Medical Services in the Old-Age Assistance Program

by Ruth White *

The experiences of the States in making determinations of permanent and total disability under the new program for aid to the permanently and totally disabled and in devising procedures for making payments to the suppliers of medical services with Federal financial participation, as authorized by the Social Security Act Amendments of 1950, have focused attention sharply on the health problems of assistance recipients. The importance in all assistance programs of medical care to restore disabled persons to self-dependence whenever possible becomes increasingly evident. Because problems inherent in the administration of medical assistance are of such widespread concern, the Bureau of Public Assistance is issuing in the near future a summary report of a study made in 1946 on the medical aspects of public assistance administration. The following article, based on detailed information reported by 20 States, summarizes on one of the chapters in that report.

PUBLIC assistance agencies have followed varying practices in providing medical services for assistance recipients. They may provide medical care for a recipient by including an amount for such care in his assistance payment or by making payment directly to the medical practitioner or agency supplying the service. The funds for medical care may come from the program through which the recipient gets maintenance assistance, from another assistance program, or from both. The cost of the care provided may be met in one payment, either prepaid or postpaid, or it may be met in installments. Different types of medical services may be provided through different payment methods and from the funds of different assistance programs.

In a 6-month period in 1946, 20 States[1] undertook to record information from a sample of assistance cases on the volume and cost of all the medical care provided, by type of service, program funds, and payment method. The data relate to care provided from assistance funds. Reports from local agencies participating in the study indicate that in some localities the recipients also received certain types of services, without charge to the assistance funds. These services were provided by public hospitals and clinics, private health agencies, service clubs, churches, county physicians, or private practitioners. In some of the States, the amount of care provided to recipients and not paid for by assistance agencies is known to have been substantial in certain areas not included in the sample—Cook County, Ill., and Hudson County, N. J., for example.

Assistance funds were used to pay for physicians' services in all States. Such funds were commonly supplemented, usually on the physician's recommendation, by drugs, hospitalization, bedside nursing services, prosthetic devices, and other types of care. Although dental services were included in most State medical care plans, they comprised a small part of total medical assistance. Agencies in most of the 20 States provided, in some measure, all the types of services enumerated, either "as needed" or in specified circumstances or emergencies. Care in nursing or convalescent homes was provided by most States for some recipients.

Though there may have been significant changes since 1946 in the content of the medical care provided by certain States, the information in the study on the relative number of recipients receiving services and on the proportions receiving specified types of services probably reflects the current situation in most States reasonably well.

The cost of medical services has, of course, risen greatly in the past few years. According to unpublished data from the Bureau of Labor Statistics index of retail prices for moderate-income families in selected large cities, these costs rose by 26 percent between December 1946 and December 1951. The cost of physicians' services and drugs increased one-sixth. The greatest rise was in hospital rates, which in 1951 were 67 percent higher than in 1946.

There is little information to indicate whether costs of medical care for recipients of assistance have risen

---

*Division of Program Statistics and Analysis, Bureau of Public Assistance. The article is adapted from Part II of the report, *Medical Care in Public Assistance, 1946* (Public Assistance Report No. 16). Part I of the report (issued in October 1948) consists of 21 separate documents—"Introduction to State Reports" and "State Reports Nos. 1–20)." Part II summarizes the findings of the study, both for 20 States that kept detailed records for 6 months on the types, volume, and cost of services supplied to individual cases in each assistance program and for 22 additional States that provided some information on the administrative aspects of medical assistance at the State level.

