homes found to be exempt from law	272
Homes contemplating opening	19
Homes found to be included in law	224
Homes being investigated as to status under law	18
Applications received	254
Licenses in effect	163
Licenses voided	6
Licenses not issued pending fulfillment of requirements	46
Applications denied	5
Applications in process of being denied	4
Applications received but not requiring nor desiring licenses	30
Were or were to be converted to board-and-room	11
Went out of business	10
Exempt by local ordinance	5
Exempt under law for other reasons	4
Homes with applications on file that changed location	8
Before licensure	6
After licensure	2
Homes with applications on file that changed owners	6
Before licensure	3
After licensure	3
New homes interested in opening subsequent to law	27
That did apply and open	8
That have not yet applied	19
Original inspections by central office of homes with applications on file	97
Original inspections by field personnel of homes with applications on file	121
Homes with applications on file not inspected	36
Rechecks by central office staff (approx.)	75
Rechecks by field personnel	100

TABLE II. NUMBER OF UNSATISFACTORY FACILITIES IN THE 218 HOMES INSPECTED

Plumbing—Includes back siphonage hazards, number of toilet fixtures and condition	519
Heating—Complete check upon complaint only	1
Lighting—Includes ratio of window to floor area and artificial lighting	35
Ventilation—Includes bed spacing and room ventilation facilities	40
General Conditions—Includes condition of home structurally, decoratively, and hygenically; use of basement and third floor rooms; telephone service; and provision of community room	54
Personnel—Includes number and qualifications of employees and qualifications of operator	45
Water Supply—Includes private water supplies contaminated or subject to contamination, and facilities for hot water	43
Sewerage—Includes private sewage disposal facilities that do not meet department standards	22
Food Handling—Includes adequacy and condition of food handling facilities and kitchen and techniques in handling food and dishes	396
General Hygiene—Includes such items as presence of vermin; storage of garbage; supply and condition of bedding and linens; type of beds; type and handling of bedpans, commodes, cuspidors, etc.; and condition of residents' clothing	104
Administration—Includes medical supervision of the homes, medical examination of residents, and isolation facilities	138
Records—Includes residents' register, signed physicians' orders, and records of personal possessions, physical examinations, food served, and home-resident contracts	504
General—Includes adequacy of space for storage of personal possessions of residents	4

NOTE: These headings agree with those appearing in the Minimum Standards. It is not possible to satisfactorily check the adequacy of food served residents during the original licensure inspection.

Plan Followed in Correcting Hazards

Inspections of the homes applying for licenses showed that originally none met all of the minimum standards promulgated by the department. Inspections of all homes made for this department by the Division of Fire Prevention, Department of Public Safety, reveal that nearly all homes were inadequately protected against fire hazards. No licenses were issued until all fire hazards were corrected. Correction of all conditions involving serious health hazards were likewise required prior to licensing. Where the correction of conditions not involving serious health hazards would be delayed by the critical shortage of certain materials and labor, their completion was temporarily waived for initial licensing because of the serious need for nursing home facilities. An over-all picture of the first year's activity in the licensure of nursing homes brings out several interesting aspects.

Defects Found in Homes Housing Old Age Pension Recipients

Homes primarily housing Old Age recipients barely meet the standards required for original licensing. The common defects originally found were the owners' and employers' lack of training and experience, insufficient help, periodic overcrowding, lack of records of physicians' orders, lack of information on the residents, their personal belongings, the quantity and quality of food served, insanitary plumbing installations, and insanitary food-handling techniques. Many of these factors combine to create what might be termed a depressive atmosphere in these homes; however, the owners with few exceptions are apparently sincere in providing facilities and care which meet the minimum requirements as was evidenced by their co-operation in making the necessary improvements.

Defects in Homes Housing Self-Supporting Patients

The homes included in the self-supporting resident group were, in general, found to be fairly satisfactory. This group of homes, however, was characterized by conditions which most commonly included lack of interest in the residents other than providing good physical care, lack of adequate records, insanitary plumbing installations, and insanitary food-handling techniques. This group of owners and employees were found to be fairly well qualified and co-operative as reflected in making the recommended improvements.

Conditions in Not-for-Profit Institutions

The third classification of endowed, religious, fraternal, nonprofit establishments, with few exceptions, were found to be superior in quality, while the most common defects were insanitary plumbing installations, food-handling techniques, together with a lack of suitable rec-

ords. The superintendents and employees were on the whole well qualified, conscientious, and interested in their residents, and with few exceptions co-operated in making the recommended improvements.

Difficulties in Homes Located in Rural Areas

Homes in all of these three groups, however, when located in rural areas or small communities not having public water supplies or sewerage facilities, in general, lacked many of the required items of sanitation. This probably can be attributed primarily to the expense which is involved in providing adequate water and sewerage facilities and to the difficulty in securing and obtaining competent employees in such areas.

Future Needs

The experiences summarized above indicate that there is considerable need in the field of educating the operators of these nursing homes to their responsibility not only in maintaining minimum physical facilities but also in providing a cheerful environment with provision for some program of diversional occupation therapy. Experience thus far has fairly well indicated that a licensing program is a very necessary foundation to a super-structure of good care for the chronically ill, the long-term convalescent, and the geriatric patient.

In the administration of any new act experience usually reveals need for certain changes to clarify and facilitate administration.[1] This

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[1]The Nursing Home Act is state-wide in its application to private homes except where municipal ordinances are operative. Local licensure exists in Chicago, Evanston, Midlothian, Rockford, and Waukegan. The Chicago-Cook County Health Survey, in commenting on licensing in Chicago, made the following statement in a preliminary report: "Licensing of homes in Cook County exclusive of Chicago and Evanston and certain other municipalities is required under State law, and the necessary inspection is the responsibility of the State Department of Public Health. The procedure prescribed by the statute seems to be satisfactory and free from the confusion which complicates licensing in Chicago.

"Homes operated within Chicago's city limits are subject to municipal licensure under an ordinance adopted by the City Council in 1938 and amended in February 1945 and March 1945. Scattered through various chapters of the Municipal Code are numerous specific requirements to be met before issuance of a license. So many chapters and requirements are involved that it becomes difficult to ascertain just what the requisites are. For example, some may be found in each of chapters 8, 40, 43, 47, 48, 49, 66, 67, 81, 90, 101, and 136. Before a license may be obtained, inspection must be satisfactory to the Board of Health, the Building Department, the Fire Department, and the Department of Streets and Electricity. Lack of harmony by these departments in formulating their requirements has made the procedure for qualifying so involved and complicated that home operators frequently find themselves unable even to interpret them—to say nothing of meeting them.

"This inability to interpret or meet municipal requirements is a major stumbling block in the way of improving the quality of facility and care. When events occur which focus public attention adversely on homes and institutions, those which have applied for license and have made an earnest attempt to comply with the requirements have to bear the brunt of the onus. The burden thus placed on licensed homes and institutions is obviously unfair.

"A genuinely co-operative attitude on the part of the licensing and inspecting authorities in assisting the operators in construing these requirements and complying with them will accomplish much toward bettering the care for the chronically ill. (Footnote continued on page 254)

Nursing Home Act is no exception in this regard but experience thus far has indicated that it is built on basically sound principles. The results and benefits to the aged brought about by this Act substantiate this conclusion. The encouraging and successful results obtained by the department have, in no small part, been brought about through the close co-operation and the valuable assistance rendered by the Illinois Public Aid Commission.

