

HEALTH CARE FOR THE AGED IN THE STATE OF WASHINGTON

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This is the second report of a health services program for recipients of old-age assistance. The first described the program in Colorado and appeared in Health Information Foundation Perspectives a-2. This report shows the major features of a parallel program in the State of Washington. There is now great concern with health services for the aged, but there is a paucity of data on the use of services by this age group in specific programs. This is particularly true for out-of-hospital services including nursing home care. The reports by Health Information Foundation are, then, prepared as convenient sources of information. These reports do not result from original research projects; instead they rely wholly on existing data, official publications, and interviews with key individuals.

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INTRODUCTION

The present medical care program for old age assistance recipients in the State of Washington is the result of long experience with various methods of providing such care. The present program is of interest both because of the comprehensive care it provides and the unusual administrative mechanisms it employs. Among its unusual features are these:

- The state contracts with a voluntary health insurance agency for physicians' care of its assistance recipients. This care is actually provided through a number of local, physician-sponsored medical care plans that give recipients free choice of physician.
- The state contracts with a prepaid dental care agency for dental services for assistance recipients, allowing them essentially free choice of dentist.
- The program supports very extensive use of nursing home facilities by its old age assistance recipients. About one out of six of these is a nursing-home patient.
- It provides recipients with virtually all needed health services — including physicians' home and office calls, prescribed drugs, appliances, and dental care and dentures.

This study, while not intended as an analysis in depth, presents the essential features of the Washington program—its development, provisions, utilization, and costs—for those in other areas who are concerned with providing health care for the aged and for other groups.

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LATE IN 1940 THE VOTERS of the State of Washington approved a referendum (Initiative 141) establishing a full, statewide medical care program for old-age assistance recipients. Initiative 141 assigned administrative and fiscal responsibility for this program to the state Department of Social Security, although the actual administration of the program was to be borne by county welfare offices. The desired scope of the medical care program was only suggested by the initiative: “. . . the department shall provide for those eligible for medical, dental, surgical, optical, hospital and nursing care by a doctor of recipient’s own choosing, and shall also provide artificial limbs, eyes, hearing aids and other needed appliances.”

From 1941, when the statewide program went into effect, until 1947 the Department of Social Security assumed ultimate responsibility for the program. In 1947 control of all assistance programs, including medical care, was returned by the state legislature to the counties.

In 1949 a second referendum, Initiative 172, returned full responsibility for public assistance once again to the state. Initiative 172 set the scope of the medical care program in some detail, although it did not specify how care was to be provided, except for assuring free choice of physician for the assistance recipient: “In addition to Senior Citizen grants, each recipient who is in need of medical and dental and other care to restore his health shall receive:

“(a) Medical and dental care by a practitioner of any of the healing arts licensed by the State of Washington of recipient’s own choice.

“(b) Nursing care in applicant’s home and hospital care as prescribed by applicant’s doctor, and ambulance service.

“(c) Medicines, drugs, optical supplies, glasses, medical and pharmaceutical supplies, artificial limbs, hearing aids and other appliances prescribed as necessary.”

The medical care program was first administered by the Department of Social Security, then by the Department of Health. In 1955 the program was transferred again to the Department of Social Security, at which time its name was changed to the Department of Public Assistance.

As this summary indicates, the early history of the statewide medical care program was neither uninterrupted nor stable. Nevertheless, both state and counties accumulated valuable experience in different methods of providing health care. Most of the health programs now in use were first attempted or tested in these earlier years.*

In 1955, when the medical care program for old age assistance recipients (as well as for others receiving state assistance) was returned to the Department of Public Assistance, the state initiated the present organization for providing care. It carried over the Division of Medical Care established in 1953 when the program was in the Department of Health headed by a physician assistant director who, after the transfer, then became responsible to the director of public assistance. At the same time the state carried over a twelve-member “Welfare Medical Care Committee” created to advise the assistant director. The assistant director was authorized to define the medical services to which recipients of public assistance would be entitled, within this framework:

The division of medical care shall provide for necessary physicians' services and hospital care, considering the recommendations of the welfare medical care committee, and may provide such allied services as dental services, nursing home care, ambulance services, drugs, medical supplies, nursing services in the home, and other appliances, considering recommendations of the welfare medical care committee, who shall take into consideration the appropriations available.

