

S2E10 Transcript

Are nursing homes for seniors a relatively new concept?

Ask a
Historian

 Department of History
UNIVERSITY OF WISCONSIN-MADISON

{Intro music}

Emily Tran: From the University of Wisconsin-Madison, this is Ask a Historian. I'm Emily Tran.

Today on the show: are nursing homes for seniors a relatively new concept? Professor Emeritus Tom Broman talks to Ph.D. alumna and History Department Career Advisor Christina Matta about the history of eldercare in Europe and the United States.

We'll learn about the medieval origins of hospitals as privately funded, all-purpose charitable institutions and the 19th- and 20th-century demographic and social transformations that shifted responsibility for care of the poor and elderly to the public. Tom and Christina explain that as more and more people began to live longer, federal legislation provided new government funding directly to seniors and to states for poor relief and elder care, and for the building of hospitals that shaped the development of the nursing home industry.

[MUSIC FADES OUT]

Our episode today is inspired by a question submitted by our listener Dustin. Dustin writes, "Are nursing homes for seniors a relatively new concept? Thinking on all the books and movies I've absorbed, nursing homes aren't represented before the 19th century, so far as I can tell. Did we just take care of our elderly as a matter of tradition?" To answer Dustin's question, Professor Emeritus, Tom Broman spoke to Christina Matta.

Christina Matta: My name is Christina Matta. I am the career advisor and the alumni liaison for the Department of History. And I am also one of the History of Science Ph.D. alumni.

Tom Broman: My name is Tom Broman. I am an Emeritus Professor of History of Science and History of Medicine. I retired about four years ago. And among other things, I taught a course on the History of Medicine that Christina TAed for back in the last century - was it the last century? I can't remember. Anyway, it was a while ago. I'm Co-director with Sarah Thal of Wisconsin 101, the History Department's public history project.

[MUSICAL INTERLUDE]

Christina Matta: So it seems to me from this question that we could potentially take it in a number of directions, including discussions of poverty and illness, morality, the changing experience and nature of aging in the United States and popular portrayals as Dustin has referred to in his question. It seems these themes map somewhat onto rough chronological divisions between say 1700 and now, so I wonder if we should start with some context and chronology. And the reason I've picked 1700 is roughly the origin of what we would recognize now as a hospital. But there was a different purpose to these institutions in the late 17th and early 18th century. They were not a place for specialized care, but rather a place for individuals, whether they were ill, who have no other resource for that care, or they don't have a family that is willing or able to take them in, so early hospitals become sort of where you don't want to be. That's

not a good sign if you're in the hospital. So Tom, I wonder if you could elaborate a bit on the purpose and origin of hospitals and who ended up there and why?

START HERE

Tom Broman: Sure. Hospitals arise as medieval foundations. As you suggested, they begin really as kind of all-purpose charitable institutions and they are funded by private endowments frequently, although sometimes you would find princely or royal patrons starting a hospital. How early do they begin? Well, there's evidence of the earliest – what was actually called an “almshouse” in Worcester in England in 990. That was probably – although it's called now in almshouse and in fact that building is still in operation as an almshouse, apparently. It was called an almshouse; it was probably one of these all-purpose hospitals. And by “all-purpose”, I'm talking about a home for elderly people who had no family relations, could be people with disabilities, could be orphans, could be widows. In other words, they provided a kind of local outlet for charitable services. One of the more famous hospitals of the Middle Ages was the Hôtel-Dieu in Paris. Legend has it, that it was founded in 629, but the first written records of the institution of that hospital, the Hôtel-Dieu - or the home of God, hostel of God - come from the year 829. So we're starting in a pretty early date and those institutions tended to spread and grow because one of the ways that a good Christian could do good works was to leave a fortune upon dying to the benefit of these institutions. So they tended to grow over time.

One of the important innovations that happens actually during the Reformation starting the 16th century is a conceptual distinction between the deserving and undeserving poor. It arises from an idea that salvation comes to those who deserve it in the form of the act of acceptance of God's grace. So this is a kind of Protestant idea, especially Calvinist idea, the separation between the deserving and the undeserving poor means that the institutions become more closely focused on caring for people who are otherwise seen as innocents in God's eyes. So that would again be orphans, people with disabilities such as blindness, the elderly. It would rule out people who are perhaps beggars or prostitutes, people who were seen as not worthy of social attention. By the 18th century, where the question began, we really see the foundation of new hospitals, which are focused more clearly on care of the sick and the separation of those institutions from other institutions for care of the poor, which are designated as almshouses. And there's a big mixture of these. There's no clear separation, but you're beginning to see a separation between focusing hospitals out of care of sick people specifically, or perhaps surgeries that could be done under a more or less controlled setting, versus more all-purpose welfare institutions, which tend to be put into other institutions now.