"In recent years the concentration of both medical and lay attention upon the problems of the chronic invalid has served to emphasize the need for higher standards of both care and facilities. Licensure through a State agency has been considered a most likely means of attainment, and efforts have been made to establish a comprehensive State Licensure Law. Continued and continuous activity in this direction is advocated."

SECTION XIII

MINIMUM STANDARDS FOR PRIVATE NURSING HOMES

As Prescribed by the
Illinois State Department of Public Health in 1945

SECTION 4 (a). "The department shall prescribe and publish minimum standards in relation to the construction of the home including plumbing, heating, lighting, ventilation, and other housing conditions, which shall ensure the health, safety, and comfort of residents and protection from fire hazards."[1]

Satisfactory compliance.—This item shall be deemed to have been satisfied if:

Plumbing

(1) All fixtures are protected against back-siphonage as follows:
   a. All lavatory and sink faucets discharge at least one inch above the maximum spill line of the fixture.
   b. All bath tub, laundry tub, etc., faucets discharge at least two inches above the maximum spill line of the fixture.
   c. All flushometer valve type toilets are equipped with an approved vacuum breaker installed on the discharge side of the flush valve and at least four inches above the rim of the toilet bowl.
   d. All wall reservoir gravity type toilet or urinal flush tanks are equipped with an approved vacuum breaker ball cock installed at least one inch above the overflow pipe.
   e. All other plumbing is so installed that contamination can not, in the opinion of the department, be siphoned back into the water supply piping.

(2) No physical pipe connections exist between a potable and non-potable water supply.

(3) All plumbing is of such size and so installed that fixtures are adequately served and satisfactorily drained.

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[1]Section 4a of House Bill 252 (Gibbs, Van der Vries, Wellinghoff, and Stransky), approved July 17, 1945. The entire Act may be found in *Illinois Revised Statutes 1945*, Chapter 111½, Paragraphs 35.16 through 35.30.

(4) Adequate flush-type toilet facilities of a type approved by the department are provided and such toilets are easily accessible, conveniently located, clean, substantially constructed, in good repair and are maintained in a sanitary condition at all times. Toilet seats are preferably of open-front construction. No frostproof toilets are provided. One water closet is provided for each ten ambulatory residents or major fraction thereof. Where urinals are provided for men, a water closet and urinal is provided for each fifteen ambulatory males or major fraction thereof. Separate toilet facilities for each sex are provided where deemed advisable by the department.

(5) Handwashing facilities consisting of a lavatory and soap are provided in each toilet room for each fifteen ambulatory residents or major fraction thereof, and individual towels are provided for each resident. See "General Hygiene, Beds and Linens" for regulations on towels and wash cloths.

(6) Adequate bathing facilities are provided and such facilities are easily accessible, conveniently located, clean, substantially constructed, in good repair and are maintained in a sanitary condition at all times. Showers or tubs are provided with hand grips or otherwise protected to minimize possible accidents.

(7) Drinking fountains, if provided, meet the design features as recommended by the department.

Heating

(1) Each room or ward in which residents are housed, or to which residents have reasonable access, can be heated to not less than 80°F. under all weather conditions. Heat is preferably supplied from a central heating system and all heating appliances other than electrical are properly vented to the outside.

Lighting

(1) Evenly distributed artificial light equivalent to not less than one-half watt of electric light per square foot of floor area is provided in each room or ward in which residents are housed or to which residents have reasonable access. A properly designed reading lamp equivalent to a 50-watt electric bulb is located convenient to residents who desire to read.

(2) The floor area is not greater than eight times the window area in all rooms occupied by residents.

(3) All halls, toilets, kitchens, basements are well lighted and are equipped with artificial lights for night use.

Ventilation

(1) A floor area of not less than 60 square feet is provided for each resident in the sleeping room; the ceilings are not less than 7 feet; and the space between beds is not less than 3 feet.

(2) Each room or ward to which residents have reasonable access has properly located window openings, and such windows are maintained so that they may be readily opened and closed. Windows which can not be opened from the top are equipped with ventilating shields so that direct drafts may be minimized.

General Conditions

(1) The building is substantially constructed, in good repair, all doors and windows close readily and effectively, screen doors open outward, all outer openings are effectively screened with screens of not less than 16 meshes per inch during the fly season, and all door and window screens fit properly.

(2) A community room for residents, such as a living room, is provided for reading and other recreational purposes, unless resident rooms are equipped for that purpose or the type and nature of residents accommodated do not, in the opinion of the department, render such a community room necessary.

(3) Rooms above the second floor are not used for the accommodation of residents unless elevator facilities are provided, except that at existing establishments, ambulatory residents may be housed in rooms above the second floor level without elevator facilities if two avenues of exit in case of fire are provided from each floor above the second floor level and other necessary precautionary measures as may be recommended by the State Fire Marshal are carried out. Third floor rooms may be used with permission of the department.

(4) Basement rooms are not used for the accommodation of residents. Any room not equipped with a full standard sized window entirely above the ground surface will be considered a basement room.

(5) The recommendations of the State Fire Marshal are followed in all matters pertaining to fire prevention and safety.

(6) The home is so located that it is not subject to flooding, the site is well drained, is located on an all-weather road; the premises, both inside and outside, are in a clean and sanitary condition.

(7) Satisfactory telephone service is provided.

SECTION 4 (b). "Number and qualifications of all personnel, including the nursing personnel, having responsibility for any part of the care given to residents."

Satisfactory compliance.—This item shall be deemed to have been satisfied if:

Personnel

(1) The nursing home is in charge of a qualified and responsible superintendent whose duty it shall be to maintain a desirable standard of environmental sanitation at the nursing home and who is fully authorized and empowered to carry out such recommendations of the department as may be necessary in order that the establishment may comply with State Statutes and department's standards governing nursing homes.

(2) All persons in charge of, employed by, or associated with the nursing home are of suitable character and temperament to function in their appointed capacity and to provide adequate care and comfort of the residents; the superintendent and all persons in supervisory or responsible positions are not less than 21 years of age and have not been convicted of any crime; no employee is less than 16 years of age; and all employees, including the superintendent, are free of contagious disease in a communicable stage.

(3) The nursing home is under the supervision of a physician licensed by the State of Illinois.

(4) The person who is definitely in charge of the nursing service of the home is either a registered or a graduate nurse or a practical nurse having sufficient experience to qualify her for the responsibility for the care of patients in the institution. When the size of the service requires, additional nursing personnel is employed to give adequate care to sick residents. In employing nursing personnel, careful inquiry is made as to training, previous experience and other qualifications for the position, and this information made a matter of record.

(5) The nursing home is covered at all times by adequate nursing service. Provision is made for this coverage during vacations and other relief periods. Adequate nursing service is provided for night care of patients. No treatment or medication is given without a written order signed by a legally licensed physician.

SECTION 4 (c). "All sanitary conditions within the nursing home and its surroundings, including water supply, sewage disposal, food handling, and general hygiene, which shall ensure the health and comfort of residents."

Satisfactory compliance.—This item shall be deemed to have been satisfied if:

Water Supply

(1) Water is obtained from a safe public water supply as determined by the department.

