APPENDIX

A note on nomenclature

In collating the information forthcoming from this study it has been striking that the diversity of symptoms and diagnosis that are associated with nasal blockage and rhinorrhoea can reasonably be summarized in one diagnosis: the *upper respiratory syndrome.* This is all the more reasonable since the mucous membrane of nose, throat, sinuses and eustachian tubes is anatomically in continuity and probably affected in entirety during any inflammatory process, whatever its cause. Added to this is the fact that aetiology in cases of this sort is rarely established with any precision and that rhinorrhoea and nasal blockage may be due to a diversity of causes. That the term 'common cold' is a misnomer has now been generally accepted and in all probability several factors are operative in any one case to produce the symptoms formerly attributed to it.

Thus it is proposed that the single term upper respiratory syndrome should be used to describe all cases with rhinorrhoea and nasal blockage and that the designations 'acute' should be employed when the symptoms are of short duration and 'chronic' when they are of long duration. In cases where malar aching or frontal headache are prominent the suffix " with marked sinusitis " should be added, and in patients with auditory symptoms the suffix " with marked eustachian catarrh " should be used. With this simplified terminology such vague terms as catarrh are eliminated and anachronistic diagnosis like common cold are rendered unnecessary. By simplification a clearer appreciation of the nature of the disorder, and hence a more rational approach to treatment, can be achieved.

IN OTHER LANDS

A STUDY OF THE GERIATRIC SERVICES IN THE UNITED STATES

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THIS SURVEY WAS TO DETERMINE how the United States were handling the future of their old people's care in the light of their new Medicare Bill, now being debated by Congress. The problems that confront the Federal Government are many, the greatest being that there are

over 50 different States which are autonomous in their government and although the Public Health Department can advise the local State Government they can have no power to force any issue. Eighteen months ago the Federal Government set up a department to deal with old people's homes and welfare. This department consists of a team of two physicians, an administrative officer, a nursing adviser, an occupational therapist and a physiotherapist. This team can be sent to advise any State Government by request. At the moment there is only one team to cover the whole of the country, and when it is considered that a large proportion of the privately owned nursing homes may be nothing more than low-grade lodging houses the task is enormous.

The population of America is 186,000,000 of which 17.3 million are over the age of 60. Ten thousand are over the age of 100 and by 1970 there will be 3.7 million men and women in the 80 age group.

According to a recent Public Health Service inventory, the nation has 23,000 nursing homes for the aged and care homes. They accommodate less than 600,000 persons. Only 9,700 of these homes are staffed and equipped to give skilled nursing care, and they have room for only 388,700 patients. Because the nursing home shortage is a nation-wide problem, Federal assistance has been provided to stimulate aid instruction and improve facilities to overcome the shortage. Unfortunately, the bed population over the whole country varies tremendously—from 3.6 per thousand in North Carolina to 30.1 per thousand in the State of Washington. In 1954 the Hill Burton Act provided ten million dollars to aid the voluntary non-profit homes and the public homes.

Homes are divided into residential homes without skilled nursing, residential care homes with skilled nursing and skilled nursing homes, i.e. those with a medical staff. One of the best types of skilled home is in New York and is called The Home for the Aged Hebrews. This is divided into two branches, one in the Bronx and one in Manhattan. This home grew up from a small residential home supported by charity. Over the past few years, because of the fact that aged homes find that their residents eventually require nursing care, they have evolved an infirmary side and a residential side. The infirmary side is now an accredited part of Mount Sinai Hospital. Out of a total population of 300 beds, 196 have residential care and 114 are on the infirmary side. There is a permanent full-time medical staff led by Dr Zeman.

In both homes, the Manhattan and Bronx, each patient is subjected to X-ray, E.C.G. and E.E.G. before they are admitted, and on the basis of these and other tests the patient is admitted to either the infirmary side or the residential side. The great advantage of having two sides

to the home is that this stops the necessity of the patient being shifted to hospital in the event of an acute medical illness. All surgical conditions are treated at Mount Sinai Hospital. Round the corner from the Manhattan home there is an affiliated day-plan department called the Catherine Engels Centre. This centre provides day care, occupational therapy and meals for elderly patients whilst their children are working. The ideal plan would be to provide care for the grandchildren as well as the aged parent, to allow second generation to continue their work as well as looking after their offspring and parents at night.

The following shows the total number of homes and beds throughout the country which come under the heading of skilled nursing homes.

Privately owned and able to receive a grant from the State	8,297
Voluntary non-profit homes	853
Church related homes	438
Other non-profit homes	415
Public homes	432

The privately owned form a large part of the total homes in America, but the publicly owned have an average of 61 beds and the privately owned an average of 24 beds.

Since there is no national health service in America, let us look at the ways in which the older person pays for his care. Forty-six per cent in a recent survey had private insurance for hospital care and ten per cent were insured for doctors' visits. The rest of the population are made up of those who can afford the 15,000 dollars a year charged in some of the homes we visited, and the very indigent who receive social security. And if a special grant is made, this only makes 110 dollars a month in New York, which pays for the public side of a private home or a State home. To obtain social security of a minimum of 40 dollars a month, at least six months work is required by the person or the husband. In States where the old people's assistance is only 60 dollars a month the number of homes is significantly lower.

