Ownership and Size of Nursing Homes

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THE HISTORY of nursing homes in this country has led to a particular pattern in their ownership and size. Most nursing homes are proprietary. Linked to this type of ownership is the typically small bed capacity of these establishments. It is our purpose here to see just what is the size of existing nursing homes, how many of these homes are operated commercially, or how many are under voluntary and public auspices, and how these two features of ownership and size are interrelated.

We will be primarily concerned with the 7,000 establishments described in the parent report of this study as "skilled nursing homes" (*1*). The national inventory of nursing homes and related facilities on which this study is based set these skilled nursing homes in perspective within a broad family of facilities. Along with skilled nursing homes, the inventory included "personal care homes," some offering skilled nursing and some not, as well as "sheltered homes." As in the earlier report, these related types of facilities will be drawn in for comparative data.

So rapidly has the nursing home developed during the past 20 years that its history seems more like an eruption than an evolutionary development. Its rapid growth was influenced by the convergence of a number of social and economic circumstances. The principal ones can only be mentioned here in passing. They include the extension of the life span and marked increase of the aged population, changes in family structure and in living arrangements which have tended toward shelving of the older people, and the growing prominence of the chronic diseases, among both young and old. Although the social and biological factors are the basic elements which combined to create a need, their effect was precipitated by additional important elements. Perhaps the most important among these was the disrepute into which the public almshouse had fallen and the emergence of a new philosophy in public welfare in the Social Security Act of 1935. When society turned from almshouses and chose to place cash assistance in the hands of the needy aged, the resulting expanded demand for private living quarters for older people, many of them infirm or ailing, stimulated a significant response.

The easiest and quickest response came from sources requiring the least immediate outlay in capital and organization. Expediency led to widespread use of existing family structures, not otherwise fully occupied, with the homeowner or lessee often having an applicable skill such as nursing and an interest in such an ac-

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Mr. Solon and Miss Baney, health program analysts in the Division of Hospital Facilities, Public Helath Service, present their second report on the national inventory of nursing homes and related facilities. *The first report, which appeared in the December 1954 issue of Public Health Reports, p. 1121, introduced overall national estimates and an analysis of the distribution of facilities among States and Territories.*

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tivity as a source of income. Here then was an opportunity for small proprietary ventures.

Some actually started as nursing homes. Some started as boarding homes for elderly people. But in historical background, even as in contemporary operation, the line between homes which offered nursing care and those which provided domiciliary services was not sharply drawn. With the passage of time, homes which had begun as room-and-board enterprises gradually, sometimes imperceptibly, assumed responsibility for meeting personal care and nursing needs as these arose among their aging residents. Thus, many of today's nursing homes are yesterday's small private boarding homes for older people. The current nursing home situation with respect to ownership and size reveals the imprint of these origins.

Ownership of Skilled Nursing Homes

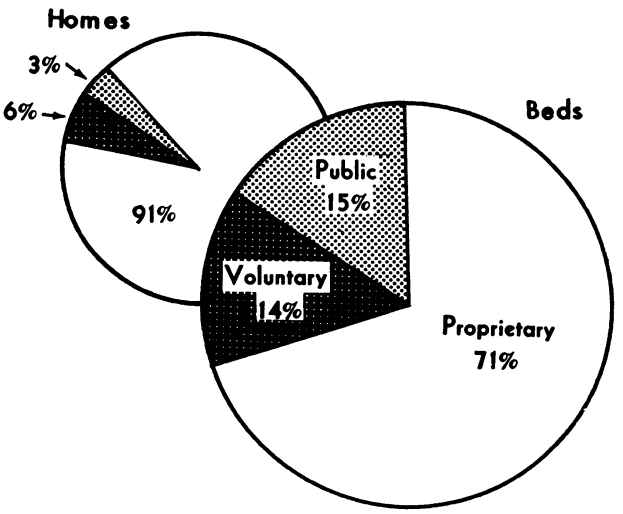
Nursing home is often understood in common parlance to mean private nursing home. This association almost justifies itself, for fully 91 percent of all skilled nursing homes are operated under private commercial ownership.