(Chapter 273, 1955 Sessions Laws)

*The problems, issues, and experience of the state's medical program prior to 1948 were discussed in two earlier studies by Dr. Anderson: *Administration of Medical Care; Problems and Issues*, Bureau of Public Health Economics Research Series No. 2, School of Public Health, University of Michigan (Ann Arbor, 1947) and *Prepayment of Physicians' Services for Recipients of Public Assistance in the State of Washington; Problems and Issues*, Bureau of Public Health Economics Research Series No. 4, School of Public Health, University of Michigan (Ann Arbor, 1949).

One of the most important developments to follow was an agreement in 1956 with the Washington State Dental Service Corporation for that dental prepayment agency to administer the state's public assistance dental care program. From October, 1956, to mid-1958 several different dental programs were operated experimentally in different parts of Washington. Then, in June, 1958, Washington became the first state to have a statewide prepaid dental contract for assistance recipients. It had earlier been the first state to contract for physicians' services with a prepayment plan.

Other developments in the medical care program since 1955 included the first cost analysis of Washington nursing home operation, permitting payment rates based on actual cost averages, improved liaison and control between the division of medical care and physicians' furnishing services to its assistance recipients, revision of the list of drugs which could be prescribed routinely, and improved hospital reimbursement methods to allow for the mounting costs of hospital care.

As noted later, problem areas remain in the Washington program for old age assistance recipients, some of which will undoubtedly prove difficult to solve. But the developments of the past five years have consistently been directed toward meeting the problems of a medical care program — chiefly those of climbing costs and use of services — without curtailing services believed necessary to the recipients. The broad, flexible program that has resulted deserves study.

THE PRESENT MEDICAL CARE PROGRAM

OAA Recipients About one out of five—48,000 of the estimated 260,000 — aged people in the State of Washington receives old age assistance (OAA). Almost 65 per cent of OAA recipients are women. While the growth of Federal Old Age, Survivors, and Disability Insurance rolls (OASDI) has lowered the number of people receiving state assistance, it has also changed the character of the state old age assistance caseload. The OAA caseload has become increasingly one of the *older* aged, particularly of older women. Almost 40 per cent of OAA cases are 80 years of age or more; the average age of OAA recipients is between 75 and 80.

Eligibility for Assistance In Washington, people in need are eligible for old age assistance if they are 65 or over and have resided in the state for five of the past nine years and a full year before applying for assistance. To be eligible for assistance, applicants are limited in resources to \$200 in savings and a maximum of \$500 in cash and life insurance cash value.

The state sets no minimum or maximum assistance grants, paying recipients "reasonable allowances for shelter, fuel, food, clothing, household maintenance and operation, personal maintenance, and necessary incidentals." These allowances are determined from annual cost of living studies. Under "average conditions," the minimum grant is \$75 per month—less any income the recipient may have. The average grant, including vendor payments, is now \$90 per month.

Physicians' Services In most of the state, physicians' services are provided OAA recipients by physician members of the state's county medical bureaus—Washington's unique, physician-sponsored independent prepayment plans. The Department of Public Assistance contracts for these services through the Washington Physicians Service, an association of the independent county plans. Washington Physicians Service, paid a flat \$3.31 monthly payment per assistance recipient, distributes this payment (less a small administrative charge) to the various county medical bureaus according to the number of OAA recipients in each bureau area. Coverage of assistance recipients under this contract begins one month after they join the assistance rolls. During the first month, care is provided under a direct fee-for-service arrangement.

An exception to the contract arrangement with Washington Physicians Service exists in urban King County (Seattle), the state's largest county, which contains about a fourth of the state's OAA recipients. Most medical care for indigents in King County is provided in the county hospital, which is entirely supported by state funds. Limited physicians' care is provided on a fee-for-service basis by physicians in private practice. The following description of the program for providing physicians' services covers only the counties now in the program under the contract between Washington Physicians Service and the State Department of Public Assistance.

Under the terms of this agreement, physicians of the county bureaus in all counties of the state except King County furnish old age assistance

recipients all "needed" medical care, including surgery, home and office visits, visits in a hospital or nursing home, diagnostic X-rays and laboratory tests, and specialist services. Medical services excluded are principally those covered in direct payment by the Department to hospitals (X-ray and radiation therapy, physical therapy, diagnostic X-rays and laboratory procedures for hospitalized recipients, and the administration of anesthesia) and treatment of tuberculosis and mental illnesses beyond diagnosis.

