THE HOSPITALIZATION, HOUSING AND ACCOMMODATION OF THE AGED*

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The problem of hospitalization, housing and accommodation of the aged is not unique to South Africa. It is a world-wide problem and, judging by the number of books published on this subject, it is a problem that is taxing the best brains in the world today.

'Old age' as a problem has been recognized since the dawn of time. Hippocrates mentioned it 2,000 years ago, and pointed out what was to be expected after the proverbial three score years and ten. To his mind old age was purely a geriatric problem, but since his time gerontological problems have cropped up which he had never even thought of considering. The problem of hospitalization and accommodation barely existed then, but have increased through the ages as the proportion of the aged to the entire population increased.

There are many reasons for this, which, rightly or wrongly, induced some recent investigators to formulate the theory that, as a country develops, the percentage of people above the age of 65 increases. The number of people above the

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age of 65 is therefore a measure of the degree of development of the population. It is even stated that if the percentage of old persons in a particular community is less than 10% of the total, then that community is 'under-developed'.

It might be mentioned that the White aged population of the Cape Province in 1956 was 9% of the total White population. Investigations tend to point to a much lower figure for the aged Coloured to total Coloured population — probably 4·5% or less. What the figure is among the Bantu is not known, but it must be very small indeed. For comparison it can be stated that most Western countries have percentages of well above 10%.

Statistics

For the purposes of this paper only the White population of the Cape Province was considered. A study of the 1956 census returns showed that the total White population of this Province was 935,085, and the number of persons over 65 in the Cape totalled 85,000. This figure can be divided as follows between the 132 districts:

Cape area (two districts)	22,500
Port Elizabeth	7,000
East London	4,000
Kimberley	2,000
Uitenhage	1,300
Paarl	1,100
83 smaller towns	46,800
42 Bantu areas	200
Total	84,900

This means that in every district, except the towns and Bantu areas, there are about 550 individuals over the age of 65. These figures will be referred to again later in this article when the problem of accommodation is considered in greater detail.

Classification

Elderly people are usually classified according to whether they are healthy, chronically ill, frail, helpless, senile, etc. or alternatively, according to their ages. Both these methods of classification are, however, unsatisfactory because there are too many variable factors. For instance, some people are senile at the age of 70 while others are normal at 85. I should therefore like to suggest a more practical classification which cuts across both the above methods and allows for individual differences. Five possible categories, based on methods of accommodation, suggest themselves:

1. Those accommodated at home with relatives. This group consists of about 95% of all the aged, depending on the particular locality where they live. In rural areas most old people live with their near relatives as was customary in bygone times and is still practised in some rural areas and among the non-European people of South Africa.

2. Those living alone in flats, boarding houses or hotels. This group includes old people who maintain themselves on their pensions or private incomes. Their accommodation is often very unsatisfactory and inadequate; the food is often poor, and the quality of the accommodation is usually in proportion to their incomes. This group of people cause great concern and difficulty when they become chronically ill, incapacitated, or senile.

3. Those accommodated in old-age homes. In this group are those who live and enjoy their old age in old-age homes where they are housed very efficiently although on a somewhat sub-economic basis.

4. Those accommodated in institutions for the chronically sick. When old people become chronically ill they can at present go to hospitals which cater for this type of patient, but, unfortunately, these institutions are few and far between and not very popular — not for lack of care or nursing, but because people do not like going to places where life is monotonous and the outlook futile.

5. Those accommodated in mental institutions. This group consists of demented, psychotic and senile people, who can only be housed in mental hospitals because it is not advisable for them to be nursed in ordinary old-age homes by their relatives, or in hospitals.

Survey in Two Cape Town Hospitals

To obtain a clearer picture of the position in hospitals as regards the aged, a survey was made in the two largest hospitals in the Cape Town area, namely Groote Schuur Hospital and Conradie Hospital. (Dr. T. Jones, Medical Superintendent of the Conradie Hospital, kindly assisted in this matter.) The investigation conducted at the Groote Schuur Hospital was conducted during the period 1 July - 31 December 1960. It was found that 16·6% of all the White admissions to the wards were over the age of 65. It was also found that in the 5 major medical and surgical White wards 27% of the population was over 65 and 18% over 80 years of age. The length of stay corresponded very closely to the length of stay of those in the other age groups, viz. 54% were discharged before the 12th day and only 0·4% stayed longer than 100 days. The average length of stay was 12·38 days — a close approximation to the 12·42 days for all patients including Coloured patients. During the above period there were daily between 60 - 70 patients over 65 (7 - 8% of the total) in all the wards in this hospital, but since they conformed to the pattern of the other age groups, they were not noticed and were no burden.