(2) If a safe public water supply is not available, the water is obtained from a private source meeting the approval of the department. Its publications "Wells, Dug, Drilled, and Driven" and "Cisterns" will be used as a guide in judging this item.

(3) The supply is adequate in quantity and delivered under sufficient pressure to satisfactorily serve all fixtures in the home.

(4) There are facilities in the home for furnishing an adequate supply of hot water.

(5) No sources of nonpotable water are available on the premises without special permission from the department.

Sewerage

(1) All sanitary wastes from the home are discharged to a public sewer system as approved by the State Sanitary Water Board.

(2) When a public sewer system is not available the sanitary wastes are disposed of in a manner meeting the approval of the State Sanitary Water Board.

Food Handling

(1) All persons connected with the handling of food are free of contagious disease in a communicable stage.

(2) All food and drink stored, prepared or served in a nursing home is wholesome and free from adulteration.

(3) All milk used for purposes other than cooking is pasteurized milk as defined in the Milk Pasteurization Plant Law, and of the highest grade available.

(4) All milk is maintained at a temperature not to exceed 50°F. while on the premises, and is stored in such a manner as to preclude its contamination; bottled milk is not submerged in water for cooling; all milk and fluid milk products is served to the residents in the original container in which it is received from the distributor, or from the bulk container with a dispensing device approved by the department. This requirement shall not apply to cream served on the premises.

(5) All perishable food or drink is kept at or below 50°F.; no food is stored in direct contact with ice; no meat is stored in direct contact with shelves; with the exception of raw vegetables that are to be cooked, all food and drink is so stored as to be effectively protected from dust, dirt, flies, vermin, or other contamination.

(6) Kitchen. The floor, walls, and ceiling are easily cleanable and kept free from dirt, filth and grease spots, and maintained in good repair. The floor is tight, sound, and free of depressions in which liquids may accumulate. No carpets, rugs, ragged linoleum or linoleum with loose or wide-open seams is used. The walls and ceilings are smooth, light in color, and refinished as often as necessary in order to be so maintained. The walls have a washable finish to a height of at least 5 feet. Artificial lighting is provided in the kitchen equivalent to that produced by a 100-watt electric bulb for each 100 square feet of floor area. All windows are kept clean. Adequate windows or approved ventilating devices are provided to maintain the kitchen reasonably free from smoke and odors. All outside openings are effectively screened with 16-mesh screen at all times during the fly season. All furnishings and equipment are adequate, kept clean, and in good repair. Surfaces upon which food is prepared are clean and devoid of open cracks or seams, or covered with metal or other smooth impervious material.

(7) Dishes, Dish Washing, and Storage. After bactericidal treatment all dishes and utensils are so stored as to prevent their contamination; all eating utensils and tableware are kept clean and in good repair at all times; chipped, cracked, or broken dishes or glassware are not used; chipped, corroded or openseamed utensils are not used.

Every dish, knife, fork, spoon, drinking glass, cup, tray, or other utensils used in the preparation of food for the service of residents or employees is thoroughly cleaned and rendered free from injurious contamination after each separate use by:

a. Washing in warm water (110°F. to 120°F.) containing an adequate amount of an effective soap or detergent to remove grease and solids; changing the soapy wash water at sufficiently frequent intervals to keep it reasonably clean; properly stacking the dishes when a dish washing machine is used;

b. and immersion for at least 2 minutes in clean, hot water at a temperature of at least 170°F., or for ½ minute in boiling water. Unless actually boiling water is used an approved thermometer is available convenient to the vat. The pouring of scalding water over washed utensils shall not be accepted as satisfactory compliance. A two-compartment sink, or its equivalent is provided; one compartment is used for washing and the other compartment is used for rinsing and disinfection;

c. or immersion for at least 2 minutes in a lukewarm chlorine bath

containing at least 50 ppm of available chlorine if hypochlorites are used, or a concentration of equal bactericidal strength if chloramines are used. The bath is made up at a strength of 100 ppm or more of hypochlorites and is not used after its strength has been reduced to 50 ppm. Bactericidal treatment with chlorine is ineffective if the utensils have not been thoroughly cleaned. Where chlorine is relied upon for bactericidal treatment, the bactericidal treatment requirement of this item shall, therefore, be considered as violated if the utensils so treated are not clean. A three-compartment sink, or its equivalent is provided, one compartment is used for washing, one for rinsing, and one for disinfection.

d. Dishes, following disinfection, are allowed to air dry. If absolutely necessary the dishes may be dried with clean towels used for no other purpose.

General Hygiene

(1) The kitchen and all parts of the nursing home is kept free from flies, roaches, rats, and other vermin at all times. When remedial measures are employed, care is exercised to see that no material so used comes in contact with any food or is placed or stored so as to constitute a hazard.

(2) Garbage and rubbish receptacles are constructed of impervious material and are equipped with tight-fitting lids, and the contents therein disposed of as frequently as is necessary to prevent nuisances; the garbage receptacles are washed when emptied and treated with a disinfectant, if necessary, to prevent odor nuisances.

(3) Bed pan, slop jar, and cuspidor contents are emptied into toilet stools, or into slop sinks. Bed pans, slop jars, cuspidors and similar receptacles are thoroughly cleaned and effectively disinfected after each usage. Where necessary, special equipment is provided for this purpose. Sputum containers, discarded bandages and dressings, etc., are burned as soon as practicable.

(4) Floors or floor coverings are constructed so as to be easily cleaned.

(5) Bedding and Linen. Clean, freshly laundered sheets, not less than 99 inches in length and of sufficient width to completely cover the mattress and springs are provided each resident at least weekly, or more frequently as may be necessary to insure proper personal cleanliness of the resident; satisfactory bedding adequate to maintain body comfort to the residents is provided, and

such bedding is maintained in a satisfactory condition; linens are not used by more than one resident between laundering.

(6) Clean, freshly laundered towels and wash cloths are provided for each resident at least weekly or more often, if necessary, to insure proper cleanliness of the resident; such towels or wash cloths are for individual use only and common usage is not permitted.

(7) Rigid type beds, substantially constructed, in good repair, and of adequate size are provided, and such beds are equipped with a comfortable mattress and springs in good repair; mattresses are maintained in a sanitary condition and are provided with waterproof covers, when necessary; roll-away, folding, and similar type beds are not used for the accommodation of residents.[1]

(8) Adequate laundry facilities are provided in quarters used exclusively for that purpose unless arrangements are made with a commercial concern to supply complete laundry service. Table, bed linen, towels, and personal laundry are washed separately.

(9) Clothing of residents is kept neat and clean.

(10) Each resident confined to bed is bathed at least every other day; ambulatory residents are bathed at least twice weekly.

(11) There is a sufficient supply of hospital appurtenances to take care of the needs of the residents.

SECTION 4 (d). "Diet related to the needs of each resident and based on good nutritional practice and on recommendations which may be made by the physician attending the resident."

Satisfactory compliance.—This item shall be deemed to have been satisfied if:

Diet

(1) A sufficient supply of good food to provide well-balanced meals, properly cooked, with adequate amount of milk, green or yellow vegetables, and citrus and other fruits is provided; special diets as prescribed by the resident's or supervising physician are provided.