I'll give you one example of that. In Philadelphia, in the early 18th century, so in the early 1700s, you get the foundation of an almshouse by the Society of Friends, the Quakers, who were sort of the founders of Philadelphia in the first place. There's an almshouse specifically for members of the Quaker order in 1713. Two decades later, the city of Philadelphia finally found its own almshouse called the Blockley Almshouse, and that's in 1732. So you're already seeing in a city like Philadelphia separation of institutions directed towards the poor. In one case it's its sectarian – it's for Quakers. In the other it's a more general poor house.

Christina Matta: So, if we are looking at these institutions as serving multiple populations, including the poor, including the elderly, including the sick, is there a point at which there's differentiation between sick and the not-sick elderly or between different populations of people who are being served?

Tom Broman: Yes. And it comes in sort of two stages. One stage is the overall development of institutions of charity in the 19th century. And what I mean by that is, as cities grow – and this is true in Europe, it's true in North America. It's true in other places outside Europe, but what I know best is Europe and North America. As these cities grow, the complexity of their welfare needs also grows. And so you

find more and more specialized institutions appearing. You'll find insane asylums – those go back a long way, but they're now focusing more on the treatment of people with mental afflictions, as opposed to merely housing them or caring for them in ways that keep them from being what is seen as a burden on the rest of society. So you're getting mental institutions. You're also getting specific homes for elderly people. Elderly people, not just, again, general poor houses. An example of such a place is the Home for Aged Women, which was started in Boston in 1849.

That home is not a public institution. It's founded by a group of people who give money to create this institution for the care of what they want to call “respectable” older women. And again, that probably rules out beggars, prostitutes, women who had perhaps been convicted of crimes. And instead these are women who, for one reason or another, find themselves unable to have family support or a sufficient monetary means to care for themselves as they get older.

So that home for aged women is founded in 1849. And because we're talking about the United States, which is a sort of... a country with lots of racial segregation, there was a separate home for aged “colored” women founded in Boston in 1860. Again, a charitable institution founded by abolitionists funded with private money, and again, with the same idea of caring for a respectable, African-American women who have not the means to otherwise... other means to care for themselves. So these institutions start getting more complex over the course of the second half of the 19th century. But the biggest change by far would come with the Social Security Act of 1935. That's when you really begin to see the institutions begin to take their modern form.

Christina Matta: It's interesting to me that we've gone from sort of 1849 to 1935 here because that's a relatively large gap in time, and it's also interesting to me that the 1935 marker is the Social Security Act. And I'm going to emphasize the social here and ask if there are any changes - culturally or other forces - that might be driving that shift in responsibility to care for the elderly.

Tom Broman: Okay, so, the short answer to that question is, I don't know, in detail and that's - this is a time period that sort of lies well outside my specialty, which is a standard historian's dodge. But I also think a part of the “I don't know” comes from the complexity of what's going on. So let's think about several things.

One is, between 1849 and 1935, the United States undergoes massive population growth in many respects because of immigration. And with immigrants come the proliferation of ethnically based charitable organizations directed at the population that it serves. You would find retirement societies for German immigrants – actually you'd have to divide it then between Protestant, German immigrants and Catholic German immigrants, because they wouldn't help each other – Italians...Jews would be especially interested in doing this because they don't want to send their population to Christian organizations where they might be proselytized to convert. So you'll find homes for the elderly for Jewish residents in cities with large Jewish populations, like New York city and so on. So, so the complexity of organizations grows, and you also see at the local level – but not necessarily the state level – at the local level in large cities, like New York and Philadelphia and Boston and Chicago, the awareness that for the city's own purposes, there have to be institutions of support provided.

So it's at this time that you find some of the great urban hospitals: Massachusetts General Hospital in Boston or Cook County Hospital in Chicago. These are public hospitals, which become very well known as places of medical training, but also places where the poor can get medical help. Now, remember, this is the kind of hospital where you go in, you get patched up and you get sent out.

