CARE OF THE CHRONICALLY ILL

AND DISABLED AGED

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PREFACE

Problems of chronic illness and disability occur more frequently among older citizens than younger ones. Since an increasing proportion of the national population falls within the older age groups, understandably an increasing amount of attention and effort has been devoted to improving programs for care of the chronically ill and disabled aged.

Hawaii has been noted for many years as an area which has a young population. This situation, however, is changing substantially and rapidly. The proportion of persons age 65 and over will probably double during the next 20 years. Hawaii is thus in the unique position of being able to plan effectively for the care of the aged and in that planning to profit from the experiences of her sister states.

This report addresses itself to the nature of the problems of caring for the chronically ill and disabled aged and discusses some of the available alternative approaches. It was prepared at the request of the House Committee on Youth and General Welfare of the First State Legislature. The assistance of Mrs. Alexander Faye, executive director of the interim commission on aging, is gratefully acknowledged.

The study was conducted and the report prepared by Mildred D. Kosaki with the assistance of Kum Pui Lai, both of the Legislative Reference Bureau staff.

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I. INTRODUCTION

The American population is changing in character. The average age level is becoming higher, and the proportion of older people is increasing. Furthermore, women tend to outlive men, so that the changing age distribution is also characterized by an imbalance of the sexes among people 65 years and older.

Since 1900 the population of the United States has doubled; the number of persons aged 45 to 64 years has tripled; and the number of persons aged 65 and over has quadrupled.[1] In 1900 only 4.1 per cent of the population was 65 and over; by 1950 this proportion had risen to 8.1 per cent. One estimate is that it will reach 11 per cent in 1975 and about 12 per cent between 1980 and 2000.[2] These estimates do not take into account the possibility that medical science may further lengthen the life span of an individual. Table 1 furnishes data on the life expectancy of the white, non-white, and total population of the United States in 1900 and in 1957. Average life expectation has increased by 22 years since the beginning of the century. These advances have resulted primarily from the reduction of infant mortality and mortality from childhood and infectious diseases. Even further

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[1]Dorothy C. Tompkins, The Senile Aged Problem in the United States (University of California: Bureau of Public Administration, January 1955), p. 1.

[2]Council of State Governments, The States and Their Older Citizens, A report to the Governor's Conference (Chicago: the Council, 1955), p. 9.

gains may result from the control of diseases prevalent among older persons, such as heart disease and cancer.

Table 1

LIFE EXPECTANCY IN THE UNITED STATES, BY WHITE AND NON-WHITE POPULATION 1900 AND 1957

Group	Male		Female		Both Sexes	
	1900	1957	1900	1957	1900	1957
White	46.6	67.1	48.7	73.5	47.6	70.0
Non-white	32.5	60.3	33.5	65.2	33.0	62.4
All races	46.3	66.3	48.3	72.5	47.3	69.3

Source: Institute of Life Insurance, Life Insurance Fact Book 1959 (New York: the Institute, 1959), p. 109.

Why do the aged in America present a problem? Probably the chief reason lies in the major economic and social changes which have transformed a rural and agricultural society into an urban and industrial society which to date has failed to provide a role for the aging individual. Retirement to many older persons means a shift from independence to dependence and a loss of their previous status. This psychological problem is further compounded by a decline in physical fitness which accompanies aging.

The Problem of Physical Health

The extent of decline in physical fitness varies from individual to individual. Persons 65 years and older may be (a) healthy, (b) acutely ill, or (c) chronically ill and disabled. The first group poses no prob-

lems as far as physical health is concerned, although they may need help in terms of finding suitable living quarters, of using their leisure time, and of living on a minimum income. The second group is generally cared for in hospitals. The chronically ill and disabled, however, constitute the crucial health problem of the aging. They can be grouped into several classes on the basis of the medical care they require and their employability: (1) those with disability that does not interfere with employability; (2) those with disability that limits employability to sheltered employment; (3) those disabled and unemployable, but ambulatory; and (4) those who are bed-bound.[3]

The results of the 1957-1959 National Health Survey indicate that the incidence of chronic conditions increased with age; 56 per cent of persons 45-54 years of age, 77 per cent of those over 65 years of age, and 83 per cent of those over 75 years of age had one or more chronic conditions.[4] It was also found that 13 per cent of persons 45-54 years of age and 55 per cent of those over 75 years of age had partial or major limitation of activity due to chronic conditions.

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[3] Ibid., p. 33.

[4] U. S. National Health Survey Staff, Public Health Service, Older Persons, Selected Health Characteristics, Health Statistics from the U. S. National Health Survey, June 1957-June 1959 (Washington, D. C.: Government Printing Office, September 1960), p. 2.

Furthermore, persons 65 years and over had an average of 14.2 disability days and visited physicians at the rate of 6.8 times per person per year. The National Health Survey report also indicates that "while the rate of incidence of acute conditions among persons 45 years and older is no higher than for other adults in the population, it is evident . . . that the disability from acute conditions to which older persons are subject is by no means negligible."[5] During the period 1957-1959, it was found that the number of acute conditions per 1,000 persons 65 years and older was 1,626.

In the past a great proportion of people with disabling chronic illnesses was placed in hospitals, without separating those who could be rehabilitated from those who required custodial care. The concept of rehabilitation is a fairly recent one and is only now beginning to pose an alternative to the prevailing concept of custodial care as the only solution to illnesses among the aged.

The Problem of Mental Health

Approximately one-third of the total number of patients in state mental hospitals are 60 years and older, and one-fourth are 65 and over. The last century has witnessed a tremendous increase in the number of aged persons in mental hospitals. The number of persons in mental hospitals increased about three times in the period 1900-1950, while the number of patients 65 and over increased nearly tenfold. This star-

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[5] Ibid., p. 32.

tling increase cannot be attributed solely to the fourfold increase in the population of the aged nor to the greater incidence of mental disorders. A significant factor is the tendency of adult children to rely on institutional care for senile parents rather than on home care.

Opinions vary, however, on the extent to which aged patients now being admitted to mental hospitals could be better cared for in other facilities. In order to obtain a cross section of professional opinion on this matter, the Council of State Governments sent a questionnaire to officials in charge of mental hospital programs in 47 states and to 33 outstanding psychiatrists in the mental hospital field. An analysis of the 54 replies indicated that public mental hospitals are being overburdened by an ever-increasing number of older people, many of whom could be cared for elsewhere. However, in view of the present lack of other facilities, the state mental hospital seemed the best or, in some cases, the only place to send the aged infirm.[6]

Senator McNamara, Chairman of the Senate Subcommittee on Problems of the Aged and Aging, noted that this trend of placing a large proportion of the aged in mental hospitals, if uncorrected, would place an enormous burden on the taxpayers and would constitute a tragic end to thousands of lives.[7]

In recent years there has slowly developed an emphasis on the necessity of preventive measures against senility and mental disorders.

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[6]Council of State Governments, op. cit., p. 41.

[7]*Press release from the office of* Senator Pat McNamara, September 18, 1960.

The California conference on senile patients, for instance, learned that the most effective way to assist the aged is to prevent mental deterioration by providing "opportunities for normal living through education, recreation, and stimulation of interests."[8] The seventh annual conference on aging held in 1954 by the University of Michigan likewise emphasized prevention by studying methods which would foster growth and development during an individual's full life span so as to prevent the perpetuation of problems facing today's aging population.