SECTION 11. "In addition to the authority to prescribe minimum standards, the department may adopt and enforce rules and regulations relating to the operation and conduct of nursing homes and the care, treatment and maintenance of the residents thereof as it shall deem necessary for an effective administration of this Act."

Satisfactory compliance.—This item shall be deemed to have been satisfied if:

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[1]May be used at discretion of the department.

General Regulations

(1) Administration. The supervising physician makes regular visits to the establishment as often as necessary, in order to insure adequate medical care, and is available when emergency visits to the home are necessary.

(2) Physical Examination. Each resident has, at the time of admission, a complete physical examination and clinical record made by a licensed physician and such clinical record includes pertinent identifying data, diagnosis, the general physical and mental condition of the resident and specific recommendations as to the care and comfort of the resident; all of which is submitted in writing to the nursing home, which record shall be kept on file for inspection by the department whenever requested. Persons with contagious diseases in a communicable stage are not admitted to the home. Provision is made for the isolation of cases of communicable diseases contracted or diagnosed after admittance to the home, either at an isolation hospital, suitable isolation rooms, or in other manners satisfactory to the department.

(3) Patients' Records. A residents' register giving the following information is kept for each resident:

Name	Name, address, telephone number of doctor
Address	Name, address, telephone number of nearest relative
Age	Weekly rate
Sex	Date of discharge
Color	Condition on discharge
Date of Admission	
Diagnosis	

(4) Record of Clothing, etc. The home prepares and keeps lists of all clothing and notations of its condition; lists of all personal possessions in triplicate, one copy to the resident, one copy to source of referral, and the third copy to remain in the files of the home; a record of all agreements or contracts entered into between the home and the resident, which record is attached to the personal record of the resident.

(5) Physicians' Orders. A record is kept of orders written by a registered physician authorizing the administration of drugs, medicines, or other treatment to be administered by persons other than such physician, and this record is maintained as an adjunct to the individual clinical and medical record form of the resident.

(6) Meal Records. A daily record is kept of food served for each meal in chronological order for at least six months after the serving

of the meal. Such record lists the date of serving, the identity of the meal and the items of food included in the meal.

(7) Physical Examination of Employees. A record is kept of physical examination of all persons in the home who may serve the resident, and name of examining physician.

(8) Other Records. Such other records as may be required by the Department are maintained in a satisfactory manner.

(9) General. Space is provided in lockers, drawers, or closets for storage of a limited number of personal possessions of each resident.

(10) Not to Care Also for Children. No nursing home engages in the business of caring for children; a child is considered as anyone under the age of 16.

STATE OF ILLINOIS
County of Sangamon

I, Roland R. Cross, M.D., Director of the Department of Public Health of the State of Illinois, do hereby certify that the foregoing is a true copy of the Minimum Standards for Nursing Homes, in said State, promulgated under date of August 15, 1945.

In Witness Whereof, I hereunto set my hand and Official Seal of the Department of Public Health of the State of Illinois, this August 15, 1945.

Director of Public Health

SECTION XIV

PROGRESS REPORT ON THE DEVELOPMENT OF COUNTY HOMES FOR THE INFIRM AND CHRONICALLY ILL

By Norman T. Paulson, Consultant on County Homes,
Illinois Public Aid Commission

Provisions of County Home Legislation

The Sixty-fourth General Assembly at the recommendation of the Committee to Investigate Chronic Disease Among Indigents passed legislation[1] which provided for additional facilities for the chronically ill by converting county homes into homes for the "destitute, infirm, and chronically ill." This action made it possible for Old Age Pension and Blind Assistance recipients without loss of their assistance grants to enter such homes as meet standards prescribed by the Illinois Public Aid Commission. It also made care in such homes accessible to persons able to purchase care from their own resources. It permitted counties to accept patients for care from neighboring counties where facilities are lacking or are unsatisfactory. The law deleted all references to "poorhouses" and paved the way for removing the stigma attached to public nursing homes and for making them available to help meet the total community need for facilities to care for infirm and chronically ill persons. Because federal matching is not available for grants to "inmates of public institutions," expenditures for grants to Blind Assistance and Old Age Pension recipients receiving long-term care in county homes for the chronically ill are being made almost entirely from state funds.

Minimum Standards Established

The Illinois Public Aid Commission in accordance with its responsibilities as conferred by law formulated and published minimum standards[2] which county homes must meet if assistance grants will be continued for persons receiving care in the homes. These minimum

[1]Known as the Rennick-Laughlin Bills (Senate Bills 210, 212, 213, and 534, Sixty-fourth General Assembly of Illinois).

[2]See Section XV of the Appendix.

standards prescribed for the health, safety, and comfort of the patients resident in such homes; medical and nursing care; staff; physical arrangements; and financial practices and procedural arrangements between local and state officials.

State and Local Agencies Co-operate

Through agreements reached with the Illinois Public Aid Commission, the State Department of Public Health and the State Department of Public Safety have determined existing sanitary, fire, and safety hazards and have co-operated with local officials in plans for their correction. Both departments, upon request, review architects' plans, and engineers and field representatives are available for consultation. In addition to the initial inspections and recommendations of these departments, annual reinspections will be made of each home with an approved plan of operation as an additional service to the local officials responsible for the management of the institution.

Following initial evaluation and agreement regarding the adaptability of the institution to a program of chronic care the above factors and other local considerations are incorporated in a total plan worked out by responsible local officials with the co-operation and assistance of staff consultants of the Illinois Public Aid Commission. This co-operative relationship on a continuing basis helps county boards achieve and maintain good standards, serves to co-ordinate state-wide experience for the benefit of each county, and allows for maximum adaptation to meet local variations in problems.

Responsibilities of County Boards

The administration of the county nursing home program is the responsibility of the county boards of supervisors. This responsibility includes admission and discharge policies, personnel matters, charges, supervision policies, and arrangements for changes in the institution itself.

Community Interest in Program

The program has received state-wide interest and support. With few exceptions counties having facilities which county officials considered adaptable have been inspected and have received recommendations from the State Departments of Public Health and Safety. Staff consultants of the Illinois Public Aid Commission, upon request, have reviewed the program with county officials in 55 counties. Public Aid Advisory Committees have made the program a subject of 44 meetings in 29 counties. Civic, professional, religious, fraternal, social welfare, and other agencies and organizations have discussed the program in all parts of the State. In a great many instances support and participation

in the local program have become directly or indirectly an important project of these organizations or agencies.

Homes So Far Converted

The initiation of programs of care of the chronically ill in county-operated homes has progressed beyond the experimental stage. By April 1947 fifteen counties had progressed so far in the development of suitable patient care, modernization and adaptation of physical plants, and in meeting general standards of administration and organization that plans of operation have been approved by the Illinois Public Aid Commission. These counties are Champaign, De Kalb, De Witt, Fayette, Henry, Jackson, Knox, Lee, Livingston, Menard, Mercer, Rock Island, Vermilion, Warren, and Whiteside. The fifteen homes have a total capacity exceeding 916 beds.

Counties Nearing Completion of Conversion

Possibilities for further extension of the program are encouraging. Peoria, Ford, Macon, and White Counties will have completed arrangements for initiating nursing care programs in their county homes in the near future. These counties will provide an additional capacity of over 480 beds. Extensive work is under way in the county homes of eight other counties where homes have a reported capacity of approximately 500 beds.

