

**A Research Note:**

**CONGREGATE HOUSING: AN EMERGING ALTERNATIVE IN THE  
CONTINUUM OF HOUSING**

Karl H. Flaming and Paul W. O'Brien

Abstract

This paper discusses the results of a study of congregate residences located in metropolitan Denver. The study includes other categories of elderly housing under Sections 8 and 202 of the Housing and Urban Development (HUD) program in addition to those units financed by the private sector. The locations of current stock, rental ranges of the units, square footage, and what amenities are available is reported. Also included is a brief discussion of Federal Housing programs designed to provide elderly housing. In the concluding section, the paper discusses several theoretical and policy issues that are identified in this research.

Introduction

There is a growing need for more diversified housing stock for elderly individuals. Their housing needs are in a state of flux as the need grows for affordable, intermediate housing providing an alternative to the conventional single-family home which assumes a fully independent household and the full-care nursing home. This need will become more acute as the population of frail elderly increases along with the growing institutionalization of this population in nursing homes. The costs involved with housing are accelerating, and research shows that many residents are inappropriately placed in such facilities (Chellis, 1982). An unmet need has emerged for affordable, intermediate housing.

One alternative to the full-care nursing home is congregate housing. Congregate housing has been promoted as a viable alternative for elderly individuals who do not need a full-care facility. It has been called the missing link in today's elderly housing market (Chellis, 1982) because it appears to provide a bridge between independent living arrangements and full-care nursing homes. Congregate housing offers an array of amenities, security devices, and health-related components all of which are designed to enhance the lives of many elderly. Housing specialists, gerontologists and builders in the private sector believe that congregate housing may provide an effective link between the full-care nursing home and independent living (Chellis, 1982; Huttman, 1977; Malozemoff, 1978).

Congregate housing represents a form of housing designed for older individuals no longer able to maintain independent housing, but not in need of a full-care nursing home. Its major feature is the provision of meals. In addition, it typically offers ready accessibility to such services as transportation, help with laundry, and absence of such responsibilities as maintaining a yard and a house. In 1974 approximately 400 congregate residences existed nationwide (McKay, 1976).

---

Karl Flaming, Professor, Sociology, University of Colorado at Denver. Paul O'Brien, doctoral student, Department of Sociology, Colorado State University.

Flaming and O'Brien

Congregate housing is seen as a bridge to gap what is presently being offered to the elderly. When looking at raw health-cost projection statistics, it is understandable why concepts such as congregate housing are currently being funded by HUD. In a 1980 press conference Secretary Patricia Harris of the Department of Health, Education and Welfare (HEW), in an answer to a question on the costs of the "greying of America" stated:

The aging phenomenon will have a significant impact on HEW's activities. By 2030, 18 percent of the population - 55 million, will be 65 or older. Today, only one man in five and one woman in twelve are in the work force at age 64 or older. Thirty years ago half of all men 65 or older remained in the workforce. One of the most obvious results of these demographic changes will be an increased cost for programs serving older people. By 2010, the cost of Social Security, SSI, Medicare and Medicaid, Disability Insurance, and Black Lung programs is expected to triple to \$350 billion. It will jump to \$635 billion by 2025 . . . the vast majority of these payments will go to older people. (Sherwood, 1981).

The problem is that the general population knows very little about congregate housing for elderly individuals. They know little about the physical layout, the location, the staffing, and the amenities provided by such facilities. There has been no attempt to look at congregate housing as part of the complex continuum of housing for elderly individuals. Although congregate housing is viewed by many professionals as a possible link in the chain of housing alternatives for the elderly, little is known about such facilities, even though several studies have looked at this type of housing (Chellis, 1982; Conboy, 1984; Heller, 1984; Malozemoff, 1978; Pastalan, 1984; Sherwood, 1984).

#### Emerging Needs of the Elderly

Crisis is the word often used today when looking at the elderly population of the United States. Our society is experiencing new housing and health problems. The 65 and over population has grown dramatically, not only in absolute numbers, but also as a percentage of the total population (Golant, 1979). The problem is lack of housing, particularly housing that accommodates the increasingly diverse needs of the elderly.