If effective prevention of mental deterioration or mental illness is not possible at the present, early detection and treatment may cure an illness or prevent it from becoming more serious. Where such diagnosis and treatment are not available, facilities should be provided which permit individuals to have an alternative to mental hospitals.

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[8]Tompkins, op. cit., p. 51.

II. CARE OF THE AGED IN MAINLAND JURISDICTIONS

Various facilities for the aged are gradually being developed as awareness of the diverse needs of aging persons grows. Furthermore, the cost of caring for the aged might reach prohibitive levels unless preventive measures, early diagnosis and treatment, and alternatives to hospital care are provided. Consequently, facilities designed to provide such different services as diagnosis, medical services to homes with aged persons, and domiciliary care for the aged are becoming more available.

This section will discuss in greater detail facilities which are especially appropriate for the care of the aged who are chronically ill or disabled. Such facilities were described by the Council of State Governments as follows:[1]

> 1. Home Care. Many public and private welfare agencies are cooperating to supply services to aged persons in their homes, thereby taking a load off the hospitals and giving the patients happier home lives. Such home services range from a minimum of nursing care and social work to visits by physicians, bedside nursing, housekeeping service, physical and occupational therapy, and social casework.
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> 2. Nursing Homes. These provide lodging, board and nursing care to sick, invalid, infirm, disabled or convalescent persons. Well managed nursing homes can meet the specialized needs of many aged persons more effectively and at less cost than hospitals, and at the same time remove a considerable burden from them. For best results they require close administrative, professional and geographic affiliation with general or mental hospitals and the establishment of high standards.
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> 3. Foster Homes. Voluntary family agencies or public welfare bodies are placing many patients in private foster homes and supplying casework and psychiatric supervision.

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[1] Council of State Governments, op. cit., pp. 41-42.

4. Boarding Homes. Many older persons, including senile patients, need a certain amount of personal care and attention but not enough to require placement in a nursing home or hospital. Licensed boarding homes for those unable to secure such care from their own families often are effective, and they are much less expensive.

5. Geriatric Centers. Many patients are being restored to productive lives through rehabilitation programs of geriatric centers associated with general and mental hospitals, and staffed by general practitioners, psychiatrists, social workers, nurses and other persons experienced in working with the aging.

Other programs not discussed in this report, but related to care of the aged, were also described by the Council of State Governments as follows:

1. Day Care. Chronically ill persons who are ambulatory or semi-ambulatory are being cared for and offered interesting activity for eight hours a day at day care centers in their communities. This provides the necessary care during the day and permits the patients to live at home with their families.

2. Homes for the Aged. Many patients not requiring treatments are being placed in homes for the aged, usually operated by county or other public welfare departments or by religious or membership corporations. They generally are fairly large institutions, providing medical or at least nursing services, and many include care for the mildly senile.

3. The "Half-way House". Many patients are improved sufficiently in mental hospitals to be ready for discharge, but are not yet ready to return to the pressures and conflicts of community living. They need a chance to readjust. The "half-way house" is being explored as a protective setting to restore health and courage, self-respect and self-reliance.

Homemaker service programs have also been developed in at least one state. The primary purpose of such programs is "to hold the family together while the natural homemaker is incapacitated either in or out of the home; to enable the chronically ill or the aged to remain in his own home wherever possible and to permit the employed adult to stay on his job, free from worry about household management, the care

of children, an ill relative, or an elderly parent."[2]

States have used these various approaches described above to care for their aged. No one state or locality has all these facilities; the common practice is for a state or locality to provide several of the above services.

Home Care Programs

Home care programs were developed as early as 1796 by the Boston Dispensary. They were initiated because they enable patients to live in a normal setting, close to their families. Since 1940 there has been a marked increase in home care programs, partly due to the demonstration program established in New York City's Montefiore Hospital which showed that under certain circumstances, patients with long-term ilnesses could be cared for at home at less cost than in the hospital. In fiscal year 1951-52, the Montefiore Home Care Program had an operating budget of slightly more than $95,000; it had a total of 181 patients for 29,330 patient-days or at an average cost of $3.26 per patient-day.

A fairly recent publication of the Public Health Service discusses 11 home care programs in various states.[3] Administration of these programs is lodged in medical, social, or nursing agencies. Financing comes from various sources--tax funds, foundation grants, private funds, and family payments. In general, these programs offer the following kinds

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[2]Proceedings of the First National Conference of the Joint Council to Improve the Health Care of the Aged, Washington, D. C., June 12-13, 1959 (Chicago: the Council, 1959), pp. 107-08.

[3]Public Health Service, A Study of Selected Home Care Programs, Monograph No. 35 (Washington, D. C.: Government Printing Office, 1955).

of services to patients: medical, nursing, and social services; drugs and medical supplies; hospital equipment and sickroom supplies; x-rays and laboratory tests; and transportation. In addition, physical therapy, occupational therapy, prosthetic appliances, and homemaker or domestic services are offered by some home care programs. All programs make it possible for patients to be hospitalized immediately when diagnostic or therapeutic procedures are necessary.

The home care staff in some states furnishes the major portion of the services required, while in other states it functions primarily as a coordinating and purchasing agent. In most of these programs, only indigent or medically indigent patients are eligible for services under the home care programs. Some of these programs serve only the chronically and acutely ill, while others provide care only for patients with long-term illnesses.

New York City has been especially active in developing home care programs within all city and some private hospitals. By 1951 such programs were established in 13 general, 1 chronic disease, and 2 tuberculosis hospitals. A division of home care was formed in the department of hospitals, and policies governing home care were formulated. The Queens General Hospital Home Care Program in New York set forth the following criteria for accepting patients for home care: (1) medical--a plan for treatment has been made on the basis of a diagnosis; and the patient does not regularly require more than two medical visits a week; (2) nursing--the physical environment of the home is such that adequate care can be given; and family members or others can be taught to provide necessary care and are willing to assume this responsibility;

(3) financial--the patient is medically indigent.[4]

Under the Queens home care program, medical services are provided by the resident staff under the supervision of the deputy medical superintendent and the chief resident; nursing services under the direction of the nursing division, New York City Department of Health; social services by the medical social workers of the hospital staff. In 1953, the Queens program had 504 different patients whose length of stay averaged 153 days; 56 per cent received service for 180 days or more. The movement of patients between home care and hospital wards was frequent; 238 patients were so transferred because they became too ill to be cared for at home or because they needed special treatment in hospitals. An estimated 22 per cent of the patients were discharged from home care because they recovered sufficiently to attend an outpatient clinic.

Nursing or Convalescent Homes

Nursing homes are oftentimes classified in terms of the degree of skilled nursing that they offer. Skilled nursing homes are primarily designed to offer skilled nursing care, which includes services that the ordinary untrained person cannot adequately perform but that professional or practical nursing personnel can provide. Personal care homes, on the other hand, are designed primarily to provide personal services, such as help in walking, getting in and out of bed, taking a bath, dressing, feeding, preparing special diets, and supervising self-administering medications. Occasionally, personal care homes provide limited skilled

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[4] Ibid., p. 49.

nursing care to supplement their primary domiciliary function.[5]

In 1958 there were approximately 25,000 nursing homes furnishing 450,000 beds in the United States. At least 100,000 beds were "unacceptable" and in need of replacement. Nursing homes are licensed in every state and territory, except Puerto Rico and the Virgin Islands. In 42 states the health department is the licensing agency. Some states have attempted to improve the quality of nursing home care by more frequent inspections and through consultation.