Counties Having Plan Under Consideration

In addition to the 27 counties mentioned above, 23 counties with buildings of widely differing adaptability and state of repair are in process of converting their county homes into acceptable nursing care institutions or have plans under consideration and are in varying stages of progress in evaluating the possibility of such conversion. Among the counties with no county home buildings, 10 are giving serious consideration to the program either through the boards of supervisors or through leading citizen groups which have recognized the urgent need and the potential good that can be accomplished in the light of the need for this type of service in their communities. Since no buildings are available in these latter counties, interest takes the direction of possible purchase of a suitable building or of possible erection of a new building in co-operation with neighboring counties.

Special Situation with Regard to Oak Forest Infirmary, County Home for Cook County

The Commission has given special attention to the Oak Forest Infirmary which is the county home in Cook County. This institution has not yet been approved under the provisions of the Rennick-Laugh-

lin Bills because standards prescribed by the Illinois Public Aid Commission for the safeguarding of the health, safety, and comfort of patients have not been met.

The following is quoted from the report of the Medical Committee consultant to the Commission (see Section V of Appendix for the full report): "The Committee is not including in this report detailed recommendations with regard to Oak Forest Infirmary, the county institution in Cook County, since its size precludes its consideration jointly with the very much smaller downstate county nursing homes. But the committee does wish to point out that Oak Forest's location near Chicago, with its four Class A medical schools, offers unlimited opportunity for development of this particular institution into an actual chronic disease hospital. The committee recommends strongly that the Cook County Board of Commissioners take necessary action to meet the requirements of the American Medical Association for intern and resident training, so that this institution may affiliate with the Class A medical schools, and thereby become able to offer suitable care and treatment to the patients in Oak Forest."

The Chicago-Cook County Health Survey, in a preliminary report on the Oak Forest Infirmary, found various unsatisfactory conditions at Oak Forest. (See Section X of this Appendix, page 209.)

The objectives of Oak Forest Infirmary should be enlarged from that of offering custodial care to destitute and chronically ill persons to broader objectives of rehabilitating the patient. All of the modern knowledge and techniques of restoring the physical and social functions of the individual should be provided. In addition, because of the size of Oak Forest and its proximity to a great medical center there are other objectives to be achieved. The resources of the institution should be used to learn more about the problems involved in caring for and rehabilitating the chronically ill. It should also offer educational opportunities to the professional groups who contribute to the care of chronically ill people. The educational programs at Oak Forest should meet the standards set by such groups as the American Medical Association or other groups that have established requirements for professional education.

Not only has the institution not progressed toward meeting these broad objectives but many essential requirements relating to staff, program, equipment, and plant have not been met. For example, many serious fire and sanitary hazards reported months ago by the State Department of Public Safety and the State Department of Public Health respectively have not been corrected.

The Commission hopes that the Cook County Board of Commis-

sioners will take action in the near future to correct conditions now existing at Oak Forest. It is recommended that competent medical and hospital advice be obtained by the Cook County Board in planning necessary changes.

The Commission cannot help but compare conditions at Oak Forest with the program conducted at Rancho Los Amigos, the Los Angeles County institution visited by a committee of the Commission on the Care of Chronically Ill Persons. The principal fact which there impressed the Commission members was the individualism of patients, medically, socially, and occupationally. The institution's program, in addition to providing good medical care, permits medical research projects which are supervised by medical school faculty. Occupational therapy, prescribed on an individual basis, is available in the Occupational Therapy Department which includes a shoe shop and a printing shop. The rehabilitation shop, operated under state and county supervision, provides vocational training and an opportunity for the physically handicapped to learn a vocation which will permit them to reestablish themselves in community life. A Patient Employment Department helps with placement. Adult education classes are conducted under the supervision of the county board of education. Seventy-eight per cent of the patients at the Rancho are under 65 years of age and the average stay is about 2½ years. This short stay appears to be directly related to the medical and rehabilitation program of the Rancho.

Laguna Honda, the county institution in San Francisco, which was also visited by a committee of members of the Commission on the Care of Chronically Ill Persons, illustrates the way an institution of this type can affiliate with medical schools for the mutual advantage of the patients and the schools. Laguna Honda is fortunately located within the City of San Francisco and so is easily accessible to all professional and other staff. The institution provides intern and resident training under the supervision of the medical schools, and its entire medical care program is under the direction of medical school faculty.

Counties Lacking Plant Facilities

In contrast to the advancement of the county home program in those counties where suitable buildings are available, approximately one half of the counties of the State either have no county home building at all or the existing building is unsuitable for a nursing home. These counties are largely in southern, southeastern, and central western Illinois. In large areas of the State officials reported to the Commission on the Care of Chronically Ill Persons that there are no facilities for institutional care except in State institutions. They reported no pri-

vate, religious or fraternal nursing homes, no hospitals, and no housekeeping or visiting nurse service. Among the recommendations made at public hearings held by the Commission on the Care of Chronically Ill Persons for meeting the problem in these areas is that of multiple-county institutions. While officials in a number of counties have given consideration to this possibility which is permissible under the county home legislation, no workable plan has yet been developed. Although lack of materials prevents new construction at this time, it is expected that plans will be advanced that will make such construction possible when materials do become available.

Effect of Change in Program on County Home Population

Change in function of these homes with approved plans of operation brought about a change in their population, indicating that the program is serving the purpose intended by providing much-needed facilities for persons requiring specialized care. The 15 approved homes operating under this program as of April 1, 1947 have so far advanced toward meeting the need for specialized care of persons in their communities that 82 per cent of the April 1 county home population was made up of persons requiring nursing care. Of the total number of patients, 56 per cent were Old Age Pension and Blind Assistance recipients, 27 per cent were General Relief recipients, and 17 per cent were private pay residents.

The Henry County Home, with a potential capacity of 100 beds, prior to conversion to a chronic care institution, had 15 General Relief recipients in the home and no other patients. As of April 1, 1947, there were 73 patients as follows: 39 Old Age Pension recipients; 1 Blind Assistance recipient; 14 General Relief recipients; and 19 private pay patients. Of the total of 73 residents 69 require nursing care. This county has a waiting list of patients. Admissions can be made only as additional accommodations are completed in a section of the building that is now being made ready for occupancy.

In the Vermilion County Home which had a population of 100 General Relief recipients prior to conversion there were 143 patients as of January 1, 1947 distributed as follows: 80 Old Age Pension recipients; 1 Blind Assistance recipient; 40 General Relief recipients; and 22 private pay patients. Of the total of 143 residents 121 require nursing care. Separate quarters have been arranged for employees who formerly lived in the county home building to allow more service space and patients' rooms.

Difficulties Hampering Progress of Conversion

Many factors have prevented the approval of plans in counties not yet operating under the plan but where action is under way. The

institutions requiring construction work have been delayed by shortages of material, equipment, furnishings, and labor. Nursing and maintenance staff have been difficult to recruit. Development of a continuing program of medical, nursing, and personal care service with essential emphasis on recreation, occupation, and other services, and adaptation of surroundings approximating home living conditions in keeping with the changed function of the facilities involves long-range planning and in some instances is a slow process. Official apathy, long-standing prejudices, indifference, and management emphasis on the plant and farming operations rather than on individualized care of the patient, while noticeably absent in the majority of counties, hamper and delay action in some counties.

