SOCIAL SERVICE AND RELIEF IN TUBERCULOUS FAMILIES

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WHEREVER intensive work in the development of the control of tuberculosis has been undertaken, it has become increasingly clear that not only health departments and health agencies are concerned, but also relief and social service facilities of the community. This became increasingly apparent in the development of the Cattaraugus County and Syracuse health programs. The health officials were aware of the fact that tuberculosis control was dependent on development of the relief and social service program affecting tuberculous families as well as on improvement in the quality and quantity of health work done through clinic, nurse, and sanatorium.

In recognition of this fact, the Milbank Memorial Fund undertook the financial support of an inquiry into the adequacy of relief and social service for tuberculous families in Syracuse. The request for this study originated in Syracuse with the Onondaga Health Association, and was supported strongly by the health commissioner and by the local social agencies, as well as by the New York State Charities Aid Association which had taken a leading part in the planning and development of the Syracuse Health Demonstration. The study was made by the New York Association for Improving the Condition of the Poor which over more than a decade has been developing a tuberculosis relief program in the City of New York. A preliminary report of the survey has been published by the Milbank Memorial Fund under the title, "Relief of Tuberculous Families." A summary is pre-

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sented here in the belief that the picture afforded of relief facilities provided for dealing with tuberculosis in Syracuse is not far different from that which might be found in almost any community. It is the author's belief that the data throw light on the necessity for more adequate attention to the problem of social service and relief in tuberculosis programs in all communities.

Tuberculosis Relief in Syracuse

As in most communities, relief in Syracuse is given by several organizations, both public and private. The Department of Charities, however, bears the brunt of the relief program, and provides relief in homes, relief in hospitals, and child care outside of the home. The Board of Child Welfare gives allowances to widows' families, and has authority to grant allowances to women with dependent children whose husbands have been incapacitated by tuberculosis. This latter authority, however, is not utilized. The Associated Charities, Catholic Welfare, Red Cross, United Jewish Charities, and Salvation Army all participate to some degree in the relief program of Syracuse.

It is estimated that the City of Syracuse spends annually about $332,000 in its health and relief services for tuberculosis. About 85 per cent of this is expended in health services and about 15 per cent in relief. The health services include hospitalization of tuberculosis as the largest item, and, in addition, preventorium costs and the cost of the tuberculosis clinics, of nursing supervision, and of open-air classes. Approximately 85 per cent of the total health service bill is expended by the municipality, 3 per cent by the State, 6 per cent by the Federal Government, and 6 per cent by private organizations. The tuberculosis relief bill of approximately $48,000 is 8.8 per cent of the total relief bill of Syra-

cuse which is $544,000. Eighty-nine per cent of the relief expended in tuberculosis comes from public funds, and 11 per cent from private funds. Out of the $48,000 expended for tuberculosis relief, $22,000 is expended for relief in homes; $14,500 is expended for hospital care of the sick poor in local hospitals, and the balance is expended for the care of children from tuberculous families in institutions or in boarding homes. Sanatorium care for patients in the families given relief during the year studied cost $49,000, or more than twice the amount expended for material aid of such families in their homes. All health services for tuberculous families cost more than twelve times the amount expended for material relief in the homes of such families.

Method of the Syracuse Study

This study includes 1,288 tuberculous families known to the Health Department on May 1, 1929, when the inquiry was undertaken. It was impossible to make an intensive study of the social service and economic situation of all of these families. A sampling method, therefore, had to be arranged. General information about each family was obtained, enough to remove from the total number those which could clearly be classed as economically secure. In this way, 296 families were eliminated. The remaining 992 families were divided into two groups—those who received relief during the year included in the study, and those who had availed themselves of the free health or social services of the community, or were regarded as possibly requiring such care or relief. There were 211 families who had received relief, and 781 who were placed in the second group. A sample number of families was taken from each of these groups which we will call the "relief group" and the "no-relief group." Thirty-four families were selected at random from

the relief group and thirty-six families from the no-relief group. The homes of these families were visited and their economic situations and social service needs carefully studied. When the data were assembled, six of the thirty-four relief families were found to have received relief a short time preceding the year of the study, but not actually during the year of the study. These six families are therefore omitted in this discussion.