The Conradie Hospital, a 600-bed hospital of which 400 are for chronic patients, was originally a chronic-sick home where some acute wards have recently been opened. It is therefore a mixed hospital at the present. An investigation over a 6-month period showed that 25·3% of admissions were over the age of 65 and on any one day 63·09% of all patients in the wards were over the age of 65. As to the length of stay, 27% were discharged before the 12th day and 14·9% remained over 100 days. The average number of days any patient remained in hospital was 54·17.

The difference in the figures obviously points to the difference between hospitals for acute cases and hospitals for long-term cases. Further investigation showed that in the White section the average age per patient in the acute wards was 58 6 years and in the long-term wards 65·6, which might mean that all the chronic patients could not be classified in the 'aged' category.

The Elderly Patient in Hospital

Any general hospital should admit patients irrespective of their ages, and elderly people should never be denied a bed merely on account of their age. It is felt that old people should be admitted into the general wards of the hospital, for there they will get the best care and will be less liable to be neglected.

A general hospital should, however, never be saddled with the so-called 'social problems'. In every instance the family, the old-age home or the institution that referred the patient to the hospital, must be prepared to take him back. This condition should definitely be laid down and understood. Occasionally, however, beds are requested for chronic aged patients, who are often viewed with distrust, although they may well need hospital attention. Before admission to the hospital a social worker should investigate every case of this nature to ascertain the method of discharge or subsequent disposal.

If it is true that a quarter of the patients in the general medical and surgical wards of 'acute' hospitals are over the age of 65, all these wards should be well equipped to cater for the aged. Invalid-chairs, wheel-chairs, sanitary chairs, commodes, walking aids, etc. should be available and can be of great help and comfort. Soft mattresses and air-rings not only prevent bed-sores, but ease feelings of discomfort arising from wasted muscles and skin which has worn thin and lost its elasticity.

The usual nursing staff in the wards are well able to deal with geriatric patients, who sometimes make good patients and sometimes bad ones, as is the case with any other group. Nurses should, however, be taught something about human relations and dealing with the aged sick. They should be warned about the eccentricities of old people so that they might know how to react to family histories, stories about the old people's friends and colleagues, their personal idiosyncrasies, and their hypersensitiveness to draughts, food, the arrangement of lights, etc.

There are many other points in this connection which

should be borne in mind, and student nurses should be warned of all the possible pitfalls. For instance, old people usually need plenty of fluids and their backs are very liable to develop bed-sores from poor blood supply and incontinence. They tend to be static and lazy, and have to be encouraged to move and roll about in the bed.

The nursing staff should always be aware of the danger to old people of falls, either from a bed or when turning round, trying to get up, walking, or using the toilet. They should never be allowed to go to the toilet alone; it is here that the sanitary chairs are very useful. The nurses should also realize that eyesight becomes impaired with age and that in elderly people the judgement of distance, coordination, and perceiving depth are affected, especially in the dark. The proneness to vertigo and blackouts also leads to falls and should never be forgotten when dealing with the aged. It is important to realize that one-third of all the illnesses of old people originate in falls.

An important point to remember is that, just like infants, old people differ in their reaction to drugs from people in the middle-age groups.

Severe accidental or surgical shock, or even an acute illness such as pneumonia, might precipitate an irreversible senility. It might be just as well to explain this fact to relatives, otherwise the hospital or the treatment might be blamed — especially when an operation is to be performed.

Medical care for the elderly should be of the best. A patient should never be examined casually because he is old, hemiplegic, arteriosclerotic, senile, etc. Full notes should be taken and records kept. It is important that the diagnosis should be established by the best scientific means available. The treatment should be active and specific, if possible, and never only palliative. Treatment should not be by trial and error or according to a rule of thumb.