Although slightly more than 90 per cent of the nursing homes are privately owned, close to 50 per cent of the nursing homes population is supported by public funds, with state assistance ranging from $55 to $155 per month. The average monthly charge for nursing homes in 1958 was $150. In a 13-state survey, the charge was found to range from $90 to $200.

As one might expect, the population in the nursing homes is made up of persons who need varying degrees of nursing and domiciliary care.

> The average age of oldsters living in nursing homes is 80 years. Two-thirds of them are over 75 years old. Two-thirds of them are women. Less than half of them can walk alone. More than half have periods in which they are disoriented. One-third are incontinent, and two-thirds have some type of circulatory disorder.[6]

From the description above, it is evident that nursing homes need affiliation with general hospitals. This was one of the recommendations of the National Conference on Nursing Homes and Homes for the Aged. This

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[5]These definitions are based upon those found in: Public Health Service, National Conference on Nursing Homes and Homes for the Aged, February 25-28, 1958, Publication No. 625 (Washington, D. C.: Government Printing Office, 1958), p. 3.

[6]Ibid., p. 4.

arrangement is beneficial to the hospitals because they can transfer long-term patients to nursing homes and thus free beds for the acutely ill. On the other hand, nursing homes have the advantage of guidance and special medical services from the hospital. Some hospitals in Baltimore, Philadelphia, Cleveland and Chicago have made arrangements for patient transfers to nursing homes, and these working relationships are working out well.

The suggestion that general hospitals build and operate nursing home facilities was also made at the National Conference, but it was felt by the Conference that nursing home operators would then be faced with unfair competition.

It has also been suggested that nursing homes, in addition to affiliating with hospitals, should take immediate steps to provide more social and recreational programs for the long-term and mentally alert patients as well as intensive rehabilitative work.[7]

Foster and Boarding Home Care

Interest in foster homes is not restricted to care of the chronically ill. Senile mental patients, in some states, have been placed in foster homes thus reducing the number of patients in institutions while permitting those patients who can enjoy normal living arrangements to do so. These homes are usually developed under the auspices of voluntary family agencies or public welfare groups.

In general, each foster home serves only two patients who are

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[7]New York State, Charter for the Aging, Conference convened by Governor Averell Harriman, 1955 (Albany, New York), p. 200.

accepted as members of the family. In North Carolina, for example, senile patients, who are not physically ill or whose mental disturbances are mild, are placed in foster homes. This is part of a community placement program which provides that the state board of public welfare work with the county department of public welfare in finding suitable homes for patients who are ready to be released from state hospitals. The county department also supervises the boarding homes into which patients are placed and provides financial assistance for the patient's care.[8]

Hospitals and Geriatric Centers

Many general hospitals have developed chronic disease units which offer economic advantages in caring for the aged; in 1952 such chronic disease units operated at $6.63 per patient-day in contrast with a cost of $18.35 per patient-day in general hospitals.[9]

Many states are promoting the development of special geriatric units in state institutions so as to relieve the overcrowded conditions in hospitals and mental institutions. The geriatric unit of Cushing Hospital in Massachusetts, for example, has expanded its bed capacity from 300 to 700 to house aged mental patients. Other states have added geriatric buildings or units to some of their state hospitals. Still others are using tuberculosis sanatoria to provide care for aged persons. A few, like New York, have built state hospitals specifically for the care of the aged. Out-patient services at state hospitals have also

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[8] Tompkins, op. cit., p. 33.

[9] Ibid., p. 45.

been developed to facilitate hospital admissions when necessary and to avoid admission when alternative solutions are possible.

Federal Activities

Although state governments have generally been considered the agents responsible for the care of the aged, several activities of the federal government are significant.

The Hill-Burton hospital construction program has provided 135,500 new hospital beds since 1948; about 51 per cent of the total of 265,000 hospital beds added during this period. The basic act (Public Law 725, 79th Congress) authorized a survey and construction of four types of public and other nonprofit hospitals--general, mental, chronic disease, and tuberculosis hospitals. An annual appropriation of up to $75 million for grants to the states was authorized; this sum was increased to $150 million in 1949. In 1954 the Hill-Burton program was further expanded by additional yearly appropriations of (1) $20 million for chronic disease hospitals, (2) $10 million for public or nonprofit nursing homes, (3) $20 million for diagnostic centers or diagnostic treatment centers, and (4) $10 million for rehabilitation facilities (Public Law 482, 83rd Congress). The minimum state allotment is $100,000 for diagnostic or diagnostic treatment centers, $100,000 for chronic disease facilities, $50,000 for rehabilitation facilities, and $50,000 for nursing homes. In 1958, facilities constructed under the Hill-Burton program, used especially for older people, included nearly 3,400 beds in chronic disease hospitals, 3,700 beds in nursing homes, 60 rehabilitation facilities and

120 diagnostic and treatment centers.[10]

The National Institute of Health is authorized to conduct medical research into various chronic diseases which are particularly prevalent among older persons. A Center for Aging Research was established in 1956 in the NIH to stimulate research in the process of aging per se.

Research programs relating to the methods and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill were authorized in 1955 (Public Law 182, 84th Congress). An appropriation of $250,000 was made for the first year and of $500,000 for each of the two succeeding years.

Other activities of the federal government on behalf of the aging are carried on by a special staff on aging in the Department of Health, Education and Welfare; a division for research on aging in the Veterans' Administration; and a housing for the elderly unit in the Federal Housing Administration. In addition to these units which deal specifically with the aged, there are many activities and staff members which serve the aged as part of the general population.

Developing and Coordinating Programs for the Aging

While it is evident that some progress is being made in providing adequate facilities for the aging, creativity is still necessary to devise new and more effective means of meeting the needs of the aged. Construction of facilities is only the beginning; just as important, if not more important, is the necessity for preventing the ills often accompanying old age. Furthermore, it is essential to dispel the myth that aging

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[10]Federal Council on Aging, Aiding Older People; Programs and Resources in the Federal Government (Washington, D. C.: Government Printing Office, 1958), p. 17.

necessarily brings physical and mental disabilities which can only be relieved, but not effectively cured, prevented, or minimized. Rehabilitation has been successful many times when managed by capable and trained personnel.

The attack on the problems of aging must be conducted on many fronts. Research into the process of aging itself is essential. Preparation for retirement and for the use of leisure time is desirable. Provisions for economic security are necessary. The role of the aged should be reassessed; a new definition needs formulation.