In 1900, older Americans totaled 3.1 million people, representing only 4 percent of the total population. By 1950, the percentage of elderly individuals had doubled, growing steadily to 9 percent of the total population in 1960. This number has continued to grow reaching 11.3 percent by 1981 (Olson, 1982). There are currently over 25 million Americans sixty-five years of age or older. Projections indicate that the percentage of older people will increase anywhere from 14 to 22 percent of the population by the year 2030 (Olson 1982). Health concerns are paramount in the lives of the elderly. As the number of ill, elderly and handicapped adults in the nation increases, there is also an increasing urgency to develop long-term care services that do not require institutionalization (Green, Morris, Sherwood, 1981). Increasing costs are a major basis for these concerns.

If the increase in Medicaid cost during the past decade, from \$1.8 billion to \$11 billion with 40 percent of the cost going for nursing home care, is added to these figures, the economic picture is grim (Thompson, 1983). When one notes further that 25 to 50 percent of older individuals in nursing homes do not need that level of care, the need for housing alternatives within communities becomes dramatically clear (Huttman, 1977).

### Elderly Housing Issues

Today housing deprivation is prevalent among a substantial number of older Americans (Olson, 1982). Elderly individuals with no financial constraints have access to a wide range of housing. Elderly individuals on fixed incomes, however, do not have access to appropriate housing, and this problem is expected to increase due to federal cutbacks in HUD Section 202 subsidies.

The 1976 Annual Housing Survey by HUD, estimates that at least 10 percent of the elderly population's residences are physically inadequate. The other major problem affecting elderly individuals is that their homes are very often located in run-down urban centers. These residences are much older than are those of the general population. Olson (1982) states that:

Older households, however, are more likely to live in older structures (60 percent reside in housing built before 1950 and 47 percent in units constructed prior to World War II), requiring costly maintenance and heating, to own their homes, and to live in central cities or isolated rural areas (Olson, 1982).

The problem of the older housing unit is compounded by the fact that many of these homes are located in less desirable neighborhoods. In many American cities these neighborhoods are in stages of transition and are considered physically dangerous. Many of these areas are also lacking in support services for elderly individuals.

Prior to 1980, approximately 30 percent of all older households occupied housing in central cities and were concentrated within the slums or slowly deteriorating communities. One-third of the older households lived on the fringes of the central cities, often in older working-class neighborhoods. Forty percent resided in non-metropolitan areas, primarily in small rural towns or on farms (Olson, 1982).

These statistics given are for home owners. Another 28 percent of the elderly population live in apartments, boarding homes or hotels. Sixty-one percent of these renters are single and have extremely low incomes. Rental units are often more deficient than owner-occupied homes. In 1976, 17 percent of all rental units and 16 percent of those occupied by elderly individuals, had one or more major flaws compared to 4 percent of all owner-occupied homes and 6 percent of those owned by older people (Olson, 1982).

In general, the aging represent a growing proportion of the U.S. population. Many elderly individuals are concentrated in large metropolitan areas, often in declining neighborhoods. In addition, this population is less affluent and is increasingly in need of housing that falls somewhere between traditional single-family housing units and full-care nursing facilities.

### Federal Housing Programs

In order to combat many of the deficiencies found in housing for elderly individuals, the federal government has implemented many different types of programs. Of the more than four million rental units now occupied by elderly households, over 700,000 are, or will soon be, financed or insured by the federal government (Villarreal, 1977). Two major programs relating to the elderly are Section 202 and Section 8. (Other programs which assist the elderly, but are not limited to them, are Sections 236, 231 and 232.)

Section 202 housing was established in 1959 and was the first direct-loan program sponsored by the federal government. It provided construction financing and 50-year permanent financing at 3 per cent interest to non-profit and limited dividend sponsors of housing for low- and moderate-income elderly and handicapped persons. Before being discontinued in 1969, over 45,000 units in approximately 330 developments were built. Of 330 project loans, only one was foreclosed (Villarreal, 1977).

Flaming and O'Brien

The Section 202 program was revised in 1974. The revised plan now provides direct 40-year permanent financing to non-profit sponsors for construction or substantial rehabilitation of housing for the elderly, handicapped or disabled. Each project must be eligible for Section 8 rental assistance, from a special Section 202 set-aside fund. Each Section 202 housing development must be designed specifically for elderly and handicapped residents. The development can be equipped with congregate dining facilities and can provide an array of support services. These may include health, education, transportation, housekeeping, counseling, referral services, etc. However, the established rent level is to cover shelter costs only and not additional services ( i.e., congregate facilities) (Villarreal,1977).