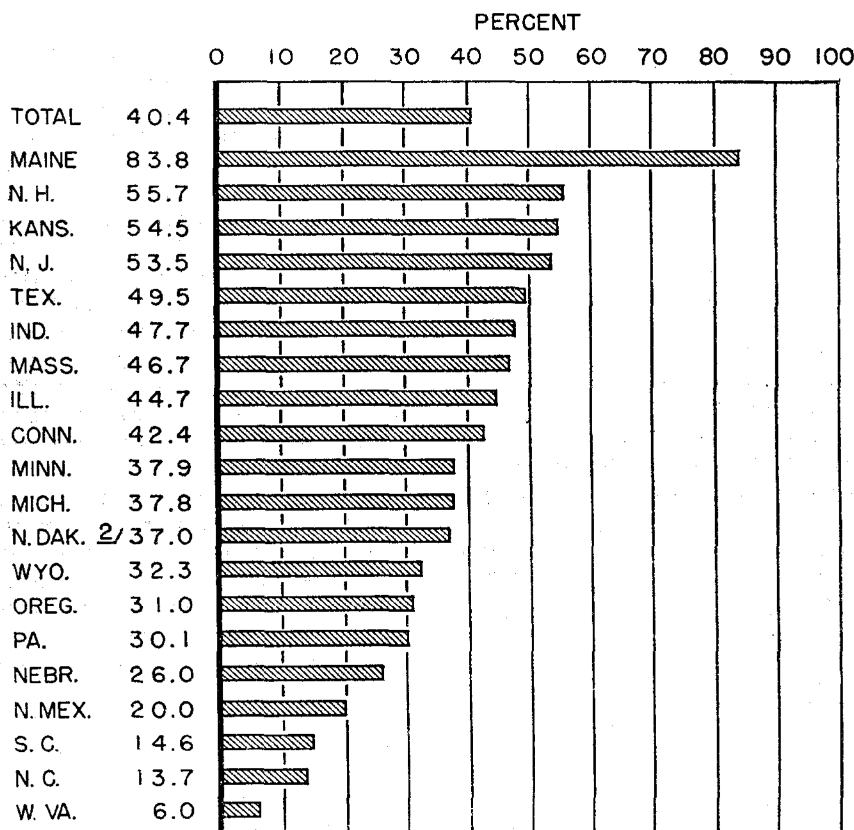
[1] Connecticut, Illinois, Indiana, Kansas, Maine, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Oregon, Pennsylvania, South Carolina, Texas, West Virginia, and Wyoming. For 13 States the data included in the sample are representative of the entire State or of selected portions of the State. In seven States, the data cannot be regarded as representing more than the counties participating in the study. (The sampling procedure is described in Appendix II of the report.) It should be recognized that, if the data represented State-wide operations in all States, the averages, percentage distributions, and ratios would be different for some States and the State rankings would be modified.

as fast as or faster than the BLS index indicates. For aged recipients and for general assistance cases the relatively heavy weight of hospital costs in the total expenditures for medical care may have resulted in an increase in the cost per assistance case that is greater than the 26-percent rise shown by the index. Information from a number of State agencies indicates that the cost of nursing-home care has also increased substantially during recent years. This item also heavily weights the figures in the States that supply a substantial amount of this type of care. Despite these changes since 1946, the data from the 20 States are useful for the light they throw on comparative State expenditures for different types of medical services.

During the 6 months covered by the study, about 2 in 5 of the recipients of old-age assistance, whose average age was about 75, received some medical services from the assistance funds of the 20 States (chart 1). The fact that recipients in different States do not have equal opportunity to obtain medical assistance is shown by the range—from 84 percent in Maine to 6 percent in West Virginia—in the proportion of cases receiving services. Half or more of the aged recipients in five States,[2] and from two-fifths to one-half in an additional five States, received medical care. On the other hand, services were made available to less than one-fourth of the recipients in the four lowest States.

[2]Including North Dakota, where the percentage would be 98 if cases receiving a routine allowance of $1 a month for physicians' services and $1 for drugs were included.

Chart 1.—*Percent of all old-age assistance cases receiving medical services, 20 States, during a 6-month period in 1946* [1]



[1]Based on number of different cases receiving assistance during 6-month period. Data for entire State or selected counties in State.

[2]Excludes cases receiving only routine monthly allowances of $1 for physicians' services and $1 for drugs.

Physicians' Services

Assistance cases receiving physicians' services.—The relative number of old-age assistance cases[3] who were receiving physicians' services, the average number of visits per case, and the average cost per visit are shown in table 1 for each of the 20 States. Included as physicians' visits are all home, office, hospital, and clinic visits for which costs were met from assistance funds. More than one-fourth of the recipients had at least one such visit during the 6 months covered by the study. In five States more than one-third of the cases, and in eight States from one-fourth to one-third, saw a doctor at least once during the period. The proportions ranged among the States from 44 percent of the old-age assistance caseload in Indiana to less than 4 percent in West Virginia and 0.1 percent in South Carolina.

The 17.6 percent shown for North Dakota represents only the recipients for whom money for this purpose was included in the budget on a postpayment basis. Probably a relatively large number of the other recipients, whose budgets included only routine amounts for medical care, saw their physician one or more times during the 6 months. From one-third to one-half of the recipients in this State probably had such services.

Although the States showed extremely wide variations in the proportion of cases receiving physicians' visits, there was a considerable degree of uniformity in the average number of visits per patient receiving such visits. In the 20 States combined, recipients seeing a doctor had an

[3]In this article, "case" is used in the sense in which it is customarily used in the field of public assistance—namely, the person or persons receiving assistance. While "recipient" and "case" are practically synonymous in old-age assistance, "case" is used chiefly here because in some instances a case may include an additional person or persons who are essential to the recipient's well-being. Another distinction should be kept in mind. "Assistance cases" or "cases receiving assistance" refer to the entire caseload. When the data refer specifically to recipients receiving medical services, however, the terms used are "cases receiving medical services," "medical care cases," "cases receiving hospitalization," and similar variants.

average of 7.2 visits in the 6 months —about one visit a month. For 10 States in the middle of the range the averages were from 6.5 to 8.5 visits per patient. In the five States that ranked highest,[4] the averages were from 7.5 to 10.4. Maine's average of 10.4 visits[5] reflects an unusually large amount of service in some areas, though the visits were relatively rare in other areas that had few physicians in relation to population.