No one agency of government can handle the multi-dimensional problems of the physical and mental health of the aged, to say nothing of the problems related to unemployment, housing, and recreation. The report of the 1961 White House Conference on Aging indicates that 44 states favor the creation of a permanent committee on aging established by the legislature to provide statewide leadership in planning for the aged. Only a few states recommend that responsibility for such planning be placed in operating departments such as the state departments of health or welfare.[11]

The Council of State Governments recommends that the governor of each state establish an interdepartmental committee on aging comprised of the heads of all agencies concerned with the problems of older persons.[12] This committee would be expected to develop and coordinate

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[11]White House Conference on Aging, Aging in the States: A Report of Progress, Concerns, Goals (Washington, D. C.: Government Printing Office, 1961), p. 155.

[12]Council of State Governments, State Programs for the Aging: A Review of the Problem and of Recent Action in the States (Chicago: the Council, December 1956), pp. 9-10.

programs for the aged and would implement whatever programs are approved by the governor and legislature. The chairman or executive secretary of the interdepartmental committee would be a special assistant on aging, appointed by the governor to serve in his office. This assistant would be provided with qualified staff to devote full time to planning and developing a comprehensive program. In order to give citizens the opportunity to participate in policy formulation, the Council recommends that the governor appoint a citizens advisory commission on aging, composed of: (1) citizens from different segments of the community, and (2) members of the state legislature. In essence, the organization makes possible comprehensive and coordinated planning and action to cope with the problems of the aged.

III. CARE OF THE AGED IN HAWAII

It is only recently that wide concern for aging as a social problem has developed in Hawaii. This is somewhat understandable in view of the relatively low percentage of people who are presently 65 years and older. But this condition will gradually undergo change if current trends continue and projections based on them are accurate.

Hawaii's Population

In March 1959 the Territorial Planning Office described the population of Hawaii, based on U. S. Bureau of the Census estimates, as follows:

> Only four States or Territories have a higher proportion of their civilian population under 18 years of age: New Mexico, Utah, Alaska, and Puerto Rico. For the continental United States, 35.3 per cent of the civilian population was under 18 as of July 1, 1957, compared with 41.5 per cent in Hawaii and 49.1 per cent in Alaska (highest of all).
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> Only two States or Territories had a lower percentage in the 65-and-over age group. For the mainland, 8.8 per cent of the civilian population fell into this age group. The proportion was 5.0 per cent in Hawaii, 4.5 per cent in Puerto Rico, and 4.4 per cent in Alaska.
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> Although Hawaii thus proved to be one of the youngest areas in the country, trends since 1950 showed it to have a much higher than average rate of increase in oldsters. Growth in the civilian population 65 and over between 1950 and 1957 amounted to 36.2 per cent, well over the mainland average of 21.0 per cent. Only four areas--Florida, New Mexico, Arizona, and Alaska--had more rapid growth in this age group.[1]

Advance tables from the U. S. Bureau of the Census indicate that in 1960 there were 29,162 persons 65 years and over in Hawaii. This represents an increase of 42.8 per cent over 1950 figures.

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[1] Hawaii Territorial Planning Office, "Population Estimates by Age for Hawaii," March 4, 1959 (mimeographed).

The number of aged persons in Hawaii will increase rapidly in the next decade. Data in Table 2 indicate that in 1959 Oahu's proportion of persons 65 and over was less than half of that for the United States. This relationship, however, is not expected to continue.

Table 2

PERCENT DISTRIBUTIONS OF THE CIVILIAN POPULATIONS OF OAHU, HAWAII, OCTOBER 1958-SEPTEMBER 1959 AND OF THE UNITED STATES, EXCLUSIVE OF HAWAII AND ALASKA, JULY 1958-JUNE 1959

Age	Oahu, Hawaii			United States		
	Both Sexes	Male	Female	Both Sexes	Male	Female
ALL AGES	100.0	100.0	100.0	100.0	100.0	100.0
Under 5	15.6	16.5	14.9	11.5	12.0	11.0
5 - 14	25.1	26.1	24.2	20.0	21.0	19.1
15 - 24	12.7	11.1	14.2	12.8	12.4	13.2
25 - 44	28.9	25.8	31.6	26.6	26.2	26.9
45 - 64	13.7	16.1	11.5	20.5	20.4	20.6
65 and over	4.0	4.5	3.6	8.7	8.1	9.2

Source: U. S. Public Health Service, The Hawaii Health Survey: Description and Selected Results; Oahu, Hawaii, October 1958-September 1959, From the U. S. National Health Survey (Washington, D. C.: Government Printing Office, May 1960), p. 8.

The projections for 1960-1980, which appear in Table 3, show that the greatest percentages of increase will occur in age groups 20-24 (90.8 per cent), 65 and over (90.1 per cent) and 60-64 (78.6 per cent), while the resident civilian population is estimated to increase by 41.5 per cent. These projections are for Oahu's population.

Table 3

PROJECTED RESIDENT CIVILIAN POPULATION
ON OAHU, 1960-1980
(in thousands)

	1960	1965	1970	1975	1980	Per Cent Increase 1960-1980
Permanent Residents	398.2	437.7	479.9	528.2	584.2	46.7
Minus: Absent in Services	10.0	10.0	10.0	10.0	10.0	--
Plus: Military Dependents	60.0	60.0	60.0	60.0	60.0	--
Resident Civilians	448.2	487.7	529.9	578.2	634.2	41.5
Resident Civilians By Age:						
0 - 4	65.6	69.9	74.6	83.2	92.9	41.6
5 - 9	56.7	64.4	68.7	73.4	81.9	44.4
10 - 14	49.7	47.5	54.1	59.4	64.1	29.0
15 - 19	37.2	45.6	43.4	51.0	55.5	49.2
20 - 24	25.0	34.0	42.4	40.2	47.7	90.8
25 - 29	28.2	30.2	39.0	47.3	45.1	59.9
30 - 34	30.3	28.6	30.6	39.3	47.6	57.1
35 - 39	32.0	29.1	27.5	29.4	38.1	19.1
40 - 44	29.9	30.2	27.3	25.7	27.6	- 7.7
45 - 49	24.1	27.8	28.1	25.3	23.7	- 1.7
50 - 54	20.6	23.1	26.6	26.9	24.2	17.5
55 - 59	16.0	19.0	21.4	24.8	25.1	56.9
60 - 64	12.6	14.5	17.3	19.4	22.5	78.6
65 and over	20.1	23.7	27.8	32.8	38.2	90.1

Source: Belt, Collins and Associates, Ltd. and Harland Bartholomew and Associates, Planning Studies and Economic Analysis, Part 3 of The Comprehensive Plan for Ala Moana Reef, Honolulu, Hawaii (December 1960), p. 74.

Incidence of Chronic Disease Among Older Persons. Much of the increase in the aged population will take place after 1960, so that the present period is a crucial one. Compounding the problem that increased numbers bring is the incidence of chronic illness. Hawaii, in this regard, is fortunate. The following summary, presented in Table 4, of the health level of persons 65 years and older on the island of Oahu indicates that Hawaii's level is remarkably high when compared with that of the same age group on the Mainland United States, excluding Alaska.

Table 4

HEALTH LEVEL OF PERSONS 65 YEARS AND OLDER IN OAHU, HAWAII, AND THE UNITED STATES: 1959

Factor	Oahu	United States
Average number of disability days due to illness or injury per person per year	16.5	42.6
Percentage with one or more chronic conditions	58	77
Percentage with some degree of activity limitation due to chronic conditions	27	42
Average number of physician visits per year	4.5	6.8

Source: Hawaii State Department of Health, Health Characteristics of Persons 45 Years and Older, Hawaii Health Survey Report No. 2 (1960), p. 9.