As though to reinforce this popular identification, the nonprofit voluntary and public institutions have historically been known by other names. Although a nursing home by any name is no less a nursing home, it is often not thought of as such when it bears the label "home for the aged" or "chronic disease hospital" or "county home."

In the present study, institutions are classified by their function regardless of type of name. The resulting facts about skilled nursing homes show that 6 percent are under voluntary (private nonprofit) auspices, of which one-third are church related. Public (State and local governmental) auspices account for 3 percent of the homes.

The picture is somewhat deceptive with these figures alone. The number of beds provided in each category of ownership has an additional significance. Because the voluntary and public homes are typically larger than the proprietary homes, they account for more beds than their small number would suggest (fig. 1). Although

Figure 1. Distribution of skilled nursing homes and beds by type of ownership, 1954.



representing together only 1 home in every 10, they provide 3 beds out of every 10. Thus, the predominance of proprietary ownership, 91 percent in terms of number of homes, is abbreviated to 71 percent in terms of number of beds.

The preponderance of proprietary skilled nursing homes is observed over and over again in the individual States (table 1). It is true that in a number of States there are relatively few proprietary skilled nursing homes or even none at all. However, these are generally States with few establishments all told. It should be mentioned here, however, that since detailed field surveys were not requested of the States for the purpose of the present inventory, the data reported for some individual States may not be wholly reliable.

Ownership of Related Facilities

Proprietary ownership is relatively less prominent in personal care homes and sheltered homes. In those categories, the voluntary and public auspices are traditionally more active than they are in skilled nursing homes (table 2).

Care Homes With Skilled Nursing

Among the several types of facilities related to skilled nursing homes, it is only in personal care homes with skilled nursing that voluntary sponsorship exceeds the proprietary in number of beds provided. Both secular and church groups have developed their programs quite

Table 1. Distribution of skilled nursing homes and beds, by type of ownership, by State and Territory, 1954