But, nevertheless, cities take on – and cities all have almshouses. They continue to have almshouses through the whole second half of the 19th century to provide a variety of welfare support for the poor. So

between 1849 and 1935, you get this tremendous demographic change in the United States. Immigration rates are just pretty, pretty high, but that forces the cities to take on new responsibilities for care of the poor and care of the elderly. I don't think you see that so much at the state level, but I could be wrong there. And you certainly don't see the federal level until the Great Depression.

Christina Matta: This is probably not something that we can comment on today, but I wonder to what extent some of that is also dependent on urbanization, not just in terms of growth of cities, but in terms of who is moving to the cities and who remains in rural areas, because it sounds like what you're describing is predominantly something that happens by municipalities. These are run by the city, whether these same kinds of organizations, whether it's an almshouse, whether it's an asylum, whether it's an orphanage or run in rural areas, that may be an interesting question to pursue.

Tom Broman: Yeah, it would be. Well, what makes that especially interesting to me is one can have all kinds of stock images of what American society looks like in this period. I'll give you two. One is the idea that with people arriving in cities, either from rural migration or from immigration from outside the country, you have families that are all working to try and earn enough money to make it, right? So you have, women were beginning to work. You have child labor before that's restricted through various legislation.

In that case, there's actually no one, you know, managing the home sufficiently to care for elderly relatives who might also be living with this family, right? So the care of the sick and the elderly becomes more difficult. I'm assuming that's a big enough of a demographic development to make this a real issue for cities.

Meanwhile, in rural areas, if you take the kind of stock “Waltons” view of America, right? “The Waltons” was set in 1930s Virginia and it was multi-generational. There, even though people might've been working very hard and not having a lot of money, it would have been conceivably - and again, I don't know if this is true as a social fact - you would have more people available to provide the care for the elderly than might be true in cities and with families staying together. But I don't know if that's a demographic enough, a demographically sound enough point.

Christina Matta: So I wonder to what extent that has to do with shifts in the age of the population as well? If we're thinking about the mid 19th century, for example, the Census Bureau has data to suggest that in about 1860 half, the U.S. population was under 20. So that's a fairly large hunk of people who either need care because they're children or cannot provide care because they're children. Only half the population is in that sort of 20-to-death stage. So it would be reasonable to expect given that. Sector of the population is all aging at the same time that you would see an increase in institutions or the type of institutions that are intended to support care for elderly populations. Is that a fair association to make between...?

Tom Broman: Yeah, completely. Yeah. Let's spend a moment thinking about how demography figures into this. So you often hear the term “life expectancy” thrown around in talking about aging and what life expectancy is, is merely a summation of the average life span of everyone in this society. Right? So people who die at the age of five, count for five, and people who died at the age of 75, you just throw them all together, divide them by the number of people in that your life expectancy. It's a very crude measure. So in 1900 life expectancy in the United States was about 40 for both men and women. Women typically live longer, but it was somewhere around 40 and journalists often misinterpret that to say, well, that means there were very few people who live beyond the age of 40. I mean, there was almost nobody older than 40 in that society. That's just completely wrong. And what's wrong is because what you had were very high birth rates - which you talked about - and comparatively high number of children dying

fairly young. That means that the deaths of those children pulls the overall average age of death, or life expectancy, down significantly. Plus the rapid number of births itself pulls that down. So a better measure of what happens between 1849 and 1935 is to ask, well, for the share of the population that lived to say the age of 12, what was their life expectancy? How long would those people live? And what you find is there's actually a reasonable number of people who live to the age of 65, just to give you one number in 1900. According to the 1900 census, there were almost exactly 76 million people in the United States. Of those 76 million, 2,187,000 were 65 to 74, another 770,000 or 75 to 84 and so on, giving a total [of people] over 65 of 3 million people. So 3 million people over 76 million were over 65 in 1900. Okay. Now, compared to what we have today, that wasn't very much, but it was also not an insignificant number of people. And as you suggested in your question, that number just would start going up. The reason it goes up is because medical care was getting better over the second half of the 19th century, wealth was growing to some extent, although the distance between the wealthy and the poor was, was very stark.