The prevalence rates for heart conditions, peptic ulcers, arthritis and rheumatism, hernia, asthma-hay fever, chronic bronchitis, visual impairments and hearing impairments ranged from 21 to 69 per cent lower on Oahu than on the Mainland.[2] The incidence of acute conditions was 15.9 per cent lower on Oahu also. However, the rate for diabetes and for paralysis of major extremities and/or trunk was higher on Oahu than on the Mainland.

Old Age Assistance. A recent report of the department of social services indicates that in June 1959, out of every 1,000 persons 65 years and over, 50 were Old Age Assistance recipients in Hawaii as compared with the national average of 156 and that for the fiscal year ending 1958, for which there are comparative State data, Old Age Assistance in Hawaii cost $1.58 per inhabitant, the lowest reported among the states.[3] Comparisons with other states should be interpreted with great care since the eligibility standards for old age assistance vary from state to state. The Commission on Aging indicates that many states are more liberal in defining minimum standards for assistance and recommends that the department of social services "relax present restrictions on retention of personal assets."[4] The report also indicated that Old Age Assistance recipients numbered only 1,429 and that they did not constitute the total needy aged population since many needy aged persons are cared for in tuberculosis, mental, and/or nursing care public institutions, are helped by private charities, or receive small government and private pensions. Other pertinent points on the aged who receive Old Age Assistance are:

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[2]Hawaii State Department of Health, Health Characteristics of Persons 45 Years and Older, Hawaii Health Survey Report No. 2 (1960), p. 9.

[3]State of Hawaii, Department of Social Services, Characteristics of Recipients Receiving Old Age Assistance, Hawaii (Mimeographed; September 1960), p. 5.

[4]State of Hawaii, Interim Commission on Aging, Information on Aging in Hawaii with Recommendations and Summaries from the Governor's State Conference on Aging, May 1960, pp. 4, 8.

1. One out of every 5 aged was confined to the home because of his physical or mental condition.

2. Five per cent of all needy aged were bed-fast or chair-fast and required continual care and attention by others.

3. More than 8 out of ten recipients either lived in their own homes, or in the home of a son or daughter or with some other relative or friend.

4. Approximately 15 per cent lived in institutions including nursing, convalescent and/or domiciliary care homes.

5. The average total monthly requirement per aged was $82.44, with aged recipients meeting 19 per cent of their requirements through their own non-cash resources and the department meeting 81 per cent or furnishing monthly average payments of $65.

6. More than one-half of the needy aged had some kind of cash or non-cash income, averaging $37.50 monthly.[5]

Hawaii's Program for the Aging

Hawaii's formal attempts to seek solutions to the problems of the aging began in 1951 when the Oahu Health Council and the Honolulu Council of Social Agencies joined together in forming the Study Committee on the Aged that began its work in 1952. This committee collected and analyzed available data regarding the number and characteristics of aged persons on Oahu, the facilities for their care, and the magnitude of future needs.

The Oahu Health Council and the Honolulu Council of Social Agencies likewise sponsored a territorial conference on planning for Hawaii's aging population in April 1954; this was attended by 300 people. Growing out of a recommendation from that conference, an Action Group on Aging was formed to do research on housing needs and to formulate plans for meeting them. Thus were developed the plans for the 1961 construction of the

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[5] Op. cit., p. 6.

Pohai Nani retirement home in Kaneohe under the auspices of the Methodist church. The Action Group on Aging also stimulated the Hawaii Housing Authority in establishing Punchbowl Homes, Hawaii's first federally-subsidized low income housing for the aged. This was opened in late December 1960.

The Action Group on Aging joined the two sponsors of the conference from which it developed in petitioning the governor to establish an Interim Commission on Aging. This commission was formed in July 1959 and is composed of 17 members from Oahu and one each from Hawaii, Kauai, and Maui. Members come from private industry, organized labor, the clergy, and seven departments of state government. The staff consists of an executive director and a secretary. The commission was charged with the responsibility of preparing for the White House Conference on Aging and of administering the $15,000 federal grant given for this purpose. A state conference on aging, held in May 1960, attracted 500 participants and initiated preparatory work for the White House Conference held in January 1961. Several other meetings were held to prepare Hawaii's delegation for active participation in the national conference. The work of the commission is currently financed from the governor's contingency fund.

Several bills have been introduced in the 1961 general session to create a permanent state commission on aging. S. B. 18 was reported out by the public health committee and passed third reading in the Senate on

April 14; it is presently in the House finance committee. S. B. 18 provides for the creation of county committees to cooperate with the state commission in defining problems and formulating plans.

Present Facilities for the Aged in Hawaii

Hawaii has no organized home care program for either the indigent or financially able. Foster home care or personal home care in Hawaii is only now being developed. One of the reasons for the rather slow development of these facilities has been the tendency in Asiatic cultures of aged persons to live with their children. However, the need for making adequate provisions for the aging is currently being emphasized.

As a result of the decrease in the number of tuberculous patients in Hawaii, the legislature in 1959 enacted legislation which permits tuberculosis hospitals to admit indigents and medical indigents who are chronically ill, provided that beds for tuberculous patients are always made available when needed. Samuel Mahelona Memorial Hospital, Kauai (Act 69), Leahi Hospital, Oahu (Act 148), Kula Sanatorium, Maui (Act 153), and Puumaile and Hilo Memorial Hospital, Hawaii (Act 234) were thus authorized to broaden their programs. This change in the statutes has resulted in the transfer of some aged persons from various hospitals to tuberculosis centers which now serve partly as chronic disease facilities.

Furthermore, the state or the county also owns some nursing homes and chronic disease facilities, some of which are largely inhabited by people 65 years and older. See Table 5 for a listing of such facilities, as well as for information on their bed capacity. The three units on Hawaii--

Table 5

PUBLIC OWNERSHIP OR CONTROL OF NURSING HOMES AND CHRONIC DISEASE FACILITIES: JUNE 1960

County	Name of Facility	Ownership or Control	Bed Capacity		Percentage of Occupancy
			Suitable[a]	Unsuitable[a]	
Honolulu	Hale Mohalu Hospital	State	0	160	49
	Maluhia	City & County	169	65	91
Hawaii	Kohala Hospital Unit	County	0	10	70
	Kona Hospital Unit	County	0	12	92
	Olaa Old Folks Home	County	0	88	97
Maui	Kalaupapa Settlement	State	0	300	67
		TOTAL	169	635	

Source: State of Hawaii, Survey Planning and Construction of Hospitals and Medical Facilities (Revised report; June 1960), pp. 54-57.

[a]Rated by Department of Health using Hill-Burton Act standards.

Kohala Hospital Unit, Kona Hospital Unit, and Olaa Old Folks Home--are occupied almost totally by persons 65 years and over. Hale Mohalu and Kalaupapa Settlement are institutions for people with Hansen's disease; in 1961 there were 17 persons at Kalaupapa (total approximately 200) and 3 persons at Hale Mohalu (total approximately 80) who were 65 years and over. Maluhia became a hospital for the chronically ill in 1956. During 1960, persons 65 years and over constituted 39 per cent of all admissions. The social service section of Maluhia has oftentimes placed patients admitted to Maluhia in nursing or boarding homes when such patients did not require hospitalization. In view of the lack of nursing home facilities

in the community, the social service section opened four private boarding and nursing homes which soon became overcrowded as public and private agencies began to use them.[6] It is felt that nursing home facilities, under private management, and a foster home placement program in the department of social services are sorely needed.