In Washington, the Public Health Department has set up a village for old people known as the D.C. Village. This village is bounded on one side by a Junior Village for orphans. The purpose of the home is to provide physical care and social rehabilitation. The village cares for 844 residents. There are 344 infirmary beds and 500 care beds. These are divided into cottages which are large single storey buildings holding 75 to 100 people in three to six bedded rooms, with a central dining room and a lounge. A registered day and night nurse with assistants is in charge of each cottage. All patients when they enter the centre, as in the New York homes are assessed in the infirmary block, and it is then decided whether

they are fit for the cottage care or infirmary care. The visiting medical staff are supplemented by final-year medical students from the local university.

Great importance is placed in keeping the brain of the cottage patient in constant use and lectures and discussions are held on political and other subjects. Although residents may require services from the staff they still have interests and abilities and responsibilities which they attempt to use to the fullest. There is a sheltered workshop programme which emphasizes the development of old and new additional skills. The total work programme is designed to motivate residents to keep active as long as they can and to feel that they are still able to make a useful contribution to the home. There is now an increasing tendency in America to make use of the Community Health Service Act of 1961. This makes Federal grants to the State health departments for establishing outpatient service for chronic sick or aged up to ten million dollars. This provides for home nursing care through nursing associations and the Home Makers Service, which is a relative to our home help scheme. The Home Maker is described as a mature specially trained woman with skills in home making and employed by a public or voluntary health or welfare organization. Her responsibilities are to provide care for the aged under the supervision of a welfare worker.

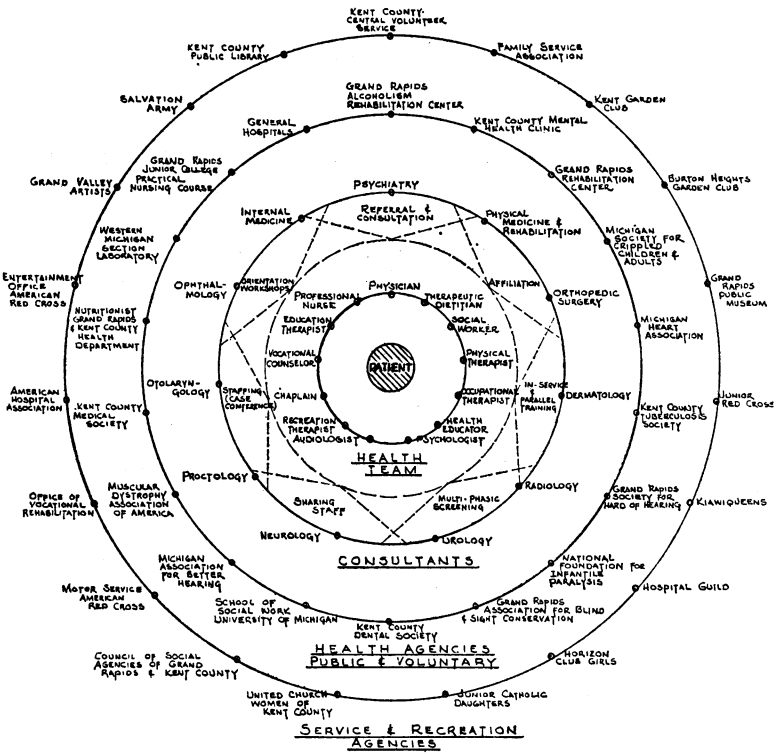
In order that a private nursing home can receive a grant from the Federal Government, the proprietor asks the local Government to make a loan or grant under the Hill Burton plan. The home must be licensed by the State Office. There must be under the Hill Burton plan a minimum of ten beds. In the homes classified as those without skilled nursing, a recent survey showed that 71.8 per cent were really lodging houses and because each person in a lodging house is entitled to receive a State security grant and also an additional grant as previously mentioned, in some cases making a total of 110 dollars a month, certain organizations in Chicago thought up a plan of building large homes with bunks up to the ceiling to cater for the aged indigent person. In this way by taking the grant from them and giving them a very little residential care, they were able to make a large profit. However, the Chicago authorities quickly stamped down on this and special regulations have been passed to ensure that certain standards are kept in these lodging houses, i.e. bed space per resident, etc.

Conclusion

It can be said that the American Federal Government are taking a far sighted policy in their geriatric services. They eventually aim to have all skilled nursing homes with a residential side, so that old people can be treated there rather than be shifted into hospitals.

They will develop in the city hospitals more outpatient facilities, and health teams will build up as the enclosed plan shows. This is the type of team which surrounds the patient at the Maple Grove Medical Care Facility in Michigan.

The Health Team of the Maple Grove Medical Care Facility, 2000 32nd Street, S.E. Grand Rapids, 8 Michigan.



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In America today they suffer from the same acute staff shortage of doctors and nurses that we have in Britain, but it is hoped that with geriatrics becoming one of the major specialities that more graduates will turn to this field.

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