Status of the Families Studied

Important factors in the sixty-four family situations discussed here proved to be the composition or make-up of the family groups, chiefly as to age and size, its economic status, and the position of the tuberculous member within the family. The general composition of the families was similar in the relief and no-relief groups; both included individuals living alone, no-child families, families with one to seven children, and broken families with either husband or wife absent. Death from tuberculosis was found to be responsible for 50 per cent of the broken families in the relief group as compared with 31 per cent in the no-relief group. The proportion of families broken because of divorce, separation, or desertion was twice as high in the no-relief families as in the relief families. One-quarter of the no-relief families, as compared with 7 per cent of the families in the relief group, had three or four adult members twenty years of age or older. Eleven per cent of the no-relief families, as compared with one-third of the relief families, had five or more children under twenty years of age. The proportion of families with no children under twenty was nearly twice as great in the no-relief group as in the relief group, or 39 per cent as compared with 21 per cent. There were one or more children under five in 43 per cent of the relief families as compared


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with 25 per cent of the no-relief families. In the no-relief families, there was an average of 1.8 per cent earners, while in the relief families, this average was 1.4 per cent. Put in another way, there were 3.7 persons to be supported per wage earner in the relief families, as compared with 2.7 in the no-relief families. The scale of earnings was lower in the relief families; 54 per cent of the wage earners in the relief families earned less than $20 a week as compared with 36 per cent in the no-relief families.

Relief Families

Thirteen wage earners in the relief group who contributed to the family income during the year were classed as having active cases of tuberculosis, nine of them male heads of families and four of them wives. This fact is significant in our consideration of the inadequacy of social service and relief. Only 5 per cent of the tuberculosis cases in the relief families and 7 per cent in the no-relief families refused sanatorium care; 50 per cent of the cases in the relief families and 44 per cent of those in the no-relief families had received sanatorium care. It is worth noting, however, that two wives and one male head in the twenty-eight relief families left the sanatorium without permission because their families were not being cared for. No similar reasons were found in the no-relief group.

The twenty-eight relief families received either hospital relief, or relief in the home, or both. There were seven who received hospital relief only. In four of these seven, the family earnings were approximately 55 to 65 per cent of the amount required to maintain a standard of living adequate for their needs. In two families, these earnings equaled 82 and 88, and in one family 95 per cent of the necessary amount. Housing for four of these seven families was considered

definitely unsatisfactory; questionable for one. There was obvious need for health instruction and social service in three of the seven families. Individuals with active tuberculosis were continuing as wage earners in these families, and in four instances wives with children under four years of age were working outside the home.

There were thirteen of the relief families which received only relief in their homes. The family earnings in four of these equaled only 24 to 40 per cent of the requisite budget. After all the relief given to these families was added, they were still from 14 to 29 per cent below the standard budget. In seven other instances, family earnings were from 47 to 77 per cent of the budget standard, and when the relief of all was added, their budgets were found to be from 10 to 37 per cent below standard. In one of the thirteen families, the earnings were adequate for needs exclusive of medical care. In three of the thirteen families, housing was definitely unsatisfactory; in three it was medium; and in the remaining seven it was considered reasonably satisfactory. Several types of problems confronted in the relief of these tuberculous families are illustrated by the conditions found: need of adjustment in the family situation so that the tuberculous individual could have sanatorium care was found in two families; inability of the wife to support the family adequately during the absence or illness of the head of the family who has tuberculosis, three families; difficulty of finding work suitable for wage earners whose tuberculosis is arrested, two families; health problem and illness other than tuberculosis in the family, two families; irregularity of employment of wage earners, two families; need of health instruction and assistance in family planning, two families; definite lack of cooperation in regard to medical care, two families.

The third group of the twenty-eight families, namely,

those receiving both hospital and home relief included six families. Relief in all of these families was inadequate. In one of these, the male head with advanced tuberculosis had left the county sanatorium because his family had not been cared for, and he was working part of the time. In three of these six families, there was an important social problem in addition to that of tuberculosis, and in one, the problem arising from tuberculosis was acute. A number of different agencies were assisting in all but one of the six families. In one instance, the family received help from four different agencies.