The Section 8 Program provides rental assistance to low-income elderly in both metropolitan and non-metropolitan areas. In this program a rental subsidy is paid to the housing owner on behalf of an eligible resident. The housing assistance payment covers the difference between up to 30 percent of a person's monthly income and the rent established for the unit. The percentage set at the beginning of the program was 25 percent. Under the direction of the Reagan administration, this amount was considered low. In 1980, new guidelines were established at the higher 30 percent level. This new rate was slowly implemented at a one percent increase yearly to the present 30 percent (HUD Guidelines, 1987). The exact income limits are defined by geographical area (Villarreal, 1977).

#### Congregate Housing

A review of the literature reveals a growing need for a more diversified array of housing stock for the elderly. Congregate housing has evolved as an integral response to the gap that existed between independent living and full-care nursing homes. Congregate housing is a relatively new type of housing given official support under Title IV of the Older Americans Act of 1970 (Greer, Morris, Sherwood, 1981). The premise of congregate housing is that it will enable elderly individuals to live independently, or at least semi-independently, for as long as possible. This will keep those who are able out of skilled nursing homes. (Huttman, 1982). Although congregate housing was given official recognition in 1970, no action was taken at that time to support the services aspect of the concept. The 50-year Section 202 funding did not cover any service costs. Congregate housing was accorded legislative support by Section 7 of the Housing and Community Development Act of 1974 that stated:

The secretary shall encourage public housing agencies to design, develop or otherwise acquire . . . housing to meet the special needs of the occupants. . . for use in whole or in part as congregate housing (Malozemoff, 1982).

Although the above amendment was approved by Congress, little action was taken, since no Federal funds were granted to help defray the costs of the services that congregate housing was to provide. It was not until 1978, under Title IV of the Housing and Community Development Amendments Act 92 Stat 2080, 42 USC 5301, that limited funding was authorized (Sherwood,1981). It was then that units were planned and built using federal subsidies to help defray the costs of the planned services.

The concept of congregate housing has therefore been under consideration for the past 17 years. Little research, however, has been reported concerning its feasibility or viability. In order to fully understand congregate housing, one must first define the intent behind it. Congregate housing was conceptualized to be a semi-independent facility for handicapped individuals of all ages, for citizens with mental disabilities, and for the elderly population. The director of the Newark Housing Authority sums up congregate housing by stating:

Congregate housing is primarily designed to prevent unnecessary institutionalization, to alleviate social isolation, to provide health education, screening, diagnostic counseling, as well as to provide a program of balanced nutrition and nutrition counseling designed to meet the needs of older people; to provide program participants with the knowledge and ability to run their households efficiently and with minimum of exertion; and to provide group interaction and a sense of community in a variety of recreational and social activities (Notte,1975).

In looking at congregate housing in relation to other types of housing, the following matrix (see Table 1) shows that congregate housing is the middle tier of the total housing concept that bridges the gap between independent and dependent living.

Table 1. The living continuum

	Independent	Congregate	Dependent
* Shelter	X	X	X
* Management	X	X	X
* Housekeeping		X	X
* Transportation		X	X
* Nutrition/Meals		X	X
* Health & Medical		X	X
* Protective/Security			X
* Commercial			X
* Social/Education./Recreational			X

\*Villarreal, 1977, p. 38.

As people grow older, features that were originally a convenience or amenity to allow more leisure, gradually become more and more a necessity. The differences between independent, congregate and dependent facilities are primarily one of degree rather than of kind (Villarreal, 1977). The same basic categories of services may be offered in all three, but a different level of services is typical in each of them. The tendency in dependent living facilities, such as nursing homes, is to provide care rather than services. This distinction between care and services implies a different attitude on the part of the management. While service is provided to the individual on demand, provision of care involves meeting the actual survival needs of the residents.

Congregate housing falls in the large middle ground between the two extremes of independent and dependent living. The focus is on providing services in response to residents who want and desire the security of knowing help is available if needed, but for whom such help is neither a permanent requirement nor usually necessary for survival (Villarreal, 1977).

#### Methods

The methodology employed in this study included two complementary strategies. A list of housing facilities for the elderly was obtained from Choice. It is a local non-profit organization which receives Federal grants to research available housing for the elderly and acts as a housing referral service for the elderly population. A total of 47 out of a possible 70 units were located within a three mile radius of central Denver, Colorado, which was the population of elderly housing to be studied.