The Hawaii State Hospital at Kaneohe also has aged persons among its patients. Separate facilities for older patients who also have physical illnesses are presently available, and the hospital is planning to offer geriatric services in the present convalescent unit when the new unit is completed. The proportion of aged admitted to the state hospital is 13 per cent as compared to 20 per cent in other states. At the present time the state hospital has more than 150 aged persons (total of 228 patients 65 years and over) whose physical problems are more prominent than their psychiatric problems. "The lack of adequate community resources for the care of the aged has resulted in the commitment to the State Hospital of elderly persons who might be better cared for in nursing or convalescent homes."[7]

A recent development in the State of Hawaii deals with the initiation of a research and demonstration project for the rehabilitation of chronically ill persons. This program is being conducted by the division of

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[6]City and County of Honolulu, Department of Health, Annual Report 1959 (August 31, 1960), p. 33.

[7]State of Hawaii, Interim Commission on Aging, Hawaii State Factual Report on Aging, 1960, in preparation for the White House Conference on Aging, January 1961 (Mimeographed; 1960), p. 88.

vocational rehabilitation in cooperation with the department of health, the Hawaii medical association, and other public and private health agencies.

> . . . The project will be carried out by a team of specialists in the fields of medicine, nursing, occupational therapy, physical therapy, medical social work, vocational rehabilitation and research and is expected to be in operation in September, 1960. Patients will be referred by their attending physicians while they are confined to a hospital, residing in a nursing home, or being cared for in their family homes. The project aims at the study and demonstration of the extent to which long term dependency can be prevented or reduced through the introduction of comprehensive rehabilitation evaluation and treatment as early as possible following the onset of disability.[8]

There are currently 38 patients in the active treatment program of this project; 30 have already been treated and discharged after intensive treatment restored them to full self-care or partial self-care.[9] Persons who are rehabilitated oftentimes do not have adequate living arrangments, and where they should be placed constitutes a real problem. This demonstration project, supported by federal and state funds, will continue for three years, after which time it is hoped that its results will be sufficiently successful to warrant full support and continuation by the state.

Present facilities for the care of the aged who are chronically ill or disabled will be described in each of the four counties. Facilities mentioned in this report are those which are publicly-owned or, if privately-owned are non-profit associations, are classified as nursing homes, chronic

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[8]State of Hawaii, Interim Commission on Aging, Information on Aging in Hawaii with Recommendations and Summaries from the Governor's State Conference on Aging, May 1960, pp. 18-19.

[9]Division of Vocational Rehabilitation, telephone conversation on April 7, 1961.

disease facilities, or domiciliary care homes by the department of health.[10] Quasi-public or private hospitals have not been studied because their populations are generally composed of those acutely ill or those whose financial means are adequate.

County of Hawaii. The data in Table 5 indicate that Hawaii has three nursing homes and chronic disease facilities which are owned by the county. However, all 110 beds are rated "unsuitable." The percentage of occupancy is nevertheless high.

The geriatric treatment center at Olaa, a unit of the Hilo Memorial General Hospital, has 88 beds with an average occupancy of 98 per cent. As of February 1, 1960, the following descriptive statistics were available:[11]

Age:	Mean, 77.7 years Range, 49 to 92
Sex:	Male, 70 (81 per cent) Female, 16 (19 per cent)
Degree of disability:	Ambulatory, 46 (53 per cent) Semi-ambulatory, 12 (14 percent) Bed-ridden, 28 (33 per cent)
Support:	Private, 10 (12 per cent) Public, 56 (65 per cent) Both, 20 (23 per cent)

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[10]The department of health is the State agency responsible for regulating private care homes and convalescent or nursing homes, both profit and non-profit. New regulations were published within the last year.

[11]Hawaii State Factual Report on Aging, p. 82.

In 1959 the Thirtieth Territorial Legislature passed S. C. R. 107 which requested the department of public welfare to develop private home facilities in Hawaii county and to place present and future inmates of the Old Folks' Home in private homes. In its final progress report to the First State Legislature, dated October 21, 1959, the department stated that six personal care homes had been recruited and that persons who would otherwise be sent to Olaa Old Folks' Home would be placed in the personal care homes instead. The department also indicated that recruitment would continue until "there are enough approved personal care homes to accommodate all aged and handicapped persons who do not require hospital or special care but who either have no families who can care for them or who are unable to care for themselves."

A March 15, 1960 report of the department of social services indicated that 5 patients, placed in four personal care homes in Hawaii county, were receiving monthly assistance ranging from $21 to $75, with an average of $56.20.

City and County of Honolulu. According to Table 5, the city and county of Honolulu has two publicly-supported chronic disease facilities which care for persons 65 years and over, but who constitute varying proportions of the hospital population; 39 per cent of total admissions at Maluhia and about 4 per cent of the total population at Hale Mohalu.

In addition, there are domiciliary care homes, nursing homes, and chronic disease facilities. These are either owned by individuals or are non-profit associations. Data in Table 6 furnish information on ownership of these facilities, bed capacities, and number of clients receiving aid from

Table 6

INVENTORY OF NURSING HOMES, CHRONIC DISEASE FACILITIES, AND HOMES PROVIDING DOMICILIARY CARE ON OAHU, BY OWNER, BED CAPACITY, AND PATIENT SUPPORT: 1960[a]

Facility	Owner	Bed Capacity			Percentage of Occupancy	Department of Social Services	
		Suitable	Unsuitable	Total		Number of Clients	Average Assistance Per Month
Aiea Heights Rest Home	Ind.	23[b]	0	23[b]	100	9	$144.04
Ann Pearl Convalescent Home	Ind.	47	18[b]	65[b]	89	59	103.26
Berg Nursing Home	Ind.	0	50[b]	50[b]	N.A.	50	133.08
Booth Memorial Home	N.P.A.	(unwed mothers only)		22			
Crawford Home	Ind.	40	20	60	79	34	106.77
Hale Ho Aloha - Atherton Home	Ind.			23		1	65.00
Hosino Home	Ind.			19		16	75.40
Kapiolani Home	N.P.A.			75		31	51.31
Kauhane Home						1	50.00
Kida's Nursing Home						3	111.66
King's Daughters Home	N.P.A.			35		1	45.00
Korean Old Man's Home	N.P.A.			32		15	56.58
Kuakini (Japanese) Old Men's Home	N.P.A.			49		29	50.62
Laanui						2	65.00
Lewis (May) Home	Ind.			4		1	160.00
Lunalilo Home	N.P.A.			65		9	27.00
Manoa Convalescent Home	Ind.	0	17[b]	17[b]	100+	16	100.00
Manunalani Hospital and Convalescent Home	N.P.A.	82[c]	13	95	92.8		
Ono Home	Ind.	7	6	13	94	2	132.25
Pali Convalescent Home	Ind.	44	0	44	N.A.	30	140.96
Palolo Chinese Home	N.P.A.			70		36	59.26
Pareisa Home	Ind.			3			
Perez Home	Ind.			3			
Punahou Rest Home	Ind.	0	9[b]	9	100+	14	123.11
Ramon Board Home						11	71.73