Summary of Syracuse Study

Without attempting to go further into detail with regard to the Syracuse data, it may be summarized as follows:

In spite of the fact that most of the 781 families in the no-relief group were able to maintain an adequate standard of living, the data tend to indicate that there may be at least eighty families in the group which were definitely in need of relief. Financial assistance was adequate for only eight of the twenty-eight relief families, and we may therefore assume that relief was insufficient in at least 150 of the 211 families in the group which received some relief. Such relief as was given was found to be on an emergent basis, and without a definite family plan. Much of it was in the form of grocery orders to be taken by members of the tuberculous families from a grocery store operated in the basement of the Department of Charities. There was definite necessity for social service in a large number of families in both the relief and no-relief groups. It included such problems as: adjustment in the family situation so that the tuberculous family head could have sanatorium care; adjustments enabling mothers to give proper care to their young children in their own homes instead of working too much out of the home; modifying

the employment of wage earners with arrested tuberculosis; dealing with distinct mental hygiene problems (which were present in five relief families, and in three no-relief families); intensive health supervision for the protection of young children in the family (this was specifically noted in seven no-relief families); securing other living accommodations or modifying the use of those occupied; securing examination of many contact children not already examined; assistance in coping with problems of social maladjustment; planning for maximum utilization of such income as is available to the family; and other definite social factors complicating the the problem of tuberculosis control.

To What Do These Facts Point?

What is the significance of this data for other communities? The full preliminary report should be examined as further background and more detailed reports will be published subsequently. This summary, however, enables us to enumerate some of the ways in which the inadequacy of social service and relief expresses itself in most communities:

1. The Syracuse data reveal that the amount of relief available for tuberculous families is inadequate, many families not having sufficient budget when relief is added to their own income to make possible a livable standard of living, and that an additional group of families which should have relief get no relief at all. No matter how much is spent on medical diagnosis, medical and nursing supervision, and medical treatment or sanatorium and hospital care, tuberculosis cannot be arrested and controlled on a family budget inadequate for the simplest requirements of food, clothing, housing, and the necessities of life.

2. Relief for the most part is temporary and of an emergent character, and is not planned from the point of view of the


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constructive effect, either in the treatment of the tuberculosis cases in the family, or in the control and prevention of tuberculosis in those not already tuberculous. Tuberculosis is a long continued difficulty, and any relief program that does not recognize this and lay out a long term plan for dealing with it—a plan agreed to by both health and relief authorities—is not effective for its purpose. To control tuberculosis you must aim to secure a reasonably stable family. Emergent relief, however necessary, may not contribute much to a permanently stable family life.

3. Tuberculosis relief is stupidly unrelated to the realities of life. In Syracuse and in most cities of New York State, and in many other places, tuberculosis relief is given chiefly in the form of grocery orders, and in amounts not carefully related to the family needs. Relief in general is too frequently given in kind. It proceeds altogether too much upon the theory that the family must be treated not only as a pauper group, but its members as incompetent, unable to buy for themselves. The principle upon which the Association for Improving the Condition of the Poor proceeds in giving relief is that the more nearly the tuberculous family is treated like an ordinary family, and the more nearly it is aided to arrange and manage its affairs to approximate the affairs of other families in the community, the more likely is such relief to accomplish its purpose. After wide observation, we have found that, provided there be adequate supervision, the family in the average community can get more out of the dollar expended for food than we can get for it. If the family's food is bought for it, Mary Jane's shoes bought for her, the family's gas and other bills paid, and purchases made which normal families have to look after, considerable has been accomplished along the path of creating permanent dependents. This is not the road to independent, self-respecting

family units educated to manage their own affairs, including ultimately suitable preventive and remedial care of tuberculosis itself. Relief, in addition to being adequate in quantity, needs to be adapted to the vital living processes of human family life.

4. The giving of relief for tuberculous families is for the most part in the hands of personnel not adequate in number and for the most part untrained, and this is further aggravated by the fact that the supervision of such relief is both inadequate and untrained, or inadequately trained. This stands out conspicuously in Syracuse, and would in most communities. Much as we appreciate the necessity for the expenditure of additional funds for material relief, we must appreciate at the same time that unless this were preceded or at least accompanied by much more adequate provision for additional personnel, for personnel specially trained for the task, and for the provision of adequate supervision of such personnel, such expenditures for material relief would in large part be ineffective. One might add that because of the difficulties of securing trained personnel and trained supervision, relief handled by small local administrative units, such as towns, is bound to be unsatisfactory. Administrative units large enough to be economically practicable are as necessary in the development of suitable relief and social service problems as are such units in the development of our health programs.