Each county bureau sets its own fee schedule for remunerating its physician members for their services to OAA recipients. All the bureaus pay their participating physicians on a fee-for-service basis for surgery and special services. About half of the bureaus pay a "case average rate" or capitation fee for office, home, and nursing home visits, while the remaining bureaus pay a fee-for-service for these calls.

Since the total amount received by each bureau for the care its physicians provide is determined by the number of assistance recipients in the bureau area rather than by the services given, the amount often does not permit full payment of the fee set in the fee schedule established for welfare recipient care by the bureau. Where this is the case, the physicians receive only a part of the stipulated fee—the percentage determined by how much the use of services exceeds that which could be met by full payment of the fee schedule. The extent to which services are given may, for example, allow payment of only 75 to 80 per cent of the stipulated fee. At present the reported prorated fees paid to physicians in the various counties range between 65 and 100 per cent of the local fee schedules.

The need for prorating payment when the use of physicians' services exceeds the amount available for payment is believed to provide a strong incentive for local physicians to monitor the program in their bureau area. Local physicians are assumed to help control the cost of the program by influencing their colleagues to reduce non-essential office calls and medical and surgical work so that each service provided can be paid for at close to the established fee schedule. Since physicians also determine hospital and nursing home admissions, as well as drug prescriptions and the use of other medical services, this indirect control is thought to hold other medical utilization to a minimum.

A second and more important control of medical services is provided by 35 *screening physicians*—well-known practicing physicians in

each bureau who are employed by the Department of Public Assistance to review the requests of attending physicians for surgery, hospitalization, or diagnostic workups, and to approve only those essential in the treatment of a chronic, emergent, or acute condition. Screening physicians are paid on a part-time or full-time basis, depending on the amount of the physician's time spent in screening work.

The local screening physicians are regarded as vital to the success of the entire medical care program, particularly because, as already noted, physicians' decisions affect many costs in the program besides those of their own services. The screening physician in each bureau applies controls at a level most readily acceptable to local physicians. His presence avoids delays in questions about allowed treatment, and avoids direct communications with the state department which physicians often consider burdensome.

Hospital Care Complete general hospital care in ward and/or private accommodations is provided OAA recipients either in county hospitals, as in King County and three other counties, or in any voluntary hospital in the remainder of the state. The Department of Public Assistance pays each voluntary hospital a specific per diem rate based on its reimbursable costs during the preceding year up to a limit set by the department, on the basis of three groupings by size. The county hospitals are paid the full cost of their operation.

Except for the proviso that hospitalization of OAA recipients must be "necessary," no formal limits are set by the department on admissions or length of stay. In practice, however, both hospital admissions and length of stay are reviewed by the screening physicians.

Nursing Home Care The Department of Public Assistance contracts directly with individual private nursing homes for care to OAA recipients.* Almost all homes in the state — 320 of 334 licensed homes comprising almost 14,000 beds — accept OAA patients. Nursing homes are paid rates which depend on the classification of each patient according to the amount of nursing care he requires. Patients are classified by assistance department screening physicians or classification nurses into one of four groups. Most screening is now done by the full-time classification nurses, with the aim of screening all patients at

*A small proportion — less than 10 per cent — of OAA recipients receiving nursing home care are in hospitals which have nursing home beds or in retirement homes.

intervals determined by the individual patient's condition. Patients classified in "Group I" are bedfast and helpless, or either bedfast or semi-ambulatory but requiring maximum care because of their physical condition or mental confusion. For each OAA patient receiving Group I care, the home receives \$6.38 per day. Patients in Group II are confined to bed or are semi-ambulatory but require moderately complex nursing care. For each Group II patient the home receives \$5.27 per day. Patients in Group III, for whom the home receives \$4.66 per day, require bedrest or are semi-ambulatory or ambulatory with some minor additional problem requiring nursing care. Patients in Group IV (\$4.14 per day) are ambulatory or semi-ambulatory and require some degree of supervision.

The homes themselves are also classified into four groups according to the amount and complexity of nursing care they are equipped to provide. They can be paid only for the classification of patient care they can provide in terms of the number of registered and licensed practical nurses they employ. For example, a home which lacks the required staffing for Group I classification is classified as a Group II home provided stipulated licensed personnel for a Group II home are employed. It can be paid only the rates for Group II, III, and IV patients, even though it may provide care for some patients who ordinarily would be classified in Group I. All the homes agree to accept the compensation rate set by the department as payment in full for OAA patients. Where patients have some income of their own, the department determines what part of the allowed per diem payment is to be made directly by the patient.