A questionnaire was administered by a 15-minute telephone interview of 47 housing managers. Included in the questionnaire were items about entrance requirements for clients, physical properties of the units, management policies, and available services.

On-site visits, the second strategy, were made to ten units selected from the sample. Four of these were subsidized congregate residences, four were high-income congregate residences, and two were selected from the pool of private, independent-living, residence-apartment complexes. The purpose of the visits was to obtain first-hand impressions and information about the differences and similarities in elderly housing facilities available in large metropolitan areas such as Denver.

Structural and Economic Characteristics

From the total of 47 facilities surveyed, 17 were congregate, of which 4 were not subsidized. Most of the subsidized units were under the Department of Housing and Urban Development (HUD), Section 8 Program. All of the private facilities were for-profit and did not participate in any type of rent-subsidy program.

Three categories of housing facilities were identified in this study. The first was the subsidized apartment. From the total sample, 30 units fall in this category. Very often these units had been converted for elderly inhabitants by installing wider doors, ramps, and emergency pull cords. Upgraded smoke and fire detectors were installed in the apartments, corridors and open meeting areas. These apartments are solely for residents who are able to maintain an independent life style with few, if any, amenities.

The second category was the low-income, subsidized congregate facility. From the total sample, 13 housing units fit this definition. Some services for this type of facility included prepared meals, some type of emergency pull-cord system, a buddy system, and an activity director. The average cost of these units varied in accordance with HUD guidelines, which state that the monthly cost of each unit may not exceed one-third of the resident's income.

The third category was the private, for-profit, congregate residence. Four housing units were identified within the study area at the time the research was conducted. The costs of these units were considerably higher than were those of the subsidized units, with one exception. The monthly cost ranged from \$800 to \$1700. These units not only had all the amenities offered by the subsidized units, but also had other conveniences such as free laundry facilities and maid services.

Apartments, rather than townhouses, were the only type of unit found in all surveyed housing facilities. The range of square footage found in studio, one- and two-bedroom units varied greatly. The size of the unit varied from 130 to 913 square feet (see Table 2), regardless of whether the facility was congregate or not.

Table 2. Average square footage of available units

Type of Unit	Low Income		High Income
	Non-Congregate (N=30)	Congregate (N=13)	Congregate (N=4)
Studio	430	305	305
One-Bedroom	551	445	549
Two-Bedroom	671	544	781

Results

Both congregate and non-congregate units have units that provide for the needs of the handicapped. Adaptations include elevators in multi-floor buildings, wider doors to enter the apartment, handrailings for the toilet, and grab bars in the bathtub. As shown in Table 3, 14 percent of the non-congregate and 25 percent of the congregate studios were accessible to handicapped individuals. Thirty-four percent of the one-bedroom non-congregate and 29 percent of the congregate units provide special handicapped features. The two-bedroom apartments are the least likely to be adapted for the handicap with the non-congregate having 3 percent and the congregate having 13 percent of the units accessible to handicapped individuals.

Table 3. Handicap accessibility

Type of Unit	Non-Congregate (N=30)	Congregate (N=17)
Studio	14%	25%
One-Bedroom	34%	29%
Two-Bedroom	3%	13%

There are a variety of charges related to moving into a unit regardless of its status (i.e., congregate or non-congregate). Table 4 breaks the charges down into the following categories: reservation, damage, handling, processing and entry fees. Current HUD guidelines prescribe what the requirements are for these fees and which ones can be charged (HUD Guidelines, 1987).

Table 4. Move-in related charges

Type of Charge	Non-Congregate (N=30)	Congregate (N=17)
Reservation	3%	17%
Damage Deposit	86%	88%
Handling Fee	0%	5%
Processing Fee	0%	5%
Entry Fee	6%	0%

The reservation fee is charged at some facilities to ensure that a person is serious about renting a particular unit. For units that have waiting lists, it is not uncommon for a potential resident to visit many different facilities, putting his/her name on each and every waiting list. This reservation fee may be equated with buying a house, where one must place a deposit of intent, often called "earnest money".

The damage deposit is to ensure that once a resident vacates the apartment there are sufficient funds to cover the repair of any item that might have been damaged while the resident was residing in the apartment. This damage deposit is similar to deposits generally required when renting.