Cost of physicians' services.—The average cost per physician's visit in the 20 States was $2.53 per medical care case. The differences among the States in average costs reflect, in general, variations in fee schedules for visits or, in the absence of established cost figures, in charges that physicians made for needy cases. The averages do not include the cost of surgery when a separate charge was made; they do include in some States an unspecified amount for medicines.

Reports on the estimated amounts included in payments to recipients to meet medical needs did not always list separately the amounts for physicians' services and for medicines. Moreover, bills presented by physicians did not always show separately the charge for drugs dispensed or administered. The inclusion of medicines accounts in part for the relatively high averages in Maine ($2.76) and Michigan ($2.55). Such costs were included in some of the sample counties in North Carolina and probably in some instances in other States. The physicians' mileage charges were included in the amounts reported, and variations in rates or in the ratio of home visits to total visits doubtless affected average costs.

In general, however, the range in costs per visit—from $2.74 in Connecticut to about $1.30 in Oregon and Pennsylvania—reflects differences in costs permitted for visits under agency policies or charged by physicians

[4]Excluding North Dakota, because data for that State represent only visits for the 17.6 percent of assistance cases who required visits beyond those that could be purchased from routine or estimated allowances.

[5]Includes visits for which amounts were included in the budgets on an estimated basis and may represent an overstatement of services actually received.

Table 1.—*Percent of all old-age assistance cases receiving physicians' visits, average cost per case and per visit, and average number of visits, by State, during a 6-month period in 1946* [1]

State [2]	Cases receiving physicians' services				All old-age assistance cases	
	Percent of all old-age assistance cases [3]	Average cost per case	Average number of visits	Average cost per visit	Average monthly cost per assistance case	Average number of visits per assistance case during 6-month period
Total, 20 States	27.0	$18.30	7.2	$2.53	$0.88	[4] 2.1
Indiana	43.8	17.40	8.3	2.10	1.36	3.9
New Hampshire	39.5	15.15	8.0	1.90	1.08	3.4
Illinois	39.1	13.64	7.5	1.81	.93	3.1
Kansas	38.1	17.45	8.9	1.99	1.24	3.8
Maine	36.3	[5] 26.92	10.4	2.76	[5] 1.72	4.0
Massachusetts	31.2	14.56	5.4	2.58	.81	1.8
Michigan	31.2	19.62	7.7	2.55	[5] 2.41	(6)
New Jersey	30.9	15.48	7.2	2.16	.80	2.4
Connecticut	28.2	14.80	5.4	2.74	.74	1.6
Minnesota	26.2	15.09	7.7	1.95	.69	2.1
Pennsylvania	25.3	8.16	6.1	1.34	.38	1.7
Texas	24.7	14.23	6.9	2.07	.62	1.8
Wyoming	24.5	17.15	7.2	2.39	.76	1.9
North Dakota [7]	17.6	22.53	15.2	1.58	.70	(6)
Oregon	17.6	14.91	9.3	1.31	.47	1.7
Nebraska	15.6	13.12	4.9	2.68	.37	.8
New Mexico	13.2	11.83	5.5	2.14	.28	.8
North Carolina	8.8	[5] 30.34	7.3	2.64	[5] .48	(6)
West Virginia	3.8	15.17	7.9	1.91	.10	.3
South Carolina	.1	(8)	(8)	(8)	(9)	(10)

[1] Includes clinic visits and hospital visits if a separate charge was made for such visits; does not include cost of surgery when charged separately.

[2] Data for entire State or selected counties in State.

[3] Based on number of different cases receiving assistance during 6-month period.

[4] 17 States.

[5] Includes cost of some drugs supplied by physicians.

[6] Data not available.

[7] Represents cases receiving visits for which costs were met on a postpayment basis; excludes visits with costs met from routine or estimated allowances.

[8] Not computed; base too small.

[9] Less than $0.005.

[10] Less than 0.05 visits.

in the various States and localities and, to some extent, the use of low-cost clinic services. In Connecticut, for example, agency cost figures provided $2 for office calls; $3 for the first patient for home calls and $2 for each additional patient in the family; and $4 for night calls. In Pennsylvania the maximums were $1 for a visit to a physician's office and $2 for home visits if only one patient was treated and $3 if two or more patients were treated or if the call was made at night. Clinic services, which were available in some of the large cities in Pennsylvania, were paid for on the basis of actual cost up to a maximum of $1 per visit.

For the 6-month period the average cost per case receiving visits is the result of differences among the States both in the average number of visits per case and in average charges. This average cost was $18 for the 20 States and ranged from less than $15 to more than $17 in the nine States in the middle of the range (table 1).