So if conditions for living are improving slowly, and if death rates of children and infants is dying, then the life expectancy as a measure of the population as a whole begins to grow up. And especially as you begin to get more legislation passed to protect women, to prevent children from having to work in factories, your overall opportunities for living healthier lives slowly begins to get better.

Christina Matta: It would seem that, if you have decrease in childhood mortality, you have increase in standard of living that is allowing people to live over 65 in better conditions than previous, that you would then also have almost like a compression of the number of elderly people in the United States at any given moment during the early 20th century, where people who were perhaps on the younger end of elderly, i.e. the 65 to 70 bracket versus the 75 to 84 or the percentage of the population over 84 is growing at a relatively rapid rate compared to previous decades or compared to the number of people over 84 who were presumably born 20 years earlier.

Tom Broman: Yes, I think that's right. The data from the census shows quite clearly that the percentage of people between 65 and 74 grows fairly steadily between say 1900 and 1960, whereas the number of the percentage of people growing who are over 85, really crawls up pretty slowly until after 1960. Then it begins to shoot up quite a lot. We could extrapolate downwards and say the number of people between 55 and 65 really begins to grow quite a bit. Remember that the contribution of immigrants to the total population of the United States begins to slow down after 1900, right? As the population as a whole gets bigger, the amount presented by immigrants, who tend to be younger, slows down. And birth rates start falling so that the rate of growth of the U.S. population over the first half of 20th century begins to slow down a little bit. If birth rates slowing down, if immigration is slowing down, then you're going to get more people aging into that older segment of the population, 55 to 65, 65 to 75 and so on.

Christina Matta: And all this is sort of providing context and background to things like the Social Security Act of 1935.

Tom Broman: Right.

Christina Matta: Where you're already starting to see increases in the percentage of the population that counts as elderly, which is roughly again, according to Census Bureau data, it's roughly 5% of the national population, than 65 or older in 1930.

Tom Broman: Yes.

Christina Matta: So what are some of the forces behind the Social Security Act in 1935? And was that Act influential in helping promote or support the development of institutions that are specifically dedicated to that rising segment of the population that is elderly?

Tom Broman: The forces are myriad, but the most important one was the Depression itself. The Act was passed in 1935, the pressures to start passing it were there in 1934. 1932 to 34 represents the real depths of the Depression, that the lowest point of economic activity, the highest unemployment rate. And therefore the existing welfare system based on private charity had, itself, essentially collapsed, leaving large numbers of people in desperate situations and a recognition, well, at all levels of government that something had to be done. This was, after all, what Roosevelt was elected to do in 1932. So that's the context is, is as far as I know, and again like you, I'm not a specialist in American history, but I think the context is pretty clear that the desperate economic situation of the depression really pushed this idea to the front of the congressional agenda in a way that it had not been before it. Remember, I had said earlier that that poor relief was not really seen as a federal issue. It was seen as a state issue. And especially as a local issue, what the Social Security Act did was – it did a lot! I'll name a couple of things. What it's mostly known for now is providing old age pensions. It set up a system whereby working people paid in a certain amount of money every month from their paycheck matched by their employers, which then provides an old age pension once you reach the age of 65. Right? It just gives you a direct payment for getting old - for getting old enough to receive the payment. That's what Social Security is most known for.

But in fact, it did a great deal beyond that. It's set up separate systems of cash payments and direct support for other people in the United States – for example, it created all this age assistance that is actually a separate payment from the Social Security Fund was payments to older people with disabilities, people who might've had cognitive problems or physical problems. So aside from the social security payments that came from work, there was also old age assistance, there was a separate fund created for aid to the blind, there was a separate fund created for aid to dependent children. All of these were seen as poverty relief measures. And Social Security sets up all of these kinds of funds for direct relief of poverty. And these are all payments made to individuals. And the old age assistance is really important for the creation of nursing homes so I'll get back to that in a second.

A second set of provisions in the Social Security Act creates block grants to States from the federal government to set up state-based poor relief systems. This is again a very novel measure, insofar as it makes federal money available to the states to create their own systems. But, as always with federal money, it comes with strings attached. It means that the federal government begins to have a say over how the states set up their own poor relief systems. So Social Security is just a massive change in the relationship between the federal government and the states and the intervention of the federal government in poor relief. Now, what's especially interesting about the Social Security Act is this provision of old age assistance. Because from what I read on this topic, what old age assistance was meant to do – and some of these other measures like aid to the blind were meant to do this as well – it was meant to deinstitutionalize people. So by giving the elderly or the blind or orphans money, the idea was to pull them out of institutions like traditional almshouses and make them more self-sufficient. What in fact it did was give an incentive for the creation of private institutions that would provide this care.