Nursing home payments do not include physicians' services, but cover all nursing care, supervision of needed medications and treatment, and attendance to patients' personal care, as well as promotion of their self-help, providing them with a satisfactory environment, and safeguarding their personal possessions. Not covered are the cost of such personal services as haircuts, laundry, long-distance telephone calls, cigarettes, toilet articles, personal clothing, and the like, which are paid for by the patient.

Drugs The medical care program covers the cost of all "essential" drugs prescribed for OAA recipients by their physicians. Household drugs which can be purchased without a prescription are not provided in the program. Druggists are paid directly by the state for prescriptions

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they fill, at prices agreed to by the state pharmaceutical association. These prices are somewhat lower than normal prescription prices. Drugs prescribed in the hospital are included in hospital payments. Drugs which may be prescribed without special authorization by the local screening physician are listed in a limited "formulary." Drugs not in the formulary and all single prescriptions costing more than \$10 require prior authorization by the screening physician.

Dental Services The Department of Public Assistance contracts with the Washington Dental Service Corporation, one of the few dental care prepayment plans in the country, to provide dental services for OAA recipients and all others receiving public assistance.* In most of the state care is provided on a free-choice, fee-for-service basis by dentists who have signed contracts with both the Department of Public Assistance and the Dental Service Corporation. Any licensed dentist in the state may participate, and over 60 per cent do. Participating dentists are paid according to a fee schedule established by the department. In Pierce County, which includes the city of Tacoma and contains about 10 per cent of the state's OAA recipients, care is provided in a closed-panel dental clinic associated with the Pierce County Hospital, under the administration of the Washington Dental Service Corporation.

The program does not try to provide comprehensive dental care. However, it does include the extraction of teeth, filling of decayed teeth (if such treatment may prevent a future need for dentures), construction of full dentures (when maximum use and benefit can be expected), the repair of broken dentures, and X-rays.

As in the medical care program, screening dentists are used to review requested dental care when the Chief of Dental Services directs. Extraction of teeth (or palliative treatment) for the relief of pain, and repair of broken dentures may be performed by participating dentists without prior authorization. All other care requires prior authorization by Washington Dental Service Corporation. Questions about the treatment requested are referred by Washington Dental Service Corporation to the community's screening dentist, who is paid \$3 for each case he screens.

*The dental program — including its development and experience — is fully described in "The Dental Service Corporation in a Public Assistance Program: a Report from Washington State," (Public Health Service Publication No. 680), Washington, D. C., 1959.

Care for the Aged in Washington

Other Health Goods and Services The Washington Medical Care Program for OAA recipients also covers the cost of ambulance service to and from health facilities, glasses (the cost of eye examinations is included in physicians' services), limited visiting nursing services, and hearing aids and other appliances, which are generally purchased by the Department of Public Assistance and loaned to assistance recipients.

UTILIZATION AND COSTS

Despite the steady decline in the number of OAA recipients over recent years, the cost of the Washington medical care program has continued to rise. The increased use of services by recipients, related to their increased age, changes in the state program, and the increased cost of health goods and services have more than offset the lowered caseload.

Several special studies made in the past few years provide valuable data on the use of specific services by OAA recipients: The study of the role of the dental service corporation mentioned earlier gives data on the type of dental care used by OAA and other assistance recipients. Two very recent studies of nursing homes made by the department provide a wealth of data about the patient composition and the health care needs of patients in the state's private nursing homes. And an earlier study of drug utilization (discussed later) gave the department data that enabled it to reduce the cost of its drug program. With the exception of care in voluntary hospitals, basic data in other areas of use and cost do not yet exist although they might be valuable for control of costs and projections of utilization. Studies of utilization of services in the various counties would also reveal how closely the specifications for care set by the state are followed — whether or not OAA recipients in different parts of the state receive essentially the same quality and quantity of care.