The range in average monthly cost per assistance case was much wider than that in average cost per case receiving doctors' services, since the relative number of such cases was an additional factor affecting unit cost. Per assistance case, five States spent more than $1 a month for physicians' visits and seven spent less than 50 cents.

Number of visits per assistance case.—For comparability with other data on medical care, usually given on an annual basis, the data on physicians' visits and days in hospital were converted to an annual rate. The estimated number of visits per assistance case during the calendar year 1946 ranged from six or more in five States to less than one in two of the 17 States for which data may be computed (table 2).

Data are lacking on the number of visits needed on the average by persons aged 65 or over in either the general population or the assistance population. Because persons with dis-

Table 2.—*Estimated average number of physicians' visits and hospital days per old-age assistance case, by State, 1946* [1]

State [2]	Physicians' visits [3]	Hospital days
Total	4.2	1.8
Connecticut	3.2	2.0
Illinois	6.2	2.4
Indiana	7.8	1.8
Kansas	7.6	2.4
Maine	8.0	1.2
Massachusetts	3.6	2.6
Michigan	(4)	1.2
Minnesota	4.2	2.8
Nebraska	1.6	1.6
New Hampshire	6.8	4.4
New Jersey	4.8	[5] .8
New Mexico	1.6	.6
North Carolina	(4)	.2
North Dakota	(4)	6.2
Oregon	3.4	2.2
Pennsylvania	3.4	(5)
South Carolina	(6)	.2
Texas	3.6	(5)
West Virginia	.6	1.0
Wyoming	3.8	3.4

[1] Based on average monthly number of cases receiving assistance during 6-month period.
[2] Data for entire State or selected counties in State.
[3] Includes clinic visits and hospital visits if a separate charge was made for such visits.
[4] Data not available.
[5] Hospitalization not provided from assistance funds in New Jersey (most counties), Pennsylvania, and Texas.
[6] Less than 0.05 visits.

abling illnesses are more likely than able-bodied persons to need assistance, it may be assumed that recipients of old-age assistance require more medical care than aged persons in the general population. Information on physicians' visits is available, however, in a study by the Committee on the Costs of Medical Care.[6] The study showed that, among 8,639 white families, individuals aged 65 and over had on the average 4.16 physicians' visits during a 12-month period in 1928–31. Aged persons in families with incomes of less than $1,200 averaged 3.64 visits during a year, and those in families with incomes of $10,000 or more had 9.08 visits.

In seven of the 17 States, the estimated average number of visits per year for recipients of old-age assistance exceeded the 4.16 average in 1928–31, and in three other States it equaled or exceeded the 3.64 average for aged persons in low-income families. In four States, recipients had an average of less than two physicians' visits. Even without definite standards against which to measure the average number of visits required by aged recipients, it is obvious that services in some States were extremely meager.

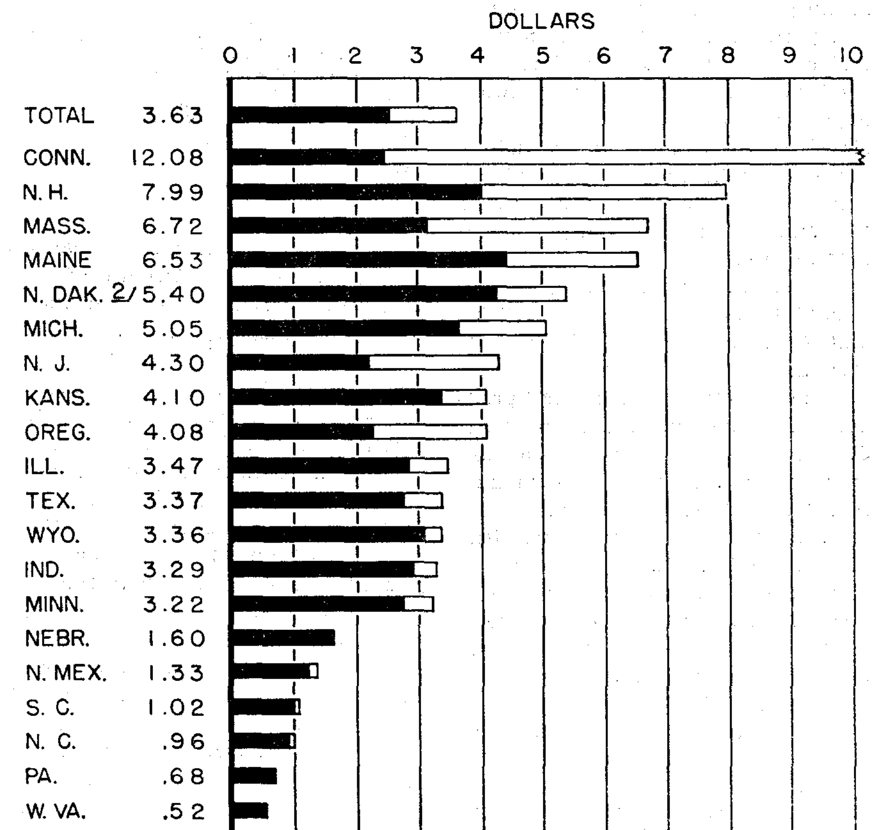
Data on visits for recipients of old-age assistance may also be compared with those received by aged persons under prepayment plans in which the subscriber pays a specified amount each month for the services provided. In 1948, individuals aged 65–69 and enrolled in the Health Insurance Plan of Greater New York had on the average 4.6 visits; those aged 70 years and over had 4.8 visits. Because old-age assistance recipients were on the average considerably older than the enrollees aged 65 and over in the New York plan, their medical needs were probably greater.[7] In 1946, the estimated average number of physicians' visits for old-age assistance recipients in six States exceeded those made for the Health Insurance Plan enrollees. For the median State the average was 3.6 visits.