5. Social service stands out as a conspicuous need in an appreciable percentage of all tuberculous families, somewhat irrespective of whether they need material relief or not. Tuberculosis is seldom the single factor interfering with normal family life. It is, on the other hand, in a very large percentage of the cases inextricably intertwined with other factors that are undermining family stability. Unless this be

recognized, any attempted vitalizing of the relief situation will be futile.

6. The handling of relief and social service is not in most communities well integrated and coordinated either, between voluntary relief and social service agencies themselves, or between these voluntary groups and the official agency or agencies. Where there is more than one official agency dealing with the problem there is all too frequently little coordination between these. A unified community program for handling tuberculosis relief and social service—a program in which the function of each agency is clearly defined and agreed to—is a fundamental requirement that is now lacking in most communities. Several organizations giving relief to the same tuberculous family without any evidence of any one of them having a long range constructive plan came out clearly in Syracuse, and would come out clearly in a study of similar communities. In spite of the fact that this is evident, it is not sufficiently appreciated by the general public, or by the professional group. At any rate, little has been done in most communities to overcome this obstacle.

7. Not only is there lack of coordination among the relief and social service agencies in most communities dealing with tuberculosis relief, there is also a lack of any effective teaming up between the health department, the private physician, and the social service agency. If the health department, or the private physician, refers the case to a social or relief agency, that in most communities ends it so far as the health department is concerned. Needless to say, it is only the starting point in any effective accomplishment for the family. Health departments can ill afford to take refuge permanently from the failure of securing dynamic results in the treatment of tuberculous families needing relief by referring them to an agency, which presumably is organized to secure

such results but which actually does not always secure them.

8. Finally, both the private physician and the clinic physician treating cases of tuberculosis are on the whole, with refreshing exceptions, not sufficiently alive to the fact that both tuberculosis treatment and tuberculosis prevention require relief and social service. Is it not, after all, part of the doctor's function if he is to be successful in treating the diseased patient and in controlling the development of tuberculosis in families to include necessary social service and relief in the family situation as a part of his responsibility? Just as the physician orders that a patient should be put to bed, that his sputum should be cared for and examined from time to time, that his temperature should be observed, that necessary X-rays should be made available from time to time as required, that certain medicine be made available, that the patient go into a hospital or sanatorium—so should he not require as a part of his treatment that the man or woman cease work if he or she should not work, that his children who are, and have been exposed, should have adequate food, adequate housing, adequate clothing, and that the essentials that make healthy living should be made available? In short, he is the master workman, and is in a position to insist that the necessary tools be made available to complete the task which he undertakes. This may look to the physician like a large order, but the records show failure in his treatment unless these are available. More than any other individual in the community, the doctor is in a strategic position to assist in educating the whole community to demand that adequate social service and relief be available. When he accepts the point of view that these resources must be available if he is to carry out his responsibility we shall be much nearer, community by community, to carrying out the social service requirements of the situation.

Conclusion

Though sketchily, enough has perhaps been presented here to indicate that social service and relief in tuberculosis is on the whole totally inadequate to the requirements of the situation. Most communities have developed their medical facilities for dealing with tuberculosis more adequately than their social facilities. Where medical facilities have been most adequately developed, as in Syracuse, social services are conspicuously inadequate. It is increasingly clear not only in Syracuse, but in Cattaraugus County and in other localities where this problem has been considered that there is a limit to productive expenditure for medical services for the control of tuberculosis without the development simultaneously, step by step, of social services for the treatment and prevention of tuberculosis.

This would seem to the author to indicate an inescapable responsibility for the National Tuberculosis Association and state and local associations to include in their programs more specifically and definitely the function of promoting adequate social service and relief facilities for dealing with tuberculosis. These agencies have wisely insisted that their function is not the giving of relief. It is equally true that their function is not the operation of medical services. Clearly, however, their function should include the promotion of both. On the whole, it would seem clear that the obligation of promotion of social services or adequate home supervision of tuberculous families has not been seriously accepted by these associations. They are in a stronger strategic position to insist on the development of such services than are state and local health departments. The latter, however, cannot escape responsibility, because if social service facilities are not made available community by community, they cannot expect full success in their programs for the prevention and control of

tuberculosis. More conscious and persistent effort might well be made, therefore, by state and local health departments in league with other state and local authorities to increase the social service and relief facilities of the community, step by step, as the sanatorium, clinical, and other health facilities are developed. Similarly, the promotion of the necessity of such facilities would seem to be an inescapable part of the responsibility of the private practicing physician who undertakes to treat tuberculosis.