Physicians' Services Data have not been compiled on the use of various kinds of physicians' services by OAA recipients, nor on the per capita or total cost of different physicians' services. As Table I shows, the per capita cost of physicians' services has risen from about \$32 in fiscal 1957 to \$40 in fiscal 1960, but what this represents in

Table I
Medical Care Cost per OAA Recipient by Type of Care

| Type of Care | 1956-1957* | % | 1957-1958 | % | 1958-1959 | % | 1959-1960 | % |
|----------------------|-----------------|--------------|-----------------|--------------|-----------------|--------------|-----------------|--------------|
| Physicians' services | \$ 31.80 | 11.0 | \$ 38.16 | 11.9 | \$ 38.16 | 11.4 | \$ 39.72 | 11.1 |
| Hospital care | 71.08 | 24.6 | 73.47 | 22.9 | 72.83 | 21.8 | 84.65 | 23.6 |
| Nursing Home care | 154.78 | 53.6 | 187.77 | 58.5 | 203.02 | 60.7 | 210.55 | 58.7 |
| Drugs | 26.36 | 9.1 | 17.36 | 5.4 | 16.59 | 5.0 | 17.41 | 4.9 |
| Dental services | 2.96 | 1.0 | 3.46 | 1.1 | 3.78 | 1.1 | 6.23 | 1.7 |
| Appliances, etc. | 1.68 | .6 | .82 | .3 | .28 | .1 | .24 | .1 |
| Total | \$288.69 | 100.0 | \$321.04 | 100.0 | \$334.66 | 100.0 | \$358.80 | 100.0 |

*From July 1 to June 30.

terms of either use or increased physicians' fees is not known. It is certain, however, that the cost of physicians' services is understated throughout because physicians' services provided in the county hospitals — particularly in King County Hospital — are included in *hospital* costs rather than as the cost of physicians' services. However, what part of the approximately \$5 million paid to county hospitals for care of OAA patients represents physicians' care it not known.

Hospital Care More data exist concerning hospitalization of OAA recipients — at least for hospitalization in voluntary hospitals. While the admission and readmission rates are not known, the average length of stay of OAA patients in voluntary hospitals was 7.4 days in fiscal 1960, a little longer in the county hospitals. This is at most one-half as long as the average length of stay for the same age-group in the general population. The average cost per day in voluntary hospitals was \$30.71, for an average cost per admission of \$227.

As noted above, the per capita cost of hospital care includes physicians' care in county hospitals, so that the actual cost is something less than the \$85 given for 1960 — possibly between \$75 and \$80.

Nursing Home Care Nursing home payments now account for close to 60 per cent of the total cost of the Washington medical care program for OAA recipients. Recent analyses of the increasing nursing home caseload and of nursing home costs and the characteristics of nursing home patients provide excellent data on use and cost of this type of care.*

From July, 1953, to July, 1960, the number of OAA recipients in nursing homes increased 56 per cent — from under 4,700 to 7,300 — while the total OAA caseload declined from 64,000 to 48,000. One out of 14 recipients was a nursing home patient in 1953; one out of six was a nursing-home patient in mid-1960.

While the increased use of nursing homes by OAA recipients cannot be attributed to any single factor, research by the Department of Public Assistance indicates that some five or six causes apparently account for most of the increase.

*"Analysis of Increase in Nursing Home Caseload, Old Age Assistance, 1955-1958" January, 1961, and "Nursing Home Cost Study," February, 1961. Both studies were prepared and issued by the Research and Statistical Unit of the Department of Public Assistance.

The first of these, it found, is the increasing average age of OAA recipients, with the result that a higher proportion of them require institutional care. The increased average age stems from the general aging of the population (credited to increased longevity) and from the loss of the "younger" aged from the OAA group as Federal OASDI benefits have broadened (the "older" aged—in particular, older women—are less often covered by OASDI, and when they are, the amount they receive is generally lower). At present, over 60 per cent of OAA nursing home patients are women; well over half of OAA nursing home patients are at least 80 years old.

Increased medical care costs have also helped increase the OAA nursing home load, the department study found. Aged people who were financially independent while well, entered public assistance rolls after their financial assets were depleted by payments for serious illness requiring long-term hospital or nursing-home care. Additionally, many aged who could otherwise still be self-supporting cannot pay for nursing home care costing between \$120 and \$200 per month without public assistance. Extended illness and the resultant depletion of their resources have meant that a higher proportion of nursing-home patients are now OAA recipients.

A third cause of the increased nursing-home load cited in the department's study was a state decision in 1954 to transfer a number of senile patients from the state mental hospitals to nursing homes. An estimated 500 of these patients were transferred between 1955 and 1958.

Other probable causes of the increased nursing-home load are discussed in the department study. The available number of nursing home beds in Washington has more than kept pace with the increased use. The number of beds rose from 7,700 in mid-1953 to over 13,000 in mid-1960. In most other sections of the country the absence of adequate nursing home facilities restricts referrals to them. In Washington, on the other hand, new home construction has resulted in some surplus of beds. Slightly over 1,000 nursing home beds are vacant, with most homes operating at about 93 per cent occupancy.