When elderly patients are brought to a casualty department no special facilities are necessary, and they should be treated as any other patients. However, in an outpatient department, where there are long queues, some consideration should be given to the aged. It is probably not practicable to start a special geriatric clinic because of the varied nature of the ailments of old people and because of the fact that a geriatric clinic must be organized on the basis of teamwork. This could be overcome by starting a geriatric reference clinic to which the aged are referred by appointment. A particular consultant or consultants who are interested in geriatric problems could then see these patients at their leisure, on appointment. It should not be difficult to arrange this.

It might not be out of place to say something here about hospitals for chronic patients, since these patients are mostly elderly people. It often happens that these patients are neglected because of the nature of the work in their wards. There is no active treatment, or very little, and nursing is at a minimum. Chronic patients should be nursed in the same wards with the other patients or, better still, in old-age homes among their friends and not in a hospital at all.

Gerontels or Old-Age Homes

It is proposed to coin a new word for 'old-age home', since this term has a stigma attached to it and should be discarded. Modern homes for the aged are well-run hotels with a hospital section. They are first-class institutions and offer much more than the old 'homes for the poor aged'. The suggestion is therefore made that the word 'gerontel', which implies status, independence, and care for the old people, be used instead.

In many recent medical and sociological surveys it has been found that the most dreaded bugbear in old age is loneliness, and I am convinced that it is essential that elderly people be cared for near their friends and relatives and in the vicinity where they have lived all their lives.

My reasons for these views are obvious:

(*a*) Old people should be near their friends and relatives because the aged do not make friends easily and the friends of their youth are very dear to them.

(*b*) They become accustomed to a particular locality.

(*c*) The community among whom they lived should take the responsibility for them.

A very strong plea is therefore made that every town should be encouraged to build and support its own gerontel, which would lessen the burden of the other towns and keep the old people in their accustomed environment with their friends.

From the figures already quoted, it is clear that each district, with the exception of the bigger towns, has ± 550 elderly people, and if, as is usual, 95% live with relatives, a gerontel to house 25 - 30 guests is all that is required for towns like Beaufort West or Upington, for instance. In the bigger towns it appears that at least 5% of the old people wish to live in gerontels, which means there would have to be 4,000 in the Cape Province and about 1,200 in the Cape Peninsula alone. Cape Town has in the vicinity of 1,100 rooms available in 13 gerontels, but then there are still long waiting lists. It should be pointed out that many of those whose names are on the waiting lists, as well as those occupying rooms, are from outside districts and should not be housed in Cape Town at all.

An attempt will now be made to describe an ideal gerontel, which would fit in with Provincial-hospital policy and render the most valuable service to the community. It should contain: (1) comfortable accommodation; (2) a sick bay for minor illnesses; (3) nursing staff to deal with any bedridden inmates; (4) visiting medical staff; and (5) competent medical auxiliary staff, e.g. social workers and physiotherapists.

The number and size of gerontels that are needed in every community, including the number of hospital beds in them, can be calculated from the available statistics.

Opinions differ as to whether these gerontels should be designed for certain types of old people only, e.g. those over 75 or those younger, for males or females, etc. The best type is probably a mixed gerontel for all ages. In a mixed gerontel, husband and wife could live together. This is desirable since the two sexes tend to have a beneficial influence on each other.

The gerontel itself should be carefully planned and, if it contains more than one floor, should be fitted with a lift. The rooms need not be large, but at least 5 rooms out of every 100 should be designed to take 2 or 3 beds. These rooms are for the chronically ill or frail inmates who are unable to help themselves; they should be distributed throughout the building. Apart from these rooms, there should also be a definite sick bay of 3 beds for every 100 inmates, where the acutely ill could be nursed.

These gerontels should be staffed with trained as well as assistant nurses to do the general nursing, of which there is quite a large amount in an institution of this nature. Should any of these inmates be admitted to a hospital, they could be returned to the gerontel as soon as they are able to be moved, where they could then be nursed among their friends. This would not only relieve the pressure on hospital beds, but would also save quite an amount of expense. That gerontels should care for their inmates when ill seems sound practice.