Factors in Long-range Planning

The conversion process has not been simply a matter of determination and provision of patient and staff accommodations, service facilities, recreational and occupational space; elimination of fire, safety, and sanitary hazards; changes, additions, repairs, and other adaptations of the physical structures. Community education, integration of the program with health and other services of the county, adoption of an over-all plan, program development, equipment, personnel adjustments, management considerations, policy determinations, budgeting and accounting procedures, financial planning, and appropriations by county government to finance the initial expenditures necessary—all of these considerations are among the multitude of factors involved in successfully launching a long-range plan and program adapted to the changed function of these institutions.

Significance of a Sound Program of Care

Substantial structural changes, elimination of fire and sanitary hazards dangerous to the health, safety, and well-being of the residents and staff, accident prevention, procurement of suitable equipment and furnishings, and other adaptations of the physical plant are fundamental beginnings in transforming the function of the county homes. From the point of view of objective it is relatively of much greater significance that those responsible for planning and organization maintain and project a sound program of care and activity for the residents in a setting that has the attributes of a HOME. Some men and women reach the county home sick or chronically invalided. Others are senile, crippled, blind or otherwise handicapped and present special problems of many different kinds.

Personnel Problems

As is to be expected there is a varying degree of development of

the programs in the county homes. Some counties have difficulty in securing a sufficient number of personnel and have been unable to get staff as qualified as local officials realize is necessary. This is true at the initiation of the program in a county. However, no programs in approved homes have been affected except for short periods. The major problem is in recruiting suitable registered nurses. Hospitals, doctors, nurses' associations, and county health departments have assisted in recruiting personnel. In Henry County the local hospital gives persons employed by the county home as practical nurses a special course of training in preparation for their duties. In Knox County the Grey Ladies of the American Red Cross are helping out three afternoons each week. In the near future it is hoped that Red Cross nurses' aides can be assigned for duty at the county home.

Management problems involved in the change of function of the program in the county homes have caused concern. In several counties local officials found it necessary to replace superintendents who could not adapt themselves to the new program.

Organization and Direction of the Medical Program

It cannot be stressed too strongly that in most counties there is need for further emphasis on careful planning and organization of the total medical service with adequate medical direction, specifically formulated over-all medical policies, and continuity in the maintenance of suitable standards of care through evaluation of the program by qualified professional persons.

In addition to the day-to-day care of the patients certain general considerations affecting their health and well-being should have professional attention. Heating, ventilation, lighting, dietary requirements, general sanitation, equipment and supplies, nursing care, initial and subsequent periodic examination of patients and staff, and recording of medical history are among some of the essential factors in the program that should meet approved standards. The medical policies of the institution should be established and directed by members of the medical profession fitted by training and experience to evaluate the requirements for a medical care program in an institution for the chronically ill. This practice would allow the program, as it progresses, to be enriched with the application of the best knowledge available from modern medical science for the purpose of the fullest rehabilitation of the patients.

In its report, "Medical Supervision and Care in Institutions for the Chronically Ill,"[1] the Committee of the Illinois Medical Society

[1]See Section V of this Appendix for full text of this report.

Consultant to the Commission on the Care of Chronically Ill Persons, in respect to the medical care aspect of the program, states that:

"The Committee believes that it is particularly important for county nursing homes in Illinois, operating under the provisions of the Rennick-Laughlin Bills, to have competent medical direction of their medical program."

This report continues with the following substantiation of this statement:

"A county board, which constitutes the governing board for the county nursing home, is made up of elected officials, and is the governing board for all other county affairs. By law, the county board is responsible for the administration of the county home, but it must be recognized that members are not selected as are boards of private institutions, solely because of their particular interest in and knowledge of the institution's program. Despite this fact, many county boards have developed programs that show considerable understanding of the needs of chronically ill persons. This understanding, of itself, should encourage county boards to arrange for good medical direction. In most counties this could best be provided by an advisory committee representing the county medical society. While county boards of supervisors are responsible for the creation, maintenance, and administration of county nursing homes, it is entirely within the law for responsibility for medical direction to be delegated to the medical profession, and such delegation assures both the county board and the patient that the best possible care is provided."

It has been demonstrated in Vermilion County that such a relationship can be successfully and harmoniously worked out between the county board of supervisors and the county medical society to the benefit of the medical program of the institution as well as to the benefit of the patients. In that county careful planning and organization of the medical service of the institution is proceeding under the direction of Dr. Harlan English, Chairman of the Vermilion County Medical Society. Local public officials in all counties where this program is planned or is in operation should give full consideration to the development of a similar plan which will ensure the availability of the best services of the medical profession.

In Knox County, where the program was recently approved by the Illinois Public Aid Commission, arrangements are already in process to establish a co-operative plan of this nature at the institution in coordination with the county medical society. The interest of the Knox County Medical Society is tangibly demonstrated by the following

resolution which it adopted while the program was in process of development:

"Whereas, the Knox County Home and Hospital is in process of conversion to a Home for convalescents and the chronically ill, and

"Whereas, the Knox County Medical Society recognizes the pressing need for such an institution, is interested in any and all projects designed to provide more adequate care to the diseased and infirm, and as the members of this Society are especially fitted by training and experience to be of service in planning and organizing an institution of this character,

"Therefore, be it resolved by the Knox County Medical Society that we offer to the Knox County Board of Supervisors, our services in an advisory capacity, in the planning of equipment, the keeping of medical records, and the general operation of the institution, in order that adequate care may be provided for the needy convalescents, the chronically ill and the infirm of this county."

In varying degree in many counties of the State, county societies, medical advisory committees or individual doctors have been exceptionally helpful in initiating good medical programs in the county homes. However, as is pointed out, the effectiveness of the total program does differ in accordance with the competence of its organization and continued direction.

Adjunct Services

It has been emphasized repeatedly in hearings of the Commission on the Care of Chronically Ill Persons that occupational and recreational therapy, social service, individual and group recreation, and social activity should receive greater attention in the programs of the county homes. While it is recognized that it is desirable to have especially qualified persons on the staff of the institution for this purpose, the resources of the community can be of great value. These resources should be used to the fullest extent in furthering such activity.

"Over-the-hill-to-the-poorhouse" is no easy thing to erase in the minds of the public. The change in connotation from "poorhouse" to "home" and all of the attendant implications is inherently a matter of program and education. The home must accept and treat its patients as individuals and human beings.

Community Support and Participation a Continuing Responsibility

A purposeful and well-directed educational approach is basically necessary to meet difficulties and differences in handling the many phases of this program. An integrated approach to all of the medical,

social, and administrative problems involved in a program of sheltered care for the infirm and chronically ill and particularly with the problems peculiar to the aged is much more important than the fact that an institution has met certain general minimum standards of operation. To accomplish such a program for the care of the sick, the medical, health, and social resources of the community must be mobilized and must function on a continuing basis. In a successful program of this kind it is highly important to get community thinking into the institution. The community must judge the institution by the success or failure in doing the job for which it is primarily responsible, the meeting of the total needs of the people for whom the program is established and for whose care the institution exists.