Under another prepayment plan, that at Trinity Hospital in Little Rock, Ark., persons 65 years of age and over covered by the plan in 1941

[6] See Helen Hollingsworth, Margaret C. Klem, and Anna Mae Baney, *Medical Care and Costs in Relation to Family Income*, Social Security Administration, Bureau of Research and Statistics Memorandum No. 51, 2d edition, page 116, May 1947.

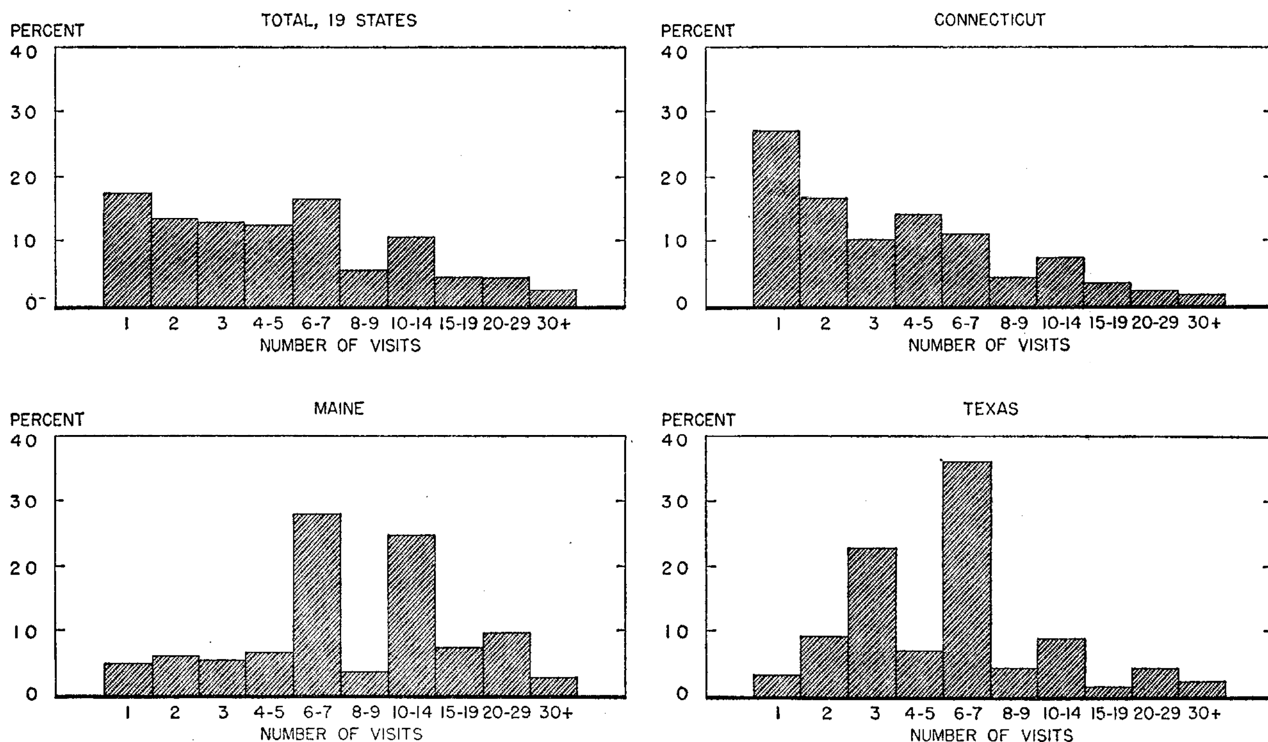
[7] New York State Joint Legislative Committee on Problems of the aging, *No Time to Grow Old*, 1951, pages 225-226. Less than one-fourth of the enrollees (aged 65 or over) in the New York plan were at least 70 years old; more than three-fourths of all old-age assistance recipients are aged 70 or over.

Chart 2.—*Average monthly cost of medical care per old-age assistance case, 20 States, during a 6-month period in 1946* [1]



[1] Data for entire State or selected counties in State.
[2] Excludes routine monthly allowances of $1 for physicians' services and $1 for drugs.