Gerontels should serve the purposes of health resorts, convalescent homes, recuperation centres, as well as chronic hospitals. They should be considered part of the general hospital with which they are associated, and should be subsidized as such. If this proposition is put to the Provincial authorities in a proper manner, there is no doubt whatsoever that they will be easily convinced. It has to be stressed, however, that a gerontel is not an old-age home or a chronic-sick hospital, but a home and a hospital for the aged where they can find company and rest, and be cared for in their own rooms.

Surveys made in England and America show that of all the old people who become so ill that they have to be admitted to a hospital, 40% recover completely, 20% die, and the rest (40%) become chronically ill and create a difficult problem if they have to live in private rooms, flats or boarding houses with nobody to care for them.

This is a problem for which there is no easy solution. A number of private nursing homes do exist, but the cost to the old people is often prohibitive. Arrangements could be made for some of them to board with private families to obviate abuse. The solution of the problem of the chronic sick probably lies in creating facilities for their care in existing gerontels or in hospitals.

A joint scheme between the Provincial authorities, the Department of Social Welfare, the Department of Health and the universities, will probably provide the ultimate solution to the problem of caring for chronically ill, elderly people.

Senility

It is well known that 3·8% of all those over 65 show various degrees of senility — from the eccentric person to the fully demented patient. This means that there are 2,500 such individuals in the Cape Province that have to be cared for. These senile, demented and psychotic old people should never be left with their families, in boarding houses, or in gerontels, because it is very difficult to control them, especially in the towns where they may be a great nuisance to their neighbours. They are often dirty in their habits and have a tendency to disappear and get involved in unsociable acts.

Whether they should be admitted to an ordinary mental hospital is debatable. Mental hospitals are no doubt well equipped to care for them, but the whole problem is extremely complicated. Moral obligations such as love and gratitude cannot be entirely ignored, and the stigma attached to having a relative in a mental hospital has, regrettably, still to be reckoned with even in the 'enlightened' days of the present century.

A hospital for senile patients will probably provide the solution. Under these circumstances it is not so necessary for them to be nursed among their friends, and 3 or 4 such hospitals at vantage points throughout the Cape, preferably near large towns, ought to be sufficient to fulfil this need.

Eccentrics

The eccentrics present a further problem. They often cause endless trouble in gerontels and to friends and relatives, and it is felt that they should be accommodated in a special type of home consisting of small bungalows where they can have all the necessary freedom and facilities, but still receive care. Their hobbies should be encouraged, e.g. reading, gardening, walking, etc., and the mere fact that they are free in this respect would make them more amenable to the necessary supervision.

Paramedical Personnel

This discussion cannot be concluded without referring to the paramedical services and their importance in a hospital for the aged. These services are being rendered by physiotherapists, occupational therapists, and medical social workers.

Most modern hospitals employ medical social workers, but their services are often sadly misused. It is the medical social worker's duty to investigate all the circumstances surrounding a patient's life, and to make arrangements for his satisfactory placement on discharge. All the necessary facilities and time to do this properly should be at her disposal. Apart from this task, the medical social worker is required to arrange about pensions, deliver messages, interview relatives, and be the go-between between sister, doctor, patient and relatives. It is her duty to be the patient's best friend in the hospital.

Such auxiliary services as physiotherapy and occupational therapy are very important to the aged. How many times does it not happen that an old lady is cured of her fractured femur, but is unable to walk without pain owing to the subsequent osteoarthritis. These services can prevent the crippling consequences that are so liable to occur in the aged. Even in assisting the old people in such simple, elementary procedures as walking, dressing and undressing, manipulating a knife and fork, going to the toilet, etc., the occupational therapists are rendering an invaluable service.

The services of these auxiliary personnel are as important (or even more important) in a gerontel as in a hospital, since they keep the inmates healthy, fit and happy and, what is more, they keep them out of hospital.

Financial Considerations

In view of the government's great obligations to both its young and its adult citizens, government departments are often reluctant to undertake costly social services for the elderly, who are considered unproductive in the economic sense. For years to come the burden of providing special services for the aged will therefore have to rest on a benevolent public.

However, in many instances, the Provincial Administration will be found willing to assist and even ready to bear the entire burden. If gerontels are envisaged and organized as part-hospital (60%) institutions, they could be subsidized on that basis.

The ideal solution would be for the State to be entirely responsible for the care of elderly people — as is the case in the rest of the so-called 'developed' world.