State	Number of homes				Beds			
	Total	Type of ownership			Total number	Percent distribution by type of ownership		
		Proprietary	Voluntary	Public		Proprietary	Voluntary	Public
Total, 51 States and Territories reported [1]	[2] 6,539	5,953	387	198	[3] 171,816	70.7	13.8	15.5
Alabama	67	59	[4] 8	—	1,446	—	—	—
Arizona	7	7	0	0	132	100.0	0	0
Arkansas	61	54	5	2	1,281	71.3	8.6	20.1
California	573	530	23	20	12,806	74.3	7.6	18.2
Colorado	52	47	4	1	1,775	89.5	5.5	5.1
Connecticut	193	186	6	1	4,868	91.8	6.8	1.4
Delaware	1	0	1	0	44	0	100.0	0
District of Columbia	7	4	3	0	311	15.8	84.2	0
Florida	43	42	1	0	[3] 475	—	—	—
Georgia	56	47	8	1	1,822	63.9	35.0	1.1
Idaho	1	0	1	0	36	0	100.0	0
Illinois	527	481	14	32	[3] 16,753	61.0	8.3	30.8
Indiana	175	175	0	0	3,035	100.0	0	0
Iowa	278	247	30	1	6,303	69.8	29.9	.3
Kansas	5	[4] 4	[4] 1	—	118	—	—	—
Louisiana	53	47	6	0	1,631	79.7	20.3	0
Maine	189	187	2	0	2,491	89.0	11.0	0
Maryland	112	103	8	1	3,604	79.0	7.9	13.0
Massachusetts	484	468	14	2	10,854	91.7	6.6	1.7
Michigan	458	394	29	35	14,256	51.1	13.8	35.1
Minnesota	178	152	17	9	4,242	65.5	26.8	7.7
Mississippi	2	0	0	2	[3] 24	0	0	100.0
Missouri	95	77	18	0	3,832	55.7	44.3	0
Montana	8	7	0	1	289	83.7	0	16.3
Nebraska	3	0	3	0	440	0	100.0	0
Nevada	10	2	0	8	239	23.0	0	77.0
New Hampshire	75	69	3	3	1,681	72.0	5.6	22.4
New Jersey	147	118	17	12	5,220	56.8	14.3	28.9
New Mexico	36	34	0	2	547	63.3	0	36.7
New York	767	739	17	11	20,717	80.4	3.8	15.9
North Carolina	4	2	2	0	59	62.7	37.3	0
North Dakota	7	5	2	0	143	63.6	36.4	0
Ohio [5]	471	418	53	0	12,838	66.9	33.1	0
Oklahoma	109	102	6	1	1,927	86.8	11.1	2.1
Oregon [2]	171	159	6	5	3,914	81.3	4.3	13.7
Pennsylvania	146	115	0	31	7,448	36.2	0	63.8
Rhode Island	40	39	1	0	642	98.1	1.9	0
South Carolina	29	26	2	1	618	71.8	21.0	7.1
South Dakota	2	2	0	0	18	100.0	0	0
Tennessee	29	26	3	0	700	80.3	19.7	0
Texas [5]	120	114	6	0	2,683	90.1	9.9	0
Utah	3	1	2	0	73	13.7	86.3	0
Vermont	82	78	4	0	841	90.0	10.0	0
Virginia	144	134	7	3	3,129	72.8	9.4	17.8
Washington	298	264	26	8	8,964	77.0	19.1	3.9
West Virginia	51	43	6	2	1,697	66.4	8.7	24.9
Wisconsin	152	133	18	1	4,267	61.6	37.5	.9
Wyoming	13	11	1	1	151	68.2	18.5	13.2
Alaska	0	0	0	0	0	0	0	0
Hawaii	3	1	1	1	366	.5	11.7	87.7
Puerto Rico	2	0	2	0	66	0	100.0	0

[1] Virgin Islands did not report. Kentucky's total of 149 homes with 2,604 beds could not be classified by type of facility, for lack of information on level of service. [2] Includes one home (22 beds) of unknown ownership. [3] Incomplete figure. Number of beds not reported for some homes (21 homes in Florida, 28 homes in Illinois, 1 home in Mississippi, and proportionately negligible numbers in 5 other States). [4] Probably incomplete. [5] May be under-reported since a considerable number of homes were not identified as to type of facility.

NOTE: A dash (—) represents "not known."

substantially in this area. We recognize these homes most commonly as homes for the aged which furnish some amount of skilled nursing care along with their primarily domiciliary services.

The introduction and expansion of nursing services in these personal care institutions is essentially similar to the experience, mentioned at the outset, of many early proprietary boarding homes. Many homes for the aged, as their residents presented increasing infirmities and developed chronic illnesses, have gradually drifted from essentially room-and-board services into the provision of skilled nursing care as well. This may be only the beginning of this trend, as it would seem that time will inevitably bring a deeper involvement in the provision of skilled nursing care on the part of homes for the aged.