So by making federal money available to the elderly, you gave the elderly the opportunity to shop around for living facilities that would cater to the needs of elderly people. So already in the 1930s, you're beginning to see the beginnings of the nursing home industry. And the sources that I read on this suggests very clearly that you're switching from perhaps municipal or county-based public facilities to, instead, privately run facilities that would cater to the needs of the elderly.

Christina Matta: So the privatization and these institutions that emerged as a result of providing relief to the elderly who were then able to afford to make some decisions about their own care – his overlapped

with some other previous institutions that we've already talked about, things like almshouses, and there's a certain longevity there in that in Philadelphia, for example, there is still an almshouse existing under more or less that title as late as the early 1950s, and it's only then that this sort of lingering institution has converted specifically to care for the elderly. So – it sounds like there's a fragmentation and an overlap and there's no sort of clear cut shift from one to the other, but we can at least conclude that if the purpose of the Social Security Act was in part to allow the elderly to be deinstitutionalized, to go back to home care, to continue staying with their families, it sounds like this defeated the very purpose of at least that part of the act.

Tom Broman: Yes, I agree. And I think we would have to take a more detailed look at several localities to see the effect, whether, for example, the aid to elderly people was sufficient to pay for in-home nursing, for example. One suspects it wasn't, but, you know, the cost of labor was less at the time. And so nursing help would have been less than it is in our own time. The other thing that we have to remember, and this goes back to your point about the existence of the almshouse in Philadelphia until the 1950s: different cities in different parts of the country had very different resources at hand for providing public assistance. And the same would have been true of states - states themselves. Remember those block grants to states that the Social Security Administration made, they themselves were used to set up various kinds of aid. So you've got this very highly heterogeneous system of public and private money being made available for various kinds of welfare related care, not just elder care.

And it only gradually morphs into what we look at as our own system, whatever that is, you know, over the course of the 20th century. Let me add one other nice data point. There was a set of revisions to the Social Security Act made in 1950 that had a couple of significant novelties in them. One of those novelties was for the first time, instead of paying money to individuals who then would choose to buy old age care on their own, the 1950 amendments gave states important – it's that this is a provision given to the states. They gave states the option of paying part of the recipient's public assistance check directly to the nursing home or the provider.

Okay. So why is that a big deal? That means that for the first time, the provider of the money was also responsible for ensuring that the money was being well spent. This is a sort of subtle point about insurance, but it's kind of an important one so I'll try to explain it. When you give money to someone, when say a government or a charity gives money to someone who then uses the money to purchase a service, the donor of the service, whether it be government or private, really has no direct involvement in either the quality or the cost of the service. That's something negotiated between the provider and the person buying it. However, when you give the state the power with federal money, you give federal money to states and the states themselves are capable of paying directly the provider of the, say the nursing home, then the states have an interest in regulating the nursing home and regulating the cost of the nursing home. And so it opens the door to a more regulated system. That's a big change. And you start seeing after the middle of the 20th century, some efforts to start regularizing and controlling nursing homes that you really hadn't seen in the 15 years between 1935 and 1950. Now there was a number of other things going on between 1935 and 1950 that might've distracted the government's attention, but nevertheless, it's an important change. I think that's worth pointing out.

The other is that some of this money could now be used to pay for public services, right? So no longer had to go exclusively to private services. So that gives the states incentives to create more state-supported and state-regulated nursing homes. So the 1950 changes are pretty significant. Licensing comes in in a lot of states – not every state, but more states start licensing nursing homes after 1950, for example, because they now have a direct interest in how those nursing homes are run.

Christina Matta: So in between 1935 and 1950 is the Hill-Burton Act, which allows for federal support of hospitals in some ways. But also if I'm not mistaken allows for the reclassification of institutes that serve the elderly as hospitals. Is that, is that correct?