Chart 3.—*Percent of all old-age assistance cases with physicians' visits, by number of visits, 19 States and selected States, during a 6-month period in 1946*



had, on the average, 6.4 physicians' visits a year.[8]

In most States, from one-fifth to one-third of the aged recipients with visits saw their doctors only once during the 6 months. All States had some cases that required a relatively large amount of attention from physicians. In two-thirds of the States, more than 5 percent of the cases receiving this type of medical care had 20 visits or more, and in six of them more than 10 percent had as many as 20 visits. The six States include North Dakota, for which the data represent largely service to cases with acute illnesses.

Distribution of assistance cases with physicians' visits, by number of visits, shows a fairly uniform pattern among the States, as illustrated by the data for Connecticut shown in chart 3. In both Maine and Texas the cost for physicians' services, usually for cases with chronic illnesses, was included in the budgets on an estimated basis. In Maine, somewhat more than one-fourth of the cases had 6–7 visits and another fourth had 10–14 visits in the 6-month period—an indication that amounts were included in assistance budgets to permit recipients to pay for either one or two visits a month. In Texas, the concentration of cases at the intervals of 3 visits and 6–7 visits suggests that one visit every 2 months was budgeted for almost one-fourth of the cases, and one visit a month for more than one-third. In individual cases the actual number of visits to a doctor may have been more or less than the estimated number budgeted.

Hospitalization

Assistance cases hospitalized.—In the 18 States for which such data are available, about 1 in 30 of the cases was hospitalized at some time in the 6 months studied.[9] Some cases had more than one spell of hospitalization. There was an extremely wide range among the 18 States in the proportions of assistance cases receiving hospitalization. In three States, more than 7 percent were hospitalized (chart 4). Under the very limited medical assistance programs in North Carolina and South Carolina, hospital costs were paid for only a few aged recipients. In the rest of the 18 States, the range was from less than 2 percent to 7 percent. Although only 2.2 percent of the cases in West Virginia were hospitalized, they represented more than a third of the number receiving any type of medical service.

In Maine, Michigan, and New Mexico, hospital costs were met for relatively few cases—2.0–2.4 percent. The amount provided in Maine was doubtless limited by the admittedly inadequate appropriations for the State's hospital-aid program, expenditures for which were included in this study. In Michigan a large share of the hospital expenses reported was met under the locally financed "afflicted-adult-hospitalization" program. In counties with low fiscal capacity, the State agency said, some persons who

[8] Margaret C. Klem, "Prepaid Medical Care at Trinity Hospital, Little Rock, Arkansas, 1941 and 1942," *Social Security Bulletin*, September 1949, page 10.

[9] In a very small proportion of the cases, a person essential to the recipient's well-being may have received hospital care.