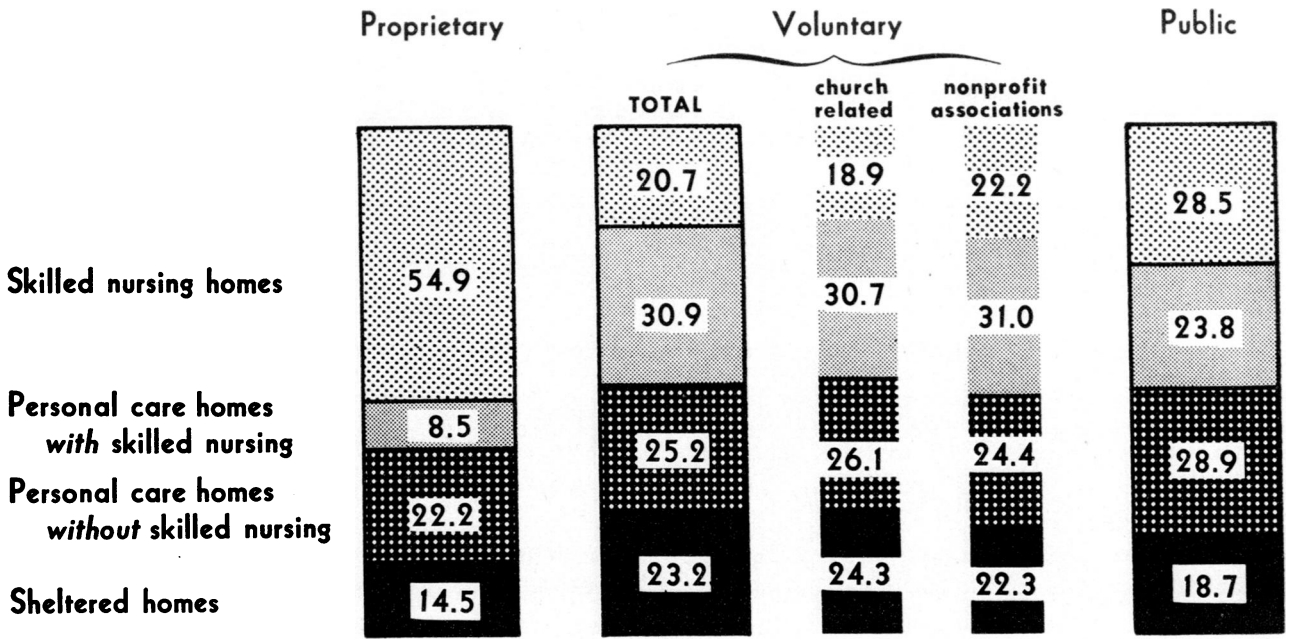
Today, one-fourth of all personal care homes

Table 2. Distribution of nursing homes and related facilities, by type of ownership, 1954[1]

Type of facility	Total	Type of ownership				
		Proprietary	Voluntary			Public
			Total	Church related	Nonprofit associations	
	Number of homes					
Total	25,000	20,700	2,600	1,050	1,550	1,700
Skilled nursing homes	7,000	6,400	400	150	250	200
Personal care homes with skilled nursing	2,000	1,300	500	200	300	200
Personal care homes without skilled nursing	7,000	5,600	900	300	600	500
Sheltered homes	9,000	7,400	800	400	400	800
	Number of beds					
Total	450,000	232,000	120,100	51,300	68,800	97,800
Skilled nursing homes	180,000	127,300	24,800	9,600	15,200	27,900
Personal care homes with skilled nursing	80,000	19,600	37,100	15,700	21,400	23,300
Personal care homes without skilled nursing	110,000	51,400	30,300	13,500	16,800	28,300
Sheltered homes	80,000	33,700	27,900	12,500	15,400	18,300
	Percent distribution of homes					
Total	100.0	83.2	10.8	4.1	6.7	6.0
Skilled nursing homes	100.0	91.0	5.9	2.1	3.8	3.0
Personal care homes with skilled nursing	100.0	65.0	25.3	11.0	14.3	9.6
Personal care homes without skilled nursing	100.0	80.5	12.8	4.3	8.5	6.7
Sheltered homes	100.0	81.7	9.4	4.7	4.6	8.8
	Percent distribution of beds					
Total	100.0	53.9	25.5	10.8	14.7	20.6
Skilled nursing homes	100.0	70.7	13.8	5.4	8.5	15.5
Personal care homes with skilled nursing	100.0	24.5	46.4	19.7	26.7	29.1
Personal care homes without skilled nursing	100.0	46.7	27.5	12.2	15.3	25.7
Sheltered homes	100.0	42.1	34.8	15.6	19.2	22.9

[1] Total national estimates for 53 States (including Territories). Number of homes and beds is given in rounded figures; percentages are based on unrounded figures.