Tom Broman: It is. And it's an interesting, it's an interesting phenomenon. Here's one of my favorite phenomena of U.S. history. Whenever the federal government turns on a spigot or fills the trough with food, all the pigs turn in that direction. And the Hill-Burton Act shows this effect. The Hill-Burton Act is one of these post-World War II pieces of legislation that says, okay, we're done spending money on the war, we're downsizing the military, and we've got all this money available to give for other purposes. So what sorts of deferred spending do we want to make here? And one thing that was, I think, a reasonable choice by the government at the time was to realize that there had not been any investment in new hospital facilities during the Depression and during World War II. So what the Hill-Burton Act does is make I think they're cost sharing grants to states to invest in upgrading hospital resources. And there's a lot of money. This is not just a tiny amount of money. And that means that there's a strong incentive for institutions to start looking like hospitals to provide medical services like hospitals do in order to qualify for Hill-Burton funding, where they can get fancy new gadgets and get nicer, you know, who knows, nicer linoleum floors, who knows what they got out of it.

But the point is that the Hill-Burton Act has the effect of sort of shaping care for the elderly to look more like medical care in order to fall under the Hill-Burton umbrella. And that's a big change because it's not clear that the elderly require high-tech medical intervention. What they require is nursing. They require people to see to their basic needs. It's not clear that they, that they need high-level medical services on a routine basis. So yeah, things like the Hill-Burton Act have have a big, big effect on that.

Christina Matta: So I wanted to come back to the idea of elderly needing high-tech care, because we've already touched on life expectancy and factors that influence that part of what happens and, you know, as we know in 20th-century medicine is there's an increase in the methods available, and an increase in the level of success of those methods, of prolonging life beyond what might otherwise be considered reasonable. And some of that is very specialized care that is for the terminally ill, very, very ill. It may also just simply be care that was not available earlier in the century when life expectancy, as you said, was hovering around 40. But I think it's also worth noting that some of this expansion is going on at the same time as some of the other factors we've already talked about as influencing development of these institutions in the 19th century: immigration is still continuing post-World War II, women are still in the workforce because many enter the workforce as men were drafted and remained in the workforce thereafter. So there's never really a sort of return to that family model that might have allowed for home care of the very old or elderly members of the family who, you know, a hundred years earlier might have been taken care of by their children or their grandchildren. There's never a point of return to that model. There's still this ongoing social shift that, that influences who is available for that care.

Tom Broman: Yes.

Christina Matta: And again, we're also, we're still seeing that increase in life expectancy. So you're getting a growing number of people who are now at that upper end who are not described by life expectancy data from 1940. That number of who is in the percentage of people population 65 to 74 for a number of reasons has continued to expand; by 2060, the Census Bureau expects life expectancy to be somewhere around 85.6 years, right?

Tom Broman: {laughs} Yeah.

Christina Matta: This is a massive change from 1930 or certainly from 1900.

Tom Broman: Okay. Well, let me just comment on the, on the social change, because in large measure, I think what you described is what I understand is happening too. So you're getting more two wage-earning families – if you sorta take “nuclear family” as the best available option for caring for the elderly – at the same time, as you're getting more people living longer. So it puts a lot of strain on family resources and because of the more sophisticated kind of medical care that's becoming available, especially after World War Two. Let me just point out that open-heart surgeries start happening. You had never been able to tear inside the thorax before and fix the heart – that starts happening in the 1950s. These are expensive sophisticated developments that require very sophisticated forms of care, and sophisticated care, you will not be surprised to hear, is expensive. So you're creating tremendous demand for medical services at the time that the cost of medical care is going up. And if that care is available to the elderly, like open-heart surgery and other kinds of surgical treatments, the elderly are finding themselves less able to pay for it.

So there's just tremendous, tremendous pressure on medical costs. And those pressures are felt, especially by the elderly

Christina Matta: On the flip side, in some ways, some of these institutions that, you know, even decades earlier in some cases, but certainly a century earlier, might've been seen as sort of “here's my place of last resort” because they now have that sort of look of the hospital because regulation has stepped in because there's now more oversight that may seem a more appealing option for a lot of people than trying to patch together family coverage. So I wonder to what extent there's, there's a shift in perspective on the institution itself – on these facilities that stops looking like, “This is where I end up because my family cannot care for me. The conditions are not necessarily great” to “Here's a place where I have companionship. I have someone who can look after my needs. I have someone who can attend to any medical issues I may have,” and it is all done in a way that is overseen if there's regulation. There's a professionalization that goes on here too. There's the emergence of gerontology as a field within medicine specifically devoted to the care of the elderly and geriatric nursing emerges too.