Table 6 (continued)

Facility	Owner	Bed Capacity			Percentage of Occupancy	Department of Social Services	
		Suitable	Unsuitable	Total		Number of Clients	Average Assistance Per Month
Rodriques Boarding Home						2	$ 42.00
St. Francis Hospital Unit	N.P.A.	0	14	14	(d)		
Sanchez Boarding Home	Ind.			3		2	44.00
Tsuha Boarding Home	Ind.			24		3	57.50
Vierra Home	Ind.			2		2	156.50
Yee Home	Ind.			17			
TOTAL		243	147	836[e]		379	$ 92.91

Sources: State of Hawaii, Survey Planning and Construction of Hospitals and Medical Facilities (Revised report; June 1960), pp. 54-55, 63. Information on "number of clients" was found in: Department of Social Services, "D.S.S. Clients Who Receive Economic Assistance for Nursing, Convalescent, Domiciliary, or Related Care as of 3/15/60" (dittoed).

Note: Abbreviations are used as follows:

(1) To denote ownership: (a) Ind.--individual.
(b) N.P.A.--non-profit association.

(2) To denote percentage of occupancy: N.A.--not available.

a Facilities providing domiciliary care can be differentiated from nursing homes and chronic disease facilities by the inclusion of information only on total bed capacity. When no information is given on bed capacity, this means that the facility was not included in the State's inventory. The column, "number of clients" refers to those who received economic assistance from the department of social services, as of March 15, 1960.

b Official capacity to be determined following approval nursing home regulations; beds in facility recorded.

c Under construction.

d Statistics included in general occupancy.

e Total number of beds in domiciliary care homes: 446.
Total number of beds in nursing homes: 390.

the department of social services. Oahu has several non-public facilities serving the aged: 16 homes providing domiciliary care and 10 nursing homes, according to the department of health. Five other facilities are listed in Table 6 because they have patients who receive some support from the department of social services.

An examination of Table 6 reveals that out of 390 beds in nursing homes and chronic disease facilities, 147 are rated "unsuitable". Occupancy in nursing homes and chronic disease facilities ranges from 79 to 100 per cent. Unfortunately, information on the percentage of occupancy in homes providing domiciliary care was not available, so it is not possible to determine what proportion of the aged in these facilities receives assistance from the department of social services. One can safely estimate, however, that approximately 50 per cent of the aged who reside in nursing homes, chronic disease facilities, or domiciliary care homes receives assistance from the department of social services.

County of Kauai. Kauai has no publicly-supported chronic disease facility. Wilcox Memorial Hospital, owned by a non-profit association, has a unit of 12 suitable beds for the treatment of chronic diseases; in 1960 there was 57 per cent occupancy.

On Kauai there are presently 23 homes providing domiciliary care: 7 can care for 4 or more persons; 15 can care for 1-3 patients; and capacity of 1 is not known. See Table 7 for an inventory of these personal care homes. The personal home care program began in 1950. Each home is inspected regularly by a team composed of the welfare administrator, fire chief, building inspector, sanitation officer, public health nurse, and

Table 7

INVENTORY OF HOMES PROVIDING DOMICILIARY CARE ON KAUAI, BY OWNER, BED CAPACITY, AND PATIENT SUPPORT: 1960

Facility	Owner	Bed Capacity	Department of Social Services	
			Number of Clients	Average Assistance Per Month
Agosto (F.) Home	Ind.	2	1	$135.00
Campos Home	Ind.	2		
Carreia (W.) Home	Ind.	2	2	117.50
Doctor (S.) Home	Ind.	9	9	122.77
Fagarang (E.) Home	Ind.	2	2	160.00
Gampon (A.) Home	Ind.	2	1	135.00
Hale Ho Olaa (Bandmann)	Ind.	8	2	100.00
Home Nanea (Battad)	Ind.	7	3	120.00
Johnson (J.) Home	Ind.	4	2	140.00
Megia (M.) Home	Ind.	3	2	130.00
Morris (F.) Home	Ind.	4	4	145.00
Old Men's Homes - Lihue Plantation	Corp.	10		
Olivas (F.) Home	Ind.	4	2	130.00
Olivas (V.) Home	Ind.	2	1	127.00
Omine (U.) Home	Ind.	3	3	80.17
Ouye (T.) Home	Ind.	3	4	100.00
Oyama (H.) Home	Ind.	3	1	100.00
Pantil (F.) Home	Ind.	2	1	100.00
Pupuhi (M.) Home	Ind.	1	1	160.00
Sugihara (N.) Home	Ind.	3	1	100.00
Terrenal (R.) Home	Ind.	3	2	160.00
Toma (I.) Home			1	160.00
Udarbe (P.) Home	Ind.	3	3	82.33
TOTAL		82	48	$121.34

Sources: State of Hawaii, Survey Planning and Construction of Hospitals and Medical Facilities (Revised report; June 1960), p. 64. Information on "number of clients" was found in: Department of Social Services, "D.S.S. Clients Who Receive Economic Assistance for Nursing, Convalescent, Domiciliary, or Related Care as of 3/15/60" (dittoed).

Note: Abbreviations to denote ownership are used as follows:
Ind.--individual
Corp.--corporation

social worker. Referrals usually originate from the physicians of patients still in the hospitals.

In 1960 the majority of the patients were over 69 years of age and were males. Out of the total of 56 patients, all were ambulatory, except for the 18 who were either bed-ridden or semi-ambulatory. There were 8 private patients who were financially independent, while 48 received assistance, averaging $121.34 per month, from the department of social services. The fee schedule developed by the department for four types of patients provides for the following home care payments:

Type of Occupant	Monthly Payment
Ambulatory	$75
Limited Ambulatory	100
Semi-Ambulatory	135
Bed-Ridden	160

County of Maui. There is only one licensed facility in the county of Maui. Hale Makua is a nursing home with 95 "unsuitable" beds and a 95 per cent occupancy rate. There are some beds available for the aged in small homes sponsored by fraternal organizations, but the exact number is unknown. Information on the number of patients who receive support from the department of social services is available and is summarized in Table 8. There were 68 patients receiving such aid in 1960, with monthly payments averaging $104.07.

Table 8

AGED PERSONS RECEIVING ECONOMIC ASSISTANCE
FOR NURSING OR DOMICILIARY CARE FROM THE
DEPARTMENT OF SOCIAL SERVICES: MARCH 15, 1960

Name of Facility	Department of Social Services	
	Number of Clients	Average Monthly Payments
Chinese Society Home	8	$ 41.31
G. Golis	1	60.00
Hale Makua	58	113.96
J. Nakamura	1	76.50
	68	$104.07

Source: Department of Social Services, "D.S.S. Clients Who Receive Economic Assistance for Nursing, Convalescent, Domiciliary, or Related Care as of 3/15/60" (dittoed).