Figure 2. Relative participation in different types of facilities, by each type of ownership: percent distribution of beds, 1954.



which provide skilled nursing services are operated by voluntary groups. However, these homes account for nearly one-half of all beds. The effect of large homes on the distribution pattern is reflected even more sharply with public homes. Although publicly operated institutions represent only one-tenth of all homes in this category, they have three-tenths of the beds.

Even though proprietary interests do not predominate here as much as they do in skilled nursing homes, they are prominent nevertheless. One-fourth of all the beds in personal care homes providing skilled nursing are found in proprietary establishments. Without dominating in number of beds, commercial ownership accounts for two-thirds of all homes in this category.

In many areas, proprietary homes which offer mainly personal care with some skilled nursing are not ordinarily distinguished from homes whose primary and predominant function is skilled nursing care. All are loosely regarded as nursing homes. This designation is sometimes even extended to homes which furnish only personal care with no skilled nursing at all. Much of the troublesome confusion over concepts and the application of standards in this field may be traced to failure to recognize legitimate differences in the character and level of care offered by different homes.

Domiciliary Facilities

Sheltered homes and personal care homes which do not provide skilled nursing are numerically dominated by proprietary auspices, but not as overwhelmingly as are the skilled nursing homes. Voluntary organizations share in these facilities proportionately more than they do in skilled nursing homes, although not as heavily as was noted for the personal care homes which offer skilled nursing.

The relative part played by public ownership in these nonnursing categories is only slightly less than in personal care homes which provide skilled nursing. Among both sheltered homes and personal care homes lacking skilled nursing, governmental operation accounts for somewhat under 10 percent of the homes and about one-fourth of the beds.

Patterns Under Different Auspices

We have seen from figure 1 and the related discussion how the different auspices share proportionately in providing the homes of each type. We may also observe how each type of sponsorship distributes its total effort among

Table 3. Relative participation in different types of facilities, by each type of ownership: percent distribution of homes, 1954

Type of facility	Proprietary	Voluntary			Public
		Total	Church related	Nonprofit associations	
Total	100.0	100.0	100.0	100.0	100.0
Skilled nursing homes	30.8	15.5	13.5	17.0	12.6
Personal care homes with skilled nursing	6.3	19.0	20.2	18.3	11.5
Personal care homes without skilled nursing	27.3	33.7	27.6	38.1	28.2
Sheltered homes	35.6	31.8	38.8	26.5	47.6

NOTE: Figure 2 gives the corresponding distribution of beds in these homes. The basic figures for table 3 and figure 2 will be found in table 2. Percentages are based on unrounded figures.

the several categories. Figure 2 and table 3 provide this perspective.

In terms of beds, the comparative bars in figure 2 point up the outstanding differences in the way the various auspices distribute their resources among the several classes of facilities. The voluntary and public sponsorships show a quite even pattern of participation in all four types. In marked contrast, proprietary interests show a heavy concentration in skilled nursing homes.

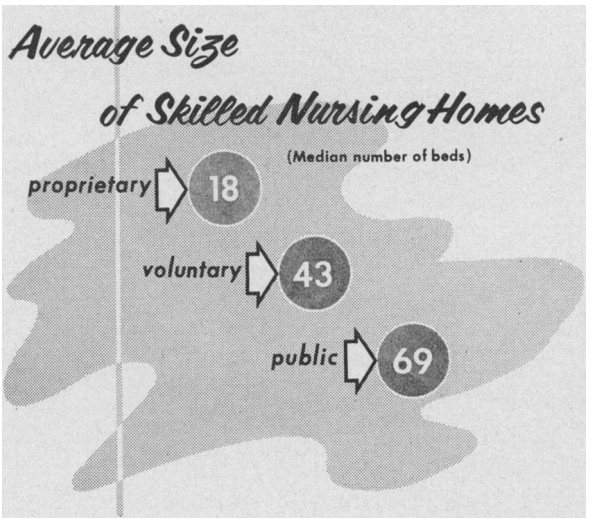
Similarities are highlighted no less than the contrasts. Within the voluntary field, the almost identical emphases of the nonprofit associations and the church-related sponsors are strikingly revealed in the charted distribution of beds.