Tom Broman: It does. Although I think we want to...we need to be clear about what time period we're talking about. In the period between the end of World War Two and the passage of the Medicare Act in 1965, nursing homes are expanding for sure. The prevalence of nursing homes is going up, but I don't know what the public perception of it is. And it's undoubtedly more complicated than any single quick summary of it would be. It depends on what communities we're talking about, whether it's, you know, a wealthy suburban Cleveland or Newark – maybe Newark was in better shape in the 1950s. But in any case, it probably depends on which parts of the country we're talking about, what the overall wealth levels are. But aside from that, the ability of this, of...I think you're onto something important that eventually we begin to start seeing that the great expansion of life. I mean, if you can look at the census data, the really rapid expansion of numbers of people living beyond the age of, say, 75 starts after 1960, and it really starts going up a lot.

And why is that? Probably again, better overall health and younger ages, better interventions to prevent people from dying from things like heart disease that they might've died from before. Who knows, reduction in cigarette smoking. I don't know what the factors are. Public health people would give you a better sense of this, but it's clear that the number of people living beyond 75 is just...starts expanding a lot after 1960. And you, you pointed that out earlier. So that presence demands some kind of...demands some kind of awareness on the part of the public about how to deal with this, the kind of arrangements that need to be made for, for people in that age group. It's worth pointing out – let's spend a moment describing the effect of the Medicare Act. The Medicare Act, for the first time, provides a federal guarantee for the hospitalization costs of the elderly. That means anyone over 65 can register with the Social Security Administration and have their hospital costs covered by the federal government through money provided through Medicare.

There's a separate opportunity. I mean, Medicare does a number of things. It too makes block grants available to the States under the program known as Medicaid. So in that sense, it, it mimics what had already been happening under the Social Security Act and the Social Security Administration, but this opportunity for the federal government to cover the hospitalization costs of the elderly is a big deal, because again, it turns on another giant money spigot and it – if you think there were nursing homes before 1965, they just start blooming like daffodils in spring after 1965. Again, because there's so much financial pressure to create hospital-like arrangements for the elderly, and then get that money reimbursed by the federal government.

So that leads to a funding crisis. It leads to a regulation crisis. It leads to scandals over the quality of care in these nursing homes. So I think going back to your point, there's a, there's a kind of a low point for nursing homes in the wake of the Medicare Act that leads them to be seen as warehouses for the elderly. And it's only from that low point that you begin to start getting more serious attention paid to the varieties of transitional care that people can get: better rehabilitation facilities for people that have had surgery and stuff like that.

Christina Matta: I think it's interesting that you're bringing up sort of this low point of the image because Dustin's original question, referenced historical portrayals, or the lack thereof, of nursing homes in popular media. And most of the portrayals I can think of have been negative. They're either sort of playing on that low point that you've just described or they're sort of harking back to 17th-century or earlier – 1800s, 1700s before then, even – of models of institutions or hospitals. I'm thinking about, for example, *The Golden Girls*, the very popular 80 sitcom, where Dorothy used to say, “Shady Pines, Ma!” every time her mother was annoying as a way of keeping her 80-year old mother from going too far afield. That was sort of a hanging, threat of –

Tom Broman: Oh, that's right! Yeah!

Christina Matta: “Hey, we're going to put you in this home.” And I think there's still a certain amount of stigma associated with whether we care for our elderly family members in the home, whether that's something that is either ethically appropriate, morally appropriate, culturally appropriate, depending on one's background. But I wonder to what extent the lack of popular portrayal that Dustin is describing is because that stigma or that representation is either inaccurate – which I would argue in many cases it is – or whether it just doesn't simply align with our social understanding anymore.

Tom Broman: It's hard to say one of the best books I've read recently on the problems of caring for the aging population is Atul Gawande's book *Being Mortal*, which I strongly recommend to someone who's interested in the problems of aging in the society. Gawande is...mostly spends some of his time talking about the kinds of medical care that's given to very elderly people, and he's basically arguing against the too-ready use of emergency room interventions or intensive care type arrangements. That there has to be a more mature reflection on the part of physicians and the medical establishment to simply allow people to die without massive intervention. So that's part of his argument.