Citizen groups should constitute themselves investigating committees of such a public institution and should demand better standards. No program can continue to grow after the impetus of its beginnings fades away without active support and even the "needling" of interested citizens. The wise county board seeks such interest in an organized manner; the indifferent ones, it is hoped, will have it thrust upon them.

Where nursing care programs are in operation they must not be allowed to deteriorate through the self-satisfaction, lethargy or indifference of elected or appointed officials. Changes in the make-up of the county board and its county home committee must not adversely affect the functioning of the program. It must be emphasized that stability in administration of these county-managed institutions is essential to obviate insecurity and confusion that can be a real danger to the health and well-being of the patients.

Continuity in administration of the program can be strengthened in various ways. Many counties no longer change the entire membership of county home committees when county boards are reorganized. In some instances these committees have been enlarged to provide a wider background of experience and qualifications in representation. Consistent efforts to acquaint all members of the county board with the development and progress of the program is proving exceptionally helpful. Public-spirited citizens are invited to attend meetings of the committees. Professionally qualified persons have participated in planning and organization of local programs.

It would seem most logical for county boards to establish and maintain a controlled and directed community interest in the county home program. This could be most effectively accomplished by appointment of a group of citizens qualified by experience to act in an advisory and consultative capacity to the county home committee,

serving for overlapping periods that would ensure continuity in the long-range program.

While there appears little danger of "back-sliding" at this time counties need to be constantly alert to steady and progressive advancement in all areas of the program in other counties as well as their own. It has been found that exchange of information and pooling of experience among the various counties have been of great value and as the practice is extended it will contribute much to the mutual benefit of the counties and to the general advancement of the program. Local officials, directors, and supervisory staff of the county homes, and other interested citizens who have recognized the importance of such a plan have visited the homes in many counties other than their own and have exchanged views on program developments and local problems. It must be constantly stressed that continued success in the advancement of the county home program is dependent upon energetic and competent direction of the various phases of the program with the constant support of the local community and full use of its resources directed toward achievement of progressively improved standards of care.

SECTION XV

RULES AND REGULATIONS IN REGARD TO STANDARDS FOR SAFEGUARDING HEALTH, SAFETY AND COMFORT OF INMATES OF COUNTY HOMES FOR THE DESTITUTE, INFIRM, AND CHRONICALLY ILL, AND TO COMPLIANCE THEREWITH

(Released by the Illinois Public Aid Commission October 19, 1945)

I. MINIMUM REQUIREMENTS

The Old Age Pension and Blind Assistance Acts provide that a resident of a county home shall be eligible for either of these forms of assistance only when the facilities of the county home with respect to construction, sanitation, and general hygiene are in conformity with standards prescribed by the Illinois Public Aid Commission for the safeguarding of the health, safety, and comfort of the inmates thereof.[1]

The following minimum standards relating to physical arrangements, staff, and care of patients, shall be met before the Illinois Public Aid Commission will approve Blind Assistance and Old Age Pension grants for persons receiving care in county homes for the destitute, infirm, and chronically ill.

A. Fire and Sanitary Hazards

1. A current report from the Division of Fire Prevention, State Department of Public Safety, shall establish that there are no fire hazards.
2. A current report from the Division of Sanitary Engineering, State Department of Public Health, shall establish that there are no sanitary hazards.

B. Medical and Nursing Care

1. Provision shall be made for physician's services at regular

[1]As amended by the Rennick-Laughlin Bills. These regulations were issued October 19, 1945 to supersede first regulations issued September 5, 1945.

intervals, and for emergency calls by a physician when a patient's condition requires this.

2. The staff of nurses, nursing attendants, and other personnel in the home shall be of sufficient number and physical ability to meet the patients' requirements and to maintain adequate standards of comfort and sanitation. Attendants giving personal care or nursing service to patients shall be sufficiently trained and experienced.
3. Facilities for easily summoning an attendant during the day or night shall be provided all patients.
4. All drugs and medicines shall be properly labeled and stored in a locked cabinet or closet to which patients do not have access. No one shall administer any sedative or narcotic drug, such as is sold only upon prescription of a physician, unless a physician has ordered the superintendent or employee, in writing, to administer such drug to the patient. In general, no drugs except such ordinary ones as aspirin, mild laxatives, gargles, and sodium bicarbonate, shall be administered except by direction of the physician.
5. An adequate diet, evaluated with due regard to quality, quantity, and preparation, shall be furnished to all patients. Special diets, when recommended by the physician, shall be furnished.
6. Methods of physical restraint shall not be used except in homes licensed by the Division of the Alienist to give care to persons with chronic mental disease or defect. If a person is so feeble physically that there is danger of falling from his bed, sideboards shall be used on the bed.

C. Physical Arrangements

1. The home shall be sightly, both within and without, and shall provide reasonable comfort for all residents.
2. The home shall be maintained in a clean and sanitary condition.
3. Adequate lighting and heating facilities shall be provided and maintained.
4. Adequate bathing and toilet facilities, on the same floor as the sleeping rooms whenever possible, shall be provided and shall be maintained in a sanitary condition.
5. Patients shall not be placed in rooms partially or completely below ground level. Non-ambulant patients shall not be placed in rooms on any floor above the second.
6. Every patient shall have a separate bed in an adequately ven-

tilated room having one or more windows. Number and spacing of beds in each room shall be such that over-crowding does not exist.

7. Adequate clean linen shall be supplied, with bed linen changed not less often than once a week, and more often than this when the patient's condition so requires. For example, the bed linen of a bed patient shall be changed at least twice a week.
8. Clean clothing shall be supplied as frequently as the patient's condition requires.
9. Provision shall be made for bathing twice a week, and assistance shall be given to patients needing it. Bed patients shall be bathed more frequently when their condition requires it.

II. COST OF CARE

The amount to be allowed in the Old Age Pension or Blind Assistance grant for care in a county home that has met the requirements for approval shall be determined by agreement with the county board of each county, taking into consideration the amount paid by townships for the same type of care. This rate shall be subject to review in one year.