Size of Skilled Nursing Homes

The size of home, in number of beds, appears as a factor more than once in the foregoing. It is especially evident when we compare the proportion of beds with the proportion of homes under each of the various auspices. A direct look at size in relation to ownership would now be in order.

The typical skilled nursing home consists of 19 beds. (Median size is used in this study so that the occasional huge institution will not unduly weight the average.) Bracketed into this average of 19 beds are very sharp variations among the different forms of ownership. The accompanying illustration tells this story. In the number of beds, the proprietary homes are typically small, the philanthropic homes average a medium size, and the public homes are characteristically large.

Within the voluntary field, there is a close similarity in size between the church related and the other nonprofit homes. The average home under church auspices has a capacity of 48 beds, and the other voluntary institutions average 40 beds.



Along with these various representative sizes there is a broad range of size among individual homes under each type of sponsorship. As table 4 shows, every size of home is to be found under every form of ownership. Despite the large average size of the nonproprietary homes, as many as one-fourth of all the homes under voluntary and public con-

trol are found to be under 25 beds in size. Some proprietary homes, on the other hand, exceed 100 beds; the largest is reported as having 300 beds.

However, although different sizes are found among the homes of every sponsorship, it is equally evident from table 4 that the overall pattern of distribution according to size varies markedly with type of ownership. The pattern shifts from a concentration in the smaller sizes among the proprietary homes to an almost identical pattern in reverse among the public homes. In terms of number of beds, the relative concentration of the public and voluntary homes in large units produces a striking observation—that two-thirds of all the beds under these auspices are in institutions of 100 beds or more.

The way in which many of today's proprietary nursing homes developed, mentioned earlier, explains the existence of homes which accommodate only 1 patient, 2 patients, or other small numbers. Many States do not license homes of such small capacity. The existence of these very small homes, however, raises a question as to their significance in the total picture. The present study reveals that homes of less than 5 beds constitute hardly more than 1 percent of all beds in skilled nursing homes.

The small average size of proprietary skilled nursing homes is repeatedly emphasized in the data for individual States. The largest median size for any State is 30 beds (Montana). The smallest average is 8 beds (Vermont). In as many as 11 States, the average home consists of fewer than 15 beds. In only 3 States is the average 25 beds or more.

Size of Related Facilities

The pattern whereby the different types of auspices tend toward respectively smaller or larger facilities is not peculiar to the skilled nursing homes. The pattern is repeated for each type of facility covered in this inventory. Uniformly, the proprietary homes are on the average the smallest and the public homes are the largest, as the following median bed capacities demonstrate:

	Proprietary	*Voluntary*	*Public*
Personal care homes with skilled nursing	14	61	80
Personal care homes without skilled nursing	9	25	38
Sheltered homes	7	27	37

Summary

Size and ownership of nursing homes are intimately related, according to this second report on the Public Health Service national inventory of nursing homes and related facilities. Proprietary homes are typically quite small, voluntary homes are considerably larger, and public homes are usually the largest. Among skilled nursing homes, which engage primary interest in this study, the median sizes under the three classes of ownership were found to be, respectively, 18 beds, 43 beds, and 69 beds.