Flaming and O'Brien

The handling fee is used by some organizations as a deposit-type device in many life-care units. This fee and the processing fee, is used by only a small percentage of congregate complexes and not at all by non-congregate facilities. Both fees are used to defray expenses related to processing applications. The entry fee is similar to a fee one pays at a private country club to gain admission. It is similar to a reservation fee in that it is not refunded upon leaving the building as would be expected with a damage deposit. The usage of this fee is extremely small.

Vacancy Rates and Waiting Lists

The vacancy rates vary from unit to unit. All subsidized units in this study have a waiting list with waiting times as long as three years (see Table 5). The subsidized units have waiting lists because rent is subsidized relative to the resident's income. The rent, therefore, is often less expensive than what one finds in the open market. With the meals and services that are offered at congregate facilities, it is clear that these congregate residences are very competitive in the open market. The combination of these factors makes the HUD subsidized elderly housing units very attractive.

Table 5. Vacancy rates

Facility	Vacancy Rate	Waiting List N=47
<u>Subsidized Units (N=43)</u>		
Studio	0%	3 months-2 years
One-Bedroom	0%	6 months-3 years
Two-Bedroom	1-2%	0-6 months
<u>High Income Units (N=4)</u>		
H1	0%	No
H2	10%	No
H3	6%	No
H4	0%	No

Table 5 shows that there are different vacancy rates according to the size unit to which one is referring. Apartment managers stated that because the one-bedroom apartment is the most popular size unit, it has the longest waiting list. The studio apartment is less popular because it is too small for many people. The two-bedroom category, on the other hand, has the highest vacancy rate because of expense and size.

In looking at the subsidy rates of these different units in Table 6, the majority of both congregate and non-congregate facilities receive subsidies. Because some of the facilities have a religious affiliation, that affiliation is noted because it is a form of private subsidy. With the backing of a religious sponsor, certain units rely on private, as opposed to government, support.

Table 6. Subsidies and religious affiliation

Type of Facility	Subsidized Public	Private	Unsubsidized N=47
Congregate	4	8	6
Non-Congregate	14	10	6

Health Services

Health concerns are paramount in the lives of many elderly. This is one area where the entire concept of shared services in the congregate complex comes into play. Table 7 lists the various health services and shows that in Denver, about three-fourths of the congregate complexes offer nursing services.

Health plays a major role in the lives of the elderly. As one ages, one becomes more dependent on health-care delivery systems. This has important implications for housing. As an individual grows older, housing must gradually incorporate more features dealing with health-related needs. The emerging congregate model is one alternative that can provide medical services directly on the premises, either on a full- or part-time basis. For example, dentists, physicians, podiatrists, and other health-care professionals can be present on the premises on a regular basis or can be available as part of a "visiting" program similar to visiting nurse program.

Table 7. Medical services offered

Type of Service	Congregate (N=17)	Non-Congregate (N=30)
Nurse	76%	36%
Dentist	17%	3%
Physician	17%	0%
Podiatrist	23%	0%

The visiting model provides residents access to health care, but at a more reduced level than would be found in a traditional nursing home. The Visiting Nurse Program is the most popular and widely used by the various residences. A nurse is able to keep patient histories and to provide the day-to-day needs of the population without the intervention of a physician.

A second pattern observed among some of the residences, the adjacent model, finds congregate residences with a medical center located near the residence. There are two distinct variations of this arrangement. In the first, the congregate residence is built next door to the hospital. In some instances the congregate residence is built on the same property, often financed by the hospital. The second variation, also found in the Denver area, has the elderly housing facility located near a medical center that is a completely autonomous and separate business. Residents, if they can afford it, have the freedom to choose to use the services as needed but are not automatically charged for them.

Table 8. Security systems

Type of System	Congregate (N=17)	Non-Congregate (N=30)
Guard on Duty	33%	16%
Staff on Duty	88%	66%
Electronic Buzzer	94%	86%
Emergency Pull Cord	70%	43%
Intercom in Room	47%	50%
Monitor in Room	11%	6%
Daily Check	100%	70%

Security Systems

Security also is an important factor in the lives of many elderly. A variety of different questions were asked to determine the overall availability of security in the buildings. Table 8 shows that a large proportion of all the facilities in Denver provide some degree of security-related services. Most common are electronic devices (e.g. buzzers). Monitors, guards, or daily checks are least common due to expense.