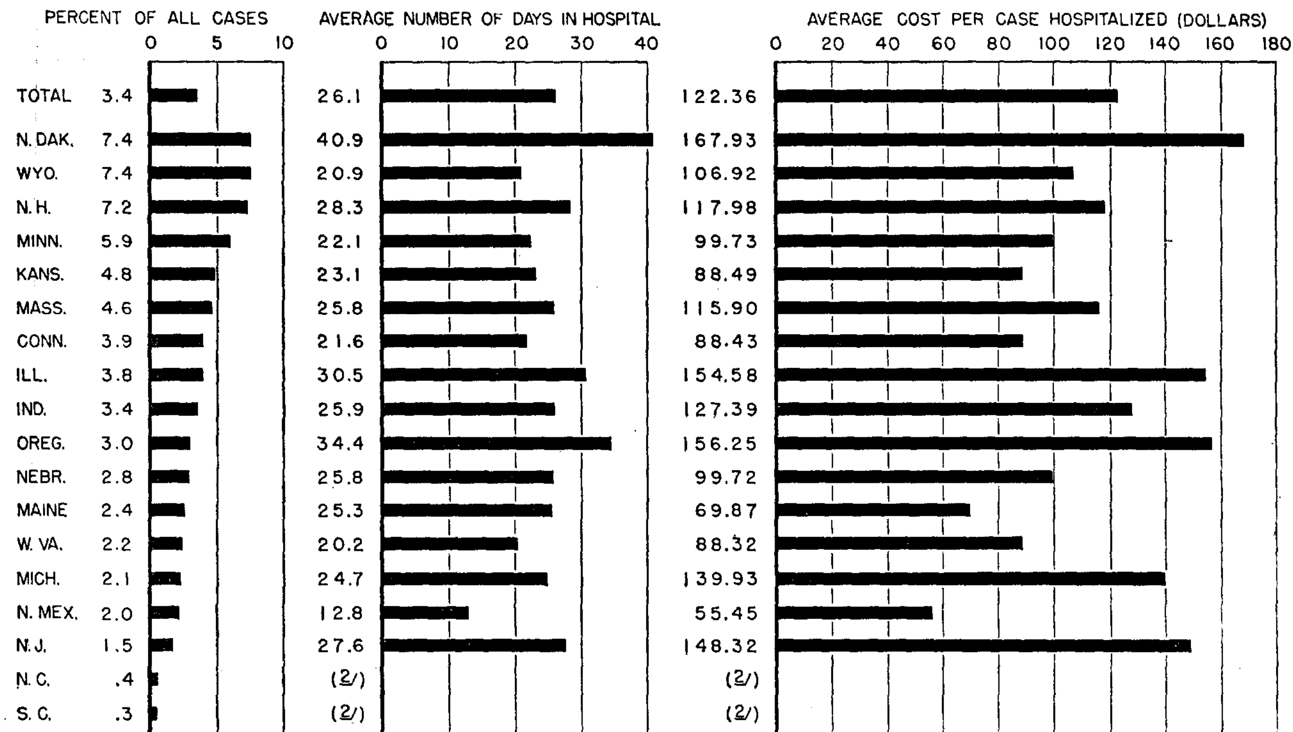


Chart 4.—*Percent of all old-age assistance cases receiving hospitalization,*[1] *average number of days in hospital, and average expenditure per case hospitalized, 18 States, during a 6-month period in 1946*

[1]Based on number of different cases receiving assistance during 6-month period (not average monthly number as in table 2).
[2]Not computed; base too small.

should have been hospitalized may have received home medical care only. In New Mexico, at least one county stated that restricted funds for medical care tended to limit the amount of service provided.

Among the other States there seem to have been no specific restrictions on service to account for the wide variation in the relative number of cases hospitalized during the period. Some States and local units required prior authorization for hospitalization but permitted immediate admittance to the hospital in emergency cases. Differences in policies or practices in this respect do not seem to have been primarily responsible for variations among the States in the amount of hospital care.

It was the usual practice in Minnesota and New Hampshire, for example, to require prior authorization for hospital care except in emergencies, but in Kansas, North Dakota, and Wyoming only a few local units customarily required such authorization.

Yet these five States ranked highest in the relative number of aged recipients hospitalized. In New Mexico and West Virginia the requirement of prior authorization probably helped the agencies to implement policies concerning the types of cases accepted and to keep expenditures within the funds available for medical assistance. In a number of States, including Connecticut, Illinois, Maine, Nebraska, and New Jersey, patients could be admitted to the hospital on the physician's recommendation without prior agency approval.[10] In some of these States, however, recipients were encouraged to discuss their medical requirements with the agency and, when needed, to request help in making arrangements for medical care.

Days in hospital.—A considerable degree of uniformity existed among the States in the average number of days in the hospital per case hospitalized (chart 4). In the 18 States combined, the average was 26 days. In most States the average was between 21 and 28 days. Oregon's hospital care averaged about 35 days; North Dakota's nearly 41. Only New Mexico had an average of less than 14.

Although the average for the 18 States combined was 26 days, three-fifths of the patients were hospitalized for less than 20 days, and probably for at least two-thirds of them the length of stay was less than 26 days (chart 5). In all States, data on the average number of days in the hospital were weighted by cases spending extremely long periods there —sometimes 100–180 days within the 6-month period. Approximately 1 out of 5 cases in North Dakota and Oregon and 1 in 7 cases in Illinois had 60 days or more of hospitalization. In the other nine States, fewer cases were hospitalized for long periods. In most States, about 20–30 percent of the cases were in the hospital less than 7 days.

[10]Connecticut required prior approval by the State medical director for care in chronic and convalescent hospitals.

Table 3.—*Percent of all old-age assistance cases receiving nursing-home and convalescent-home care, average cost per case and per month of care, and average number of months of care, by State, during a 6-month period in 1946*[1]

State[2]	Cases receiving nursing-home and convalescent-home care			
	Percent of all old-age assistance cases[3]	Average cost per case	Average number of months of care	Average cost per month
Total, 17 States[1]	2.5	$290.49	4.5	$64.72
Connecticut	10.4	525.76	4.5	117.85
New Hampshire	8.5	257.71	4.3	60.20
Massachusetts	5.7	339.03	4.9	69.72
Maine	3.9	306.05	5.0	61.35
New Jersey	3.7	341.22	4.4	76.75
Oregon	3.7	279.55	4.7	59.19
North Dakota	2.6	243.04	5.1	48.01
Michigan	2.4	321.54	3.8	84.28
Kansas	2.1	188.43	4.2	45.90
Texas	1.9	184.06	4.9	37.50
Minnesota	1.8	158.75	2.7	59.73
Illinois	1.6	228.24	4.4	51.99
Wyoming	[4] 1.5	(5)	(5)	(5)
Indiana	.8	257.66	3.9	66.78
New Mexico	.4	(5)	(5)	63.66
North Carolina	.1	(5)	(5)	(5)
South Carolina	.1	(5)	(5)	(5)

[1] Excludes Pennsylvania and West Virginia, which did not provide nursing- and convalescent-home care from assistance funds, and Nebraska, for which data are not available.
[2] Data for entire State or selected counties in State.
[3] Based on number of different cases receiving assistance during 6-month period.
[4] Data incomplete.
[5] Not computed; base too small.