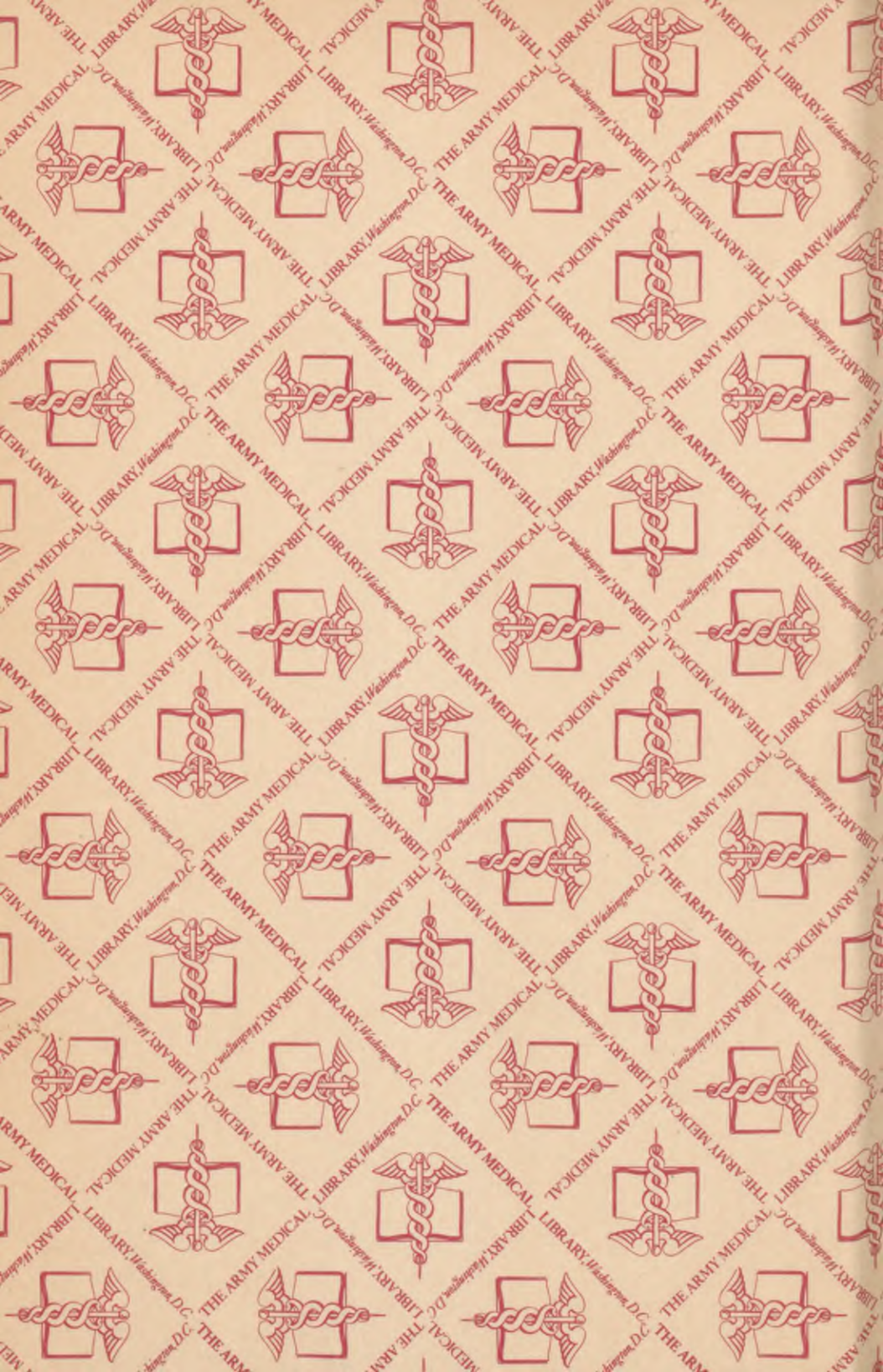
III. PROCEDURE

A. The county board or county home committee shall advise the county superintendent of public assistance if approval of the the home is desired.

B. The county board or county home committee shall prepare written requests for fire and sanitary inspection, addressed respectively to the Division of Fire Prevention and the Division of Sanitary Engineering. These requests shall be given to the county superintendent of public assistance, for transmittal to the Commission, so that arrangements may be made for immediate inspection. If an inspection has been completed within six months, and a written report is available, another will not be necessary at this time.

C. The county board or county home committee shall prepare a statement indicating that recipients of Old Age Pension and Blind Assistance will be accepted for care at the agreed rate.

D. The county superintendent of public assistance shall submit to the Commission a written report concerning the home, and shall submit it with the requests for inspection and the operating cost statement.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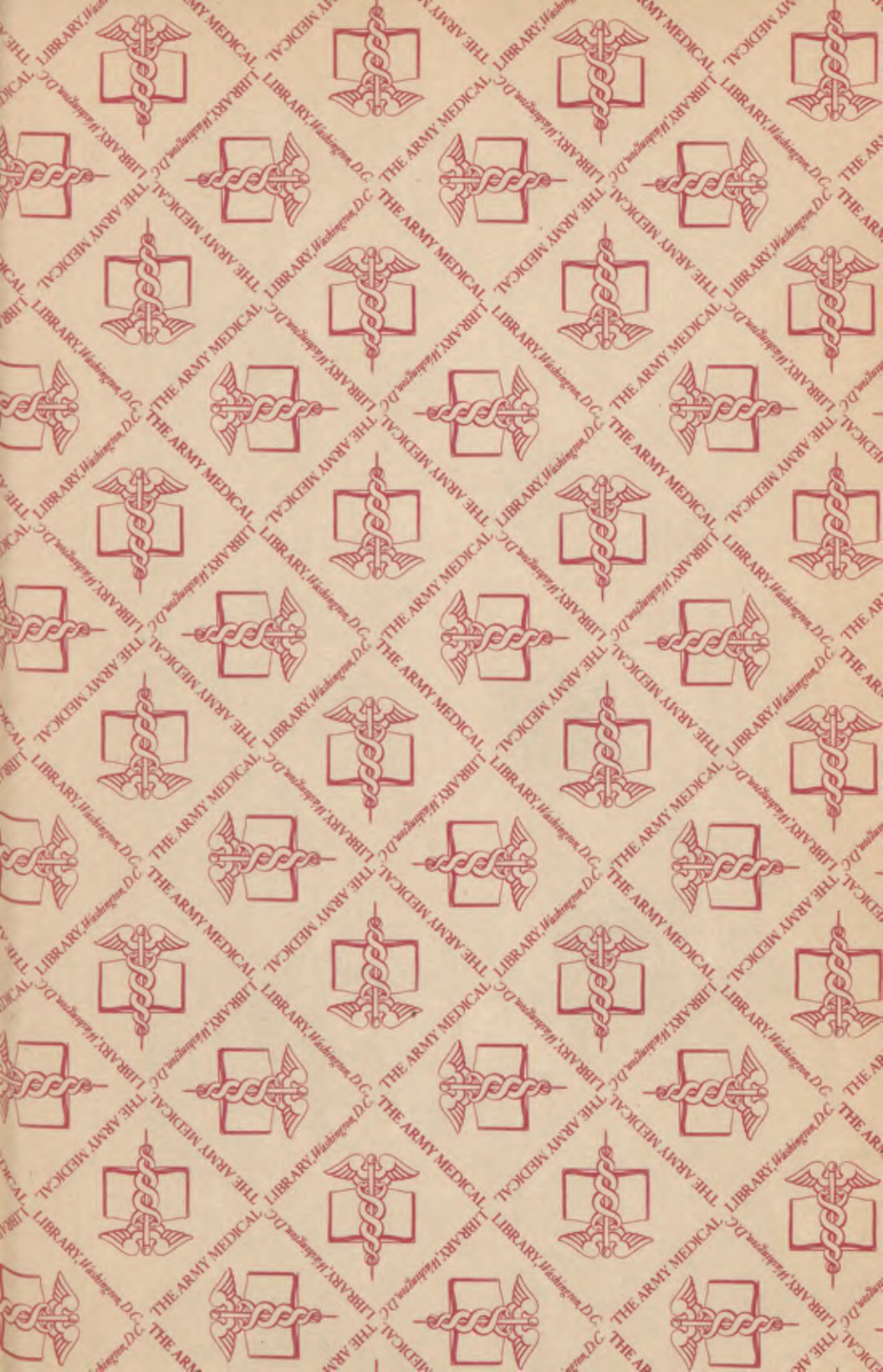
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