Transportation

Transportation is another category requiring attention by planners. Although many older individuals can drive their own vehicles, it becomes increasingly difficult as the resident ages. Table 9 shows how transportation compares in both types of facilities. In Denver, congregate facilities are much more likely to provide transportation (typically a visiting van that is provided by management and/or volunteers). Payment of any transportation-related fees is included in the basic monthly charge for in-house service or at no charge if volunteer-sponsored.

Table 9. Transportation

Type of Facility	Transportation Offered N=47
Congregate	52%
Non-Congregate	26%

Amenities are the last important component in the congregate housing package (see Table 10). The results of the study show that congregate facilities offer more amenities than do the non-congregate complexes. At the same time, the difference between the two are not always so great. For example, there is little difference between the types of facilities in the availability of laundry, general recreation area, TV area, and linen services.

Table 10. Amenities offered

Type of Amenity (N=47)	Congregate	Non-Congregate
Meals	100%	0%
Resident Storage	90%	70%
Laundry Area	88%	93%
Library	88%	73%
General Rec. Area	88%	93%
Arts and Crafts	76%	33%
Guest Parking	70%	56%
Exercise Area	70%	3%
Religious Services	70%	60%
TV Area	64%	66%
Beauty Shop	58%	23%
Garden Plots	41%	33%
Barber Shop	36%	20%
Provision for Guest	17%	3%
Linen Service	11%	13%
Swimming Pool	11%	0%
Sauna/Whirlpool	11%	0%

The major difference is the provision of meals. On-site visits reveal some variations with a few facilities providing sit-down service, some with family-style meals, but most with the more typical cafeteria style. All provide at least one major meal a day, and none require the more institutionalized style of three meals a day on a pre-determined schedule. Since most apartments have a kitchen, residents are able to choose when to take part in the congregate meal.

Perhaps most interesting about the data shown in Table 10 is the extent to which a continuum of living amenities is emerging. These results suggest that there will continue to be a further evolution of alternative housing facilities for the elderly. It is evident from the data that a wide array of services now exists among the facilities.

#### Policy Regarding Tenure

Finally, managers were asked about their policy regarding continued occupancy for residents who become unable to maintain an independent life style. In effect, the issue concerns increasing frailty as the resident "ages in place". This is a sensitive and complicated problem. Facilities lacking a personal relationship with each resident reported that they tend to leave this decision to the family and/or guardian. For the individual manager and resident, this is a difficult problem and decisions, as much as possible, are made on a case-by-case basis.

The results of this research reveal an interesting difference between the private and public facilities. The public facilities, because of government financing policies, are less able than the private complexes to adapt by adding a full-care wing or addition to the existing unit. Private developers have greater flexibility in this respect but serve a smaller market.

#### Discussion

Although this research began without a theoretical focus, congregate housing as an alternative to full-care nursing home facilities can be analyzed in the context of aging in place and the process of total institutionalization (Goffman, 1961; Schmidt, 1982). The aging in-place phenomenon is well known in the field of gerontology. Simply stated, once a person has found adequate housing that suits his or her needs, that person becomes less likely to move and more likely to remain in a particular housing facility.

It is in the context of aging-in-place that total institutionalization becomes an issue. What occurs is a gradual transformation of the facility from one which offers services and amenities to one of total care. This is a phenomenon in which congregate housing complexes, as their residents advance in age, must set aside a portion of their units to serve elderly who are no longer able to handle all of their affairs independently. The aging-in-place process results in two levels of care. One is located on the semi-independent continuum, with the other on the dependent continuum of care. In some cases, one can now find an institution within an institution.

The aging-in-place process will have many effects on current and future residents at these congregate facilities. With the move into the special sector or dependent wing of a facility, the person who has cared for him or herself, gradually loses power over his/her own life with the balance of power slowly tipping in the favor of the institution. As the individual becomes more dependent, there is an increasing possibility of institutionalization as described by Goffman (1961). The individuality of that resident will be harder to maintain, particularly in new special wings in the congregate facilities. During one on-site inspection, the manager related that all new capital construction consists of building new wings to house the population who have aged at the facility and are increasingly in need of higher levels of care.

## Flaming and O'Brien

The private sector benefits from the development of these new facilities in a number of ways. With the higher level of dependent care offered in these new satellites, the cost to the consumer increases in proportion to the level of care. Once an individual's resources are depleted, the federal government assumes the role of financing the care through Medicare. Thus the risk to the private business is greatly diminished. Finally, as in all private sector activities, there arises the issue of competition. Because none of these newer private residences are filled to capacity, they have no waiting lists. This means that the more expensive private residences must aggressively compete for the more affluent elderly who are willing to pay the higher costs associated with non-subsidized housing. It is a benefit to the private providers to retain their customer base as they move through the aging continuum.