Needs of the Aged in Hawaii

Earlier sections of this report have indicated that Hawaii presently has a small proportion of persons 65 years and over and that the health level of aged persons in Hawaii is generally better than that for aged persons on the Mainland. In spite of these two favorable conditions, there is still a shortage of adequate facilities to care for the aged who are chronically ill or disabled and there is doubt about the quality of some existing facilities.

In June 1960, the estimated state population was 599,000. Using the accepted ratio of 3 beds per 1,000 persons to provide for nursing homes, homes for the aged, and facilities for the chronically ill, except for those who can be cared for in the mental health hospitals,

tuberculosis sanatoria and Hansen's disease facilities, the department of health states that Hawaii should have 1,797 beds available. The Interim Commission on Aging reports that:

> . . . only 1,027 [beds] are in existence (57%). However, when only suitable beds are considered (those meeting Hill-Burton criteria, or approved by local fire and building agencies) the count is 712 (40% of number needed).[12]

Placement of Aged in Institutions. The shortage of nursing homes and domiciliary care homes, to say nothing of the total lack of day care centers, homemaker services, and home care programs in Hawaii, has resulted in the placement of aged persons in institutions which are not the most appropriate facilities to meet their needs. For example, aged persons who might profit most from being placed in domiciliary care homes may be found in nursing homes, thus depriving others who need convalescent care; and these people, in turn, might be placed in hospitals which are more costly and not the most appropriate means of caring for them. Such placement deprives others who may really need hospital care from receiving it. It is evident that the lack of a variety of facilities results in mis-placement of individuals as well as in loss of economy. The commitment to the State Hospital of elderly persons who might profit from nursing care is illustrative. The Commission on Aging recommends that the state "re-examine and revise existing laws in order to separate clearly

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[12] Hawaii State Factual Report on Aging, p. 79.

the group of aged patients requiring enforced institutional care from those whose needs are for guidance, home services, infirmary assistance, etc."[13]

Planning to meet the needs of the aged, in addition to promoting the placement of elderly persons in the most effective facilities to give them appropriate care, is generally guided by the principle that the aged should remain in their own homes and that they and their relatives should be provided with services so as to make institutional placement unnecessary under ordinary circumstances. The establishment of home care programs which make it possible for the elderly sick to be cared for at home with the aid of medical and nursing agencies will promote this principle. Homemaker services likewise enable the elderly to remain in their homes by lightening the household chores of those who are temporarily or permanently in need of some assistance. Day care centers also make it possible for older persons, who might be unattended during the day, to participate in interesting activities with fellow senior citizens. These facilities, however, do not offer care for the elderly sick.

Planning for the Future. Population projections for the next decade and the following one indicate that Hawaii will have a growing proportion of aged persons. The current shortage of facilities for senior citizens who need care for physical or mental illnesses will become critical unless planning is undertaken in the near future.

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[13] Ibid., p. 88.

> Perhaps the greatest defect in Hawaii's health care structure is the lack of a master plan for the total care of the aged whose health needs revolve around a unified program for chronic diseases and disabilities. . . . Such a plan revolves around early detection and early care, both in and out of hospitals, rehabilitation and prevention of chronic diseases and disabilities. . . .[14]

One often-mentioned means of providing for planning is the creation of a permanent commission on aging which would serve as a coordinating agency for the development of appropriate facilities and services.[15]

As Hawaii begins to plan more intensively for the aged, it will probably give early consideration to the development of home care programs. Such programs were mentioned as early as 1954 in the territorial conference on planning for Hawaii's aging population, and their development is listed as one of the recommendations of the 1960 governor's state conference on aging. Most of the states at the White House Conference reported a similar need, and recommended that home care services, as well as hospital services, be included in the usual prepayment health insurance plans.[16]

The need to plan an adequate program for the care of the chronically ill and disabled aged is becoming increasingly evident. The need will become critical in the next few years. This report has indicated what

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[14]Shoyei Yamauchi, "Looking Ahead to Health in Hawaii for Senior Citizens," Hawaii Medical Journal, Vol. 20, No. 1 (September-October 1960), reprint, p. 4.

[15]An alternative approach to State planning was suggested in a publication of the Council of State Governments and is discussed in this report at the end of chapter II.

[16]The need for community services and programs for older persons as seen by aged Oahu residents is described in the appendix to this report.

present facilities are, what the current shortage is, and what future needs might be in Hawaii. It has also discussed various means which have been developed in other states to provide care for the elderly sick. Consideration by the legislature of these programs in the face of growing needs seems imperative if Hawaii is to meet the challenge of providing adequate care for its aging population.

Appendix

THE NEED FOR COMMUNITY SERVICES AND PROGRAMS AS SEEN BY AGED OAHU RESIDENTS

An attempt to assess the opinions of older persons on Oahu regarding the development of various programs and services was undertaken as part of a project being conducted by five graduate students in social work to meet their research requirements for a master's degree at the University of Hawaii. Random sampling techniques were used to select the sample which was composed of 101 aged persons, most of whom live in Honolulu. Interviewing was conducted in December 1960 and January 1961, and the analysis of results is currently underway. The results of only that portion of the interview schedule which deals with community services are summarized in Table A which follows.

The data in table indicate the greatest proportion of the sample expressing the desirability of developing low cost housing. Coupled with this is the expression that the development of a family foster home program is not necessary in the opinion of 56 persons; this is the only program which a majority felt did not need to be developed. All of the services (the first six plus the one on homemaker service) which deal with care for the health of aging persons received favorable responses--i.e., their development was considered necessary by the majority of those in the sample.

Table A

THE NEED FOR COMMUNITY SERVICES AND PROGRAMS FOR OLDER PERSONS AS EXPRESSED BY 101 AGING RESIDENTS OF OAHU: 1960-61

These responses were made to the following question: "In your opinion, are the following services and programs needed for older persons in this community?"

Question	Responses		
	Needed	Not Needed	Don't Know
A free (or low cost) health clinic, even if this should eliminate choice of doctors.	79	18	4
Low cost or free (i.e., volunteer) transportation to and from doctor's office or clinic.	71	28	2
More standard or licensed nursing homes for older persons who are bed or chair-ridden.	80	8	13
Home visiting programs (volunteer service) for persons who cannot get out.	75	22	4
A visiting nurse service for persons who need nursing care at home.	88	10	3
"Meals on Wheels", (i.e., prepared well-balanced meals for home delivery at low cost).	63	31	7
More adequate low cost housing.	91	6	4
Adult education courses through the public schools.	68	28	5
More church (temple, synagogue) programs where older and younger persons could get together.	58	38	5
More church (temple, synagogue) programs mainly for older persons.	63	32	16
Homemaker Service.	68	29	4
Community workshops for disabled older persons.	82	14	5

Table A (continued)

Question	Responses		
	Needed	Not Needed	Don't Know
Community workshops for older persons still in good health.	84	14	3
More part-time work for pay.	81	17	3
More opportunities for volunteer community work.	61	36	4
A greater number of "Senior Citizen" facilities, including particularly places where older persons could go anytime they liked to talk or play games.	76	22	3
A family foster home program (so that older people without families could live with another family).	42	56	3
A mobile library service.	72	24	5

Source: Advance table from advisor to graduate student team working on a project dealing with a study of medical characteristics as related to other selected characteristics of aging residents of Honolulu.