The construction of new attractive nursing home facilities and the increasingly vigorous standards for them set by the state and their own association have undoubtedly also increased the acceptability of nursing homes by the aged, their families, and their physicians.

The Department of Public Assistance study has estimated the effects of each of the major causes of the "discrepancy" between the nursing-home caseload that might have been projected from the decreasing OAA caseload and the actual increase in nursing-home caseload. It estimates that 20 per cent of this "discrepancy" is due to the increasing average age of recipients, 15 per cent to the transfer of senile aged from the state mental hospitals, between 40 and 60 per cent to the increased costs of medical care, and the balance—5 to 25 per cent—to the greater acceptability of the homes and other social factors.

Obviously, the use of nursing homes in Washington differs from that in other parts of the country. It would be a mistake, however, to think that the large proportion of OAA recipients in nursing homes indicates that the homes are being used as boarding homes for the aged. Most nursing-home patients require substantial care. Of all public assistance recipients in nursing homes, 2,500 are Group I patients, 2,000 are Group II patients, 3,000 are Group III patients, and fewer than 600 are in the minimal-care Group IV. The department's most recent study of the characteristics of assistance recipients in nursing homes reveals these striking facts:

- Thirty per cent were bedridden most or all of the time; another 10 per cent were bedridden part of the time.
- While 48 per cent were able to walk alone or with no more help than cane or crutch, 37 per cent were unable, at least part of the time, to walk or be moved in a wheelchair.
- Only 26 per cent were always clear mentally. Thirty-seven per cent were seriously disoriented at least part of the time.
- Only 9 per cent had but one impairment requiring care. Twenty-seven per cent had two impairments requiring care, 25 per cent had three, and 39 per cent had four or more conditions that required care.
- Including cases in which care was expected to be terminal, 96 per cent were expected to remain in nursing home care for an indefinite period. Only 2 per cent were expected to need care for less than a year.

The increased cost of nursing home care is due principally to the higher number of OAA recipients in nursing homes, not to any substantial increase in payments per patient to the homes. Nursing homes have received only two special increases between 1953 and the end of 1960 — both requiring additional services. In 1957 the homes were given an increase of 40¢ per patient per diem if they agreed to provide cost data for the department's study of nursing home costs. In 1960 they received an increase of 7¢ per diem if they agreed to provide routine household drugs to patients. As a result of the recently completed cost study, a new contract, with increased rates (particularly for Group III and Group IV patients) has been instituted — the first payment system for nursing homes in Washington and perhaps in the nation based on actual per diem costs.

Drugs In 1955 the Department of Public Assistance compiled a full list of drugs which could be prescribed for OAA recipients without prior authorization. Over the two years following, drug expenditures rose sharply. An intensive study by the department of drug costs revealed that a major part of the rise was occasioned by widespread prescription of tranquilizers and anti-hypertensives (costing an estimated \$½ million per year in all welfare programs). The study also showed great divergencies in prescribing practices. For example, in two comparable nursing homes in the same city the cost per month for drugs differed by \$28 per patient. In 1957 the department curtailed its drug expenditures by limiting the list of drugs which could be prescribed without special approval to only the most "essential" and frequently used drugs. As Table I shows, the per capita cost of drugs has been about \$10 a year lower in the past three years than it was before 1957. A revised, somewhat liberalized drug formulary was recently placed in effect (October, 1960) but it is not expected to increase drug costs appreciably.

The present \$17 per year "drug cost" per person does not include drugs furnished hospitalized patients. These are included in hospital costs. In addition, nursing homes furnish their OAA patients with common household preparations (aspirin, rubbing alcohol, milk of magnesia, body lotions, etc.) without charge, for an amount included in their per diem payment. Additionally, an unknown amount is expended by OAA recipients themselves for medications not included in the program.

Dental Services The most recent data concerning the use of dental services by OAA recipients were those compiled between October, 1956, and September, 1957, for the Department of Health, Education, and Welfare pamphlet mentioned earlier. During that period, only about 6 per cent of OAA recipients applied for dental care (a substantially higher proportion of men than women). About two-thirds of the applicants for care required full dentures, and most of the remaining third required some other prosthetic services (relining, repair of broken plates, etc.). The average expenditure for each recipient receiving dental service was \$54.59.