As outlined earlier in Table 1, there are services common to all facilities. However, as the resident becomes increasingly dependent, "service" gradually is replaced by "care". This distinction between care and service is very important since it implies a different attitude on the part of management. While services are provided at the discretion and free choice of those served, provision of care involves more control of the resident's life-style by management.

In viewing the life continuum, it is easy to see that as one grows older, one becomes increasingly isolated and dependent. This begins during the "middle-old" period where the death of a spouse, decreasing financial resources, and increased health problems affect the individual. This isolation and dependence increases as one continues to age and one's peers die.

Congregate housing partially addresses this problem by offering many shared activities. Logically, this is a matter of choice for the individual. However, with such activities as common TV rooms, library, arts and crafts, exercise areas, volunteer work and social activities, the average resident does not have to be isolated if he/she chooses to participate. This is an important component in affecting social contact, which is closely related to the overall well-being of aging individuals. Clearly, the aging-in-place phenomenon found in all congregate housing facilities is better understood when examined within the perspective of total institutionalization.

Congregate housing is an intermediate alternative to independent housing and the full-care nursing home. Also located within this continuum of elderly housing alternatives are the non-congregate complexes noted in this study. In many cases, the independent-living arrangements are quite similar to the congregate facilities. The major difference is that these independent complexes do not offer meal service, the cornerstone of the congregate package. In addition, the congregate facilities are more likely to provide dietary and other health services.

## Conclusions

Congregate housing is coming of age. It gives the elderly many benefits to enhance their lives and, at the same time, is cost effective. The demographics of this country clearly show that the elderly population will continue to grow as the "baby-boomers" reach retirement age. Housing services, amenities, and options needed in the future, are being tested today.

References

- Chellis, R. D. (1982). Congregate housing for older people: A solution for the 1980's. Lexington, MA: Lexington Books.
- Conboy, R.T. (1984). Mediating structures and congregate housing program. Unpublished doctoral dissertation, The American University, Washington, D.C.
- Elder, G. H. (1985). Life course dynamics. Ithaca, NY: Cornell University Press.
- Goffman, E. (1961). Asylums. Garden City, New York: Doubleday.
- Golant, S.M. (1979). Location and environment of elderly population. Washington, DC: V.H. Winston and Sons.
- Heller, T. (1984). Service need and usage of congregate and regular housing residents. Gerontologist, 24, 143-144.
- HUD Guidelines (1987). Denver metro area subsidized housing: A HUD helper. Denver CO: U.S. Department of Housing and Urban Development Region VII.
- Huttman, E.D. (1977). Housing and social services for the elderly. New York: Praeger Publishers.
- Malozemoff, I. K. (1978). Housing for the elderly. Boulder, CO: Westview Press.
- McKay, N. (1976, June). Section 8 is working well in Dakota County, Minnesota. Journal of Housing, 76, 272-73.
- Notte, R. (1975). Testimony of Newark redevelopment and housing authority. In Adequacy of federal response to housing needs of older Americans. Hearings, U.S. Congress, Senate, Special Committee on Aging, 94th Congress. 1st Session, October, 1975 pt.13 p. 911.
- Olson, L.K. (1982). The political economy of aging. New York: Columbia University Press.
- Pastalan, L. (1984). Congregate housing for older people--A solution for the 1980's. Gerontologist, 24, 99-100.
- Schmidt, M. G. (1982). Exchange and power in social settings. International Journal of Aging and Human Development, 14 (3), 157-166.
- Sherwood, C.C. (1984). The multiple helper in congregate housing. Gerontologist, 24, 295-296.
- Sherwood, S., Greer, D.C., & Morris, J.N. (1981). An alternative to institutionalization. Cambridge, MA: Ballinger Publishing Company.
- Thompson, M.M. (1975). Congregate housing for older adults: A working paper. Presented to U.S. Congress, Senate, Special Committee on Aging, 94th Congress 1st session.
- Villarreal, P. (1977). Managing housing and services for the elderly: A resource book. Maret F. Hutchinson, (Ed.). Washington, DC: National Center for Housing Management, Inc.