Table 4. Distribution of skilled nursing homes by size of home, by type of ownership, 1954

Size of home (number of beds)	Percent distribution by size of home					
	Homes			Beds in homes of specified size		
	Proprietary	Voluntary	Public	Proprietary	Voluntary	Public
Total	100. 0	100. 0	100. 0	100. 0	100. 0	100. 0
Under 10 beds	22. 6	2. 3	2. 0	6. 6	0. 3	0. 1
10–14	18. 3	8. 3	3. 0	10. 7	1. 6	. 3
15–24	29. 5	18. 9	7. 6	27. 7	6. 0	1. 1
25–34	15. 7	11. 6	8. 1	22. 0	5. 6	1. 8
35–49	8. 3	15. 8	13. 6	16. 3	10. 6	4. 4
50–74	3. 3	16. 0	20. 2	9. 3	15. 6	9. 3
75–99	. 7	8. 3	12 1	3. 0	11. 4	7. 8
100 and over	. 6	17. 8	32. 3	4. 3	49. 0	75. 3

With 91 percent of all skilled nursing homes under proprietary operation, the popular conception of the nursing home as a small private establishment is objectively accurate. This conception, however, should not cloud the significant, though smaller, role of voluntary and public auspices in this type of facility. Although these nonprofit interests represent only 1 home in 10, they provide, as a result of their usually larger size, 3 beds of every 10.

REFERENCE

(1) Solon, J., and Baney, A. M.: Inventory of nursing homes and related facilities. Pub. Health Rep. 69: 1121–1132, December 1954.

Definition of Sanitary Engineer Revised

A revision of the 1943 definition of the term, "sanitary engineer," was approved by the Committee on Sanitary Engineering and Environment of the National Research Council, December 14, 1954. The new definition follows.

The professional occupational title "sanitary engineer" shall apply to a graduate of a full 4-year, or longer, course leading to a bachelor's, or higher, degree, with the qualifications noted below, at an educational institution of recognized standing, as defined below, with major study in engineering, who has fitted himself by suitable specialized training, study, and experience (*a*) to conceive, design, appraise, direct, and manage engineering works and projects developed, as a whole or in part, for the protection and promotion of the public health, particularly as it relates to the improvement of man's environment, and (*b*) to investigate and correct engineering works and other projects that are capable of injury to the public health by being or becoming faulty in conception, design, direction, or management.

Persons lacking in formal education who otherwise meet the terms of the above definition may be considered as having the equivalent of a full 4-year course in engineering in an educational institution of recognized standing provided they are registered engineers and have sufficient experience or training of the type defined above to substitute for the engineering education lacking. The basis of such substitution shall be 2 years of appropriate training or experience for 1 year of formal engineering education.

An educational institution of recognized standing is defined as one which is accredited by a national or regional accrediting association, such as the Association of American Universities, or the New England, Middle States, North Central, Southern, or Northwest Association of Secondary and Higher Schools, or one whose professional curriculum has been accredited by the Engineers' Council for Professional Development of the Committee on Professional Education, American Public Health Association.

The practice of sanitary engineering includes the following activities:

1. Surveys, reports, designs, reviews, direction, management, operation, and investigation of works or programs for:

(*a*) Water supply, treatment, and distribution.

(*b*) The collection, treatment, and disposal of community wastes, viz., sanitary sewage, industrial wastes, and refuse, including salvage and reclamation of useful components of such wastes.

(*c*) The control of pollution of surface waterways and ground waters, and of surface and subsurface soils.

(*d*) Milk and food sanitation.

(*e*) Housing and institutional sanitation.

(*f*) Insect and vermin control or eradication.

(*g*) Rural, camp, and recreation place sanitation.

(*h*) The control of atmospheric pollution and air quality, and of light, noise, vibration, and toxic materials, including application to work spaces in industrial establishments (including hygiene engineering).

(*i*) The prevention of radiation exposure.

(*j*) Other fields that have as their major objective the control of environmental factors affecting health.

2. Professional research and development work supporting the activities listed in 1.

3. Responsible teaching of sanitary engineering subjects in educational institutions of recognized standing.