The sharp rise in the cost of dental services in 1959-1960 (from \$3.78 to \$6.23 per person) in part reflects the effects of an increased fee schedule adopted July 1, 1959. At that time the maximum charge for full upper or lower dentures (to cite the most common service performed for OAA patients) rose from \$75 to \$90.

Comparison with Other Programs Because utilization of physicians' services and some hospital care cannot be stated for the Washington program, overall comparison with the utilization of other groups is difficult. What data exist indicate that Washington OAA recipients make unusually full use of nursing-home care and probably less total use of hospital care than do comparable groups of aged in other parts of the country as indicated by the extremely low length of stay of Washington OAA recipients. A comparison of the number of nursing home beds and general hospital beds to population in Washington state, the entire country, and a few selected states shows that Washington has three times the number of nursing home beds of the country at large and much higher than any state.* It is also comparatively well-supplied with general hospital beds. The combination makes for a generous use of facilities compared with other areas. These differences apparently reflect different regional patterns of medical care, not merely differences in the particular assistance programs.

Some cost comparisons can be made with nationwide expenditures for medical care and with the expenditures of other assistance pro-

*The article by Leslie M. Abbe, "Hospitals and nursing homes in the United States, 1959," *Public Health Reports* 74: 1089-1097, Dec. 1959 provides data on nursing homes by state. As of Jan. 1959 Washington was reported to have 4.34 nursing beds per 1000 population compared with the United States 1.43, California 1.54, New York 1.02, and Colorado 1.44. For general hospital beds derived from the American Hospital Association *Guide for 1960* the number of general hospital beds per 1000 in Washington is 3.34, United States 3.62, California 3.22, New York 4.35, and Colorado 4.00.

grams. In 1958 the nationwide per capita expenditure for insured people 65 and over, was \$214, not including expenditures for nursing homes.* The comparable per capita cost of the Washington program in 1958-1959 was \$132. Interestingly, the per capita cost of health care for the aged in Colorado, recently studied by HIF, was almost identical in 1959 (\$133), although the Colorado program provides no dental care, no prescribed drugs outside of hospital or nursing home, and only limited out-of-hospital physicians' services. When expenditures for nursing homes are included, the cost of the Washington program far exceeds that of Colorado (a per capita total of \$335 in 1958-1959, compared with \$222 in Colorado).

PROBLEM AREAS IN THE PROGRAM

As might be expected, the major problems in the Washington program, both in the present and recent past, have arisen as direct results of its continued rising costs. Even before the cost of the program for the aged reached its present near-\$20 million annual figure, the program administrators and the state legislators were concerned over the burden placed on the general population by the growing costs.

In the past several years, particular attention has been focused on three parts of the medical care program: nursing homes, the county hospitals, and drugs. The list of drugs was revised and special authorization was required for expensive prescriptions and those not part of the formulary. This revised list is assumed to enable the prescribing of life saving drugs and those of clearly demonstrated therapeutic value.

The special attention focused on nursing home costs resulted in the full cost study already discussed. Nursing home payments are now to be made on the basis of median costs for each of the different classifications of patient care. The new payments represent the first time that nursing-home payments have been related to known costs. Despite this, of course, the total cost of nursing home care for old-age assistance recipients (well over \$10 million per year) continues to be a source of concern. It has been suggested by some of those concerned with nursing-home care in Washington that this state, in its more

*Data from the nationwide family survey by Health Information Foundation and National Opinion Research Center to be published.

extensive use of these facilities, has simply progressed further along a road which all state or other medical care programs for the aged will have to follow. They suggest that nursing home care, which already accounts for over 60 per cent of the cost of the entire Washington OAA medical care program, will continue to increase in importance and that the "problem" of nursing home costs should focus merely on assuring that payments reflect actual costs and the most efficient and beneficial organization of this medical service.

The third area which has received particular attention—the county hospitals — has not resulted in any program changes. The problem in the relationship between the county hospitals and the program — in particular, between the King County hospital and the program — has been created by the fact that the county hospitals are entirely dependent for support on the state welfare programs and that their rising costs have required them repeatedly to return to the state for deficiency appropriations.

Besides those created by rising costs, the largest number of administrative problems for the medical care program have stemmed from questions arising between the different suppliers of health care services and the plan administration. These are inevitable, but in the case of the Washington program, they have been generally minor and readily resolved. The disallowed treatment that has been requested by a physician for his patient has probably been the major source of this category of problem. Since treatment or hospitalization has often already been given the assistance patient, the rejection of the request means that the service is not reimbursable (and is generally not collectible from the patient).