But part of his argument too is about reforming institutionalized nursing home-type care to allow people to live better lives that has them more cognitively active and has them more physically active. And he gives examples of nursing homes in various places that have kind of been innovative in doing this. So it's a kind of two-pronged issue as he presents it. One is about telling physicians like himself to stop doing so much heroic surgery and so on. And the other side is to make better institutional arrangements to create a less warehouse-like – that's not his term necessarily, but it's part of this bad image of nursing homes – a less warehouse-like arrangement, where people are just sitting around waiting to be fed while watching daytime TV or something. In my opinion, as someone who is not yet ready for institutionalized

care, but definitely elderly. That strikes me as where our thinking is right now, pretty much. Would you agree?

Christina Matta: I agree. And I think there's also – having not read the book, but I think there's also sort of a, we are starting to make that distinction by way of retirement communities versus nursing homes, which are intended to avoid these sort of sitting around, waiting to be fed while watching daytime TV, by providing activities, by providing neighbors and providing events or activities that that people can participate in before they hit the point where they are physically not able to live alone or care for themselves. So there's sort of a further distinction here that gets at the sector of the population that is too old to necessarily maintain a large home on their own as their family moves away, but they are not yet ready for specialized care, but that still allows for staff who have some training to be able to intervene if that is necessary. So I think there's sort of a pulling back from your options are “stay at home or be in this potentially” – again, I don't want to use “warehouse” either, but a distinction between living at home with family or by yourself, or being in a very specialized facility that's sort of meant to offset some of that medical pressure, but also that offsets some of that public perception issue.

Tom Broman: Yeah. I agree. Uh, what I don't know is whether those kinds of transitional arrangements, how widely available they are, or whether in fact you have to be fairly affluent to qualify for getting into something like that. It...to provide it more broadly would require, I suppose, a great deal of public investment, but it's absolutely a model of how one can manage to deal with the issue of what happens as you age into your seventies and eighties and nineties, and apparently into your hundreds and hundreds and tens. Not sure I want that to be my example, but who knows? Maybe we'll be back in 50 years doing this again.

Christina Matta: Trot me out and feed me my strained peaches before. {Laughs} Here's my last question for you: medical institutions, such as hospitals, medical schools in the U S are reasonably well studied in history of medicine as an academic discipline. And certainly we've talked about some of the policies that are also routinely studied, but nursing homes are not – hence Dustin's original question. Do you want to speculate as to why that is at all?

Tom Broman: I don't have a good answer. I suspect it's because....Okay, here's one of my general principles of history. One generation experiences, a phenomenon, but it's the next generation that talks about it or reflects on it. So a standard example is of the French Revolution of 1789 and the revolutionary fervor that came up in 1830. So you'd say that there's one generation that experiences the consequences of the French Revolution. It's the following generation of social theorists, including guys like Marx and Engels who begin to theorize about it. So I think you might find the same thing happening here: that we are the generation, my generation, you know, baby boomers especially, are the generation that are creating the social problem by living so long. And it's only just now becoming.... It's not enough of a phenomenon with a specific form to it that people can begin to study it as a historical phenomenon. That would be...that's my kind of guess why, but if Dustin's patient enough and waits 15 or 20 years, you'll start seeing more books about this because it's important.

Historians always will jump on whatever topic is important to the public to try and get a sense of what its roots are and how it's developed and all that sort of thing. So hang in there it'll happen.

Christina Matta: There's a whole battalion of PhD students who are looking for a topic, right? Pick that one up.

Tom Broman: Remember, remember, grad students always need something new to write about. So. {laughs}

Christina Matta: So go forth and create history, everyone! Right?

Tom Broman: Exactly. {laughs}

Christina Matta: Tom, this has been a pleasure. Thank you so much for taking the time to talk with us and to answer questions from our devoted listeners.

Tom Broman: It's a pleasure. It's been great for me too. Thanks a lot.

[Music begins]

Emily Tran: We're always looking for questions about the past to bring to our historians. You can send your question for a historian to outreach@history.wisc.edu.

This episode of Ask A Historian was produced and edited by me, Emily Tran. Major funding for Ask A Historian comes from the Department of History Board of Visitors at the University of Wisconsin-Madison. Thanks, especially to Jon Leibowitz, Peter Hamburger, and Rick Kalson. Thank you for listening.