OBSERVATIONS AND IMPLICATIONS

Since 1941 a comprehensive health program has been in operation in the State of Washington under the power given by a state referendum. The mandate has been general, but for 20 years the state has felt that nothing less than a comprehensive program was intended. Further, no source of tax funds was ever earmarked, and no statutory ceiling was ever set on expenditures. In general, expenditures have been allowed to reach their own level in accordance with what appear to be the medical needs of the age-group of 65 years of

age and over, the group with which this report is specifically concerned. Certainly, no state in the union has supported a more complete program or been more generous in providing funds. Obviously, the program has a firm place among the services provided by the state, and it would probably be impolitic to change its essential character.

A very interesting feature of the health program is the mixture of methods by which the state fulfills the intent of the law authorizing it. About 15 per cent of the expenditure is delegated to medical and dental prepayment agencies under the control of the medical and dental professional associations on a negotiated premium. This is the explicit delegation of financial control but, naturally, the physicians' influence pervades the entire program, outside of dental care. Physicians' services were first provided on a cost-plus basis, but after several years of experience with expenditure levels, the medical bureau felt able to negotiate the premium. Hospital care and nursing home care payments are made directly to individual hospitals and nursing homes on a per diem or average per diem basis. The unit price of drugs was negotiated with the professional pharmaceutical association. Appliances are purchased directly from the vendors, hearing aids on a bid basis.

The health program for recipients of old-age assistance in the state of Washington is thus geared to the current structure of the health establishment. In this arrangement much responsibility has been delegated to the medical profession. In addition to guaranteeing physicians' services, the medical profession provides an administrative mechanism. The state is thereby freed of all direct administration and supervision. The existence of the medical bureaus for many years has made this possible. The prepayment agencies serve as buffers between the state agency and physicians and permit administration to be decentralized to the county levels. County welfare departments have been able to divest themselves of complicated day-to-day administration which many welfare administrators felt would greatly overshadow other welfare activities for which they were responsible.

In this kind of a setting the health program for the aged has developed to its present status. A review of its history shows that in principle the program has remained the same, but two things deserve attention. First, the screening physicians provided by the medical bureaus in coordination with the medical director on the state level

have been set up in an increasingly elaborate framework. It is unlikely this would have been acceptable unless the physician's part of the program was integrated in the county medical bureaus.

Second, the development of the nursing home program in a relatively spontaneous manner shows other states contemplating a similar program what to expect. Undeniably, the nursing home portion accounts for a tremendous proportion of the total cost. There are no data but it does not appear that the nursing home program has appreciably reduced the cost of hospital care despite the short hospital stay. There is a great deal of concern in the state with the nursing home program and there is talk of the need to establish home care programs to reduce the cost of nursing home care. Ironically, nursing home care was regarded as a means to take the pressure off the hospitals.

The recipients of old-age assistance appear to be receiving a great deal of care, although the paucity of utilization data precludes comparisons with other programs. The state could well require more detail on the use of physicians' services from the county medical bureaus, so that it would have more information on what it was buying. Likewise, the county medical bureaus should know more about what they are providing. A scarcity of information necessary for administrative evaluation has been chronic in the state of Washington, but it apparently indicates that there is a good deal of trust between the state government and the medical profession. Certainly, there is general satisfaction with the program. Periodically, there is public concern with the rising costs resulting in legislative and administrative soul searching, but ultimately the funds are appropriated with admonitions to use the money as efficiently as possible within the mandate the state has accepted for the care of its indigent aged. So far, it can be said the state has been generous. Other states contemplating a similar program must not have any illusions about the cost of comprehensive services for the aged. ■

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These progressive representatives of the more than 200 companies supporting the Foundation decided they could serve the public interest by:

—documenting through research the accomplishments of the present system of medical care;

—defining areas in the health field in need of improvement and investigating possible solutions to current problems;

—bringing, through all media of communication, research findings, needed facts and new knowledge concerning health problems to organizations active in the health field and to the public.

Today the Foundation is studying many of the most vital problems related to health in the United States, among them the ways by which voluntary health insurance can be expanded and improved, the special problems of Americans over 65, and the opinions and attitudes of the general public toward health services.

The Foundation's President is George Buglietti; its research director is Odin W. Anderson, Ph.D.