Expenditures for hospitalization.—There is a striking similarity, among the 16 States for which these data can be computed, in the average amount paid per day in the hospital. In general, the average was about $4–5 a day; in Michigan it was $5.66, and in Maine, North Carolina, and South Carolina it was less than $3. In Maine, where the State appropriation for the hospital-aid program was not sufficient to pay the ward rates, the hospitals frequently attempted to collect from the recipient the difference between the payment from the hospital-aid fund and the actual ward rate. The agency could not, however, consider this unmet balance as a requirement in arriving at the amount of the money payment to the recipient. Both the North Carolina and South Carolina agencies recognized that the payments to hospitals were inadequate.

In most States and localities the amounts paid undoubtedly failed to cover the cost of the services furnished. At the time the study was made, hospitals throughout the country were finding it necessary to increase rates for private patients and were pressing for higher payments for services to recipients of assistance and other needy groups.

In spite of the low per diem rates in effect in 1946, hospital bills for aged recipients were sizable. During the 6-month period, payments were $100, or even more, per case receiving hospitalization in nine of the 16 States (chart 4). In North Dakota, with an unusually high average number of days of care (41 per case), the average cost per case was $168. In Illinois and Oregon, where both the average number of days in the hospital and the payments per diem were somewhat larger than those in most States, the bills averaged more than $150 per hospitalized case; the average in Michigan, which had a higher per diem rate, was $140.

Another and perhaps simpler measure of the amount of services supplied is obtained by considering total services in relation to the entire caseload. In the 18 States combined, assistance cases averaged nine-tenths of a day in the hospital during the 6 months, or 1.8 days per year (table 2). If data for North Carolina and South Carolina and for New Jersey are excluded from consideration, the median State among the remaining 15 States supplied, on an annual basis, 2 days of care per assistance case.[11]

Nursing-Home Care

The term nursing-home care is used here to include care in both nursing and convalescent homes. In some instances, homes that have been considered nursing homes might more appropriately have been classified as homes for domiciliary care. Moreover, the borderline between convalescent homes and hospitals may not have been drawn at the same point in all instances.

[11] North Carolina and South Carolina seldom used assistance funds to pay for hospitalization; in most localities in New Jersey, hospital costs are met from other than assistance funds.

Of the 20 States participating in the study, two—Pennsylvania and West Virginia—did not provide nursing-home care from assistance funds. Although Nebraska provided this type of care, the data were not reported. For the other 17 States, 1 assistance case in 40 received nursing-home care during the 6-month period (table 3). Connecticut's proportion was more than 1 in 10, and New Hampshire's was 1 in 12. At the other extreme, in North Carolina and in South Carolina only 1 recipient in 1,000 was reported as receiving such care.

For the most part, recipients in the nursing homes were receiving long-time care. For the 17 States, in the 6 months studied, the average stay was 4.5 months. North Dakota reported an average of 5.1 months; in Minnesota the average was only 2.7 months.

Table 4.—*Percent of all old-age assistance cases receiving drugs, percent receiving dental services, and average cost per case receiving each type of service, by State, during a 6-month period in 1946*

State[1]	Cases receiving drugs		Cases receiving dental services	
	Percent of all old-age assistance cases[2]	Average cost per case	Percent of all cases[2]	Average cost per case
Total	28.8	$15.92	1.4	$29.64
Connecticut	22.9	14.52	1.8	35.85
Illinois	33.8	7.56	1.4	22.50
Indiana	27.5	8.07	1.4	21.11
Kansas	34.9	14.03	1.5	14.51
Maine	[3] 65.8	[3] 17.41	.2	(4)
Massachusetts	28.0	13.33	1.7	22.42
Michigan	(5)	(5)	.2	(4)
Minnesota	24.5	11.05	2.3	29.22
Nebraska	18.6	10.75	1.5	37.82
New Hampshire	38.0	10.76	1.4	(4)
New Jersey	35.8	11.66	.7	(4)
New Mexico	12.9	16.77	1.3	49.46
North Carolina	[3] 7.6	[3] 26.00	.2	(4)
North Dakota	[6] 27.8	[6] 19.43	.9	(4)
Oregon	19.3	18.09	.8	(4)
Pennsylvania	15.9	5.79	1.4	(4)
South Carolina	13.8	35.85	(7)	(7)
Texas	42.5	22.76	2.1	35.84
West Virginia	.9	(4)	.1	(4)
Wyoming	21.6	11.36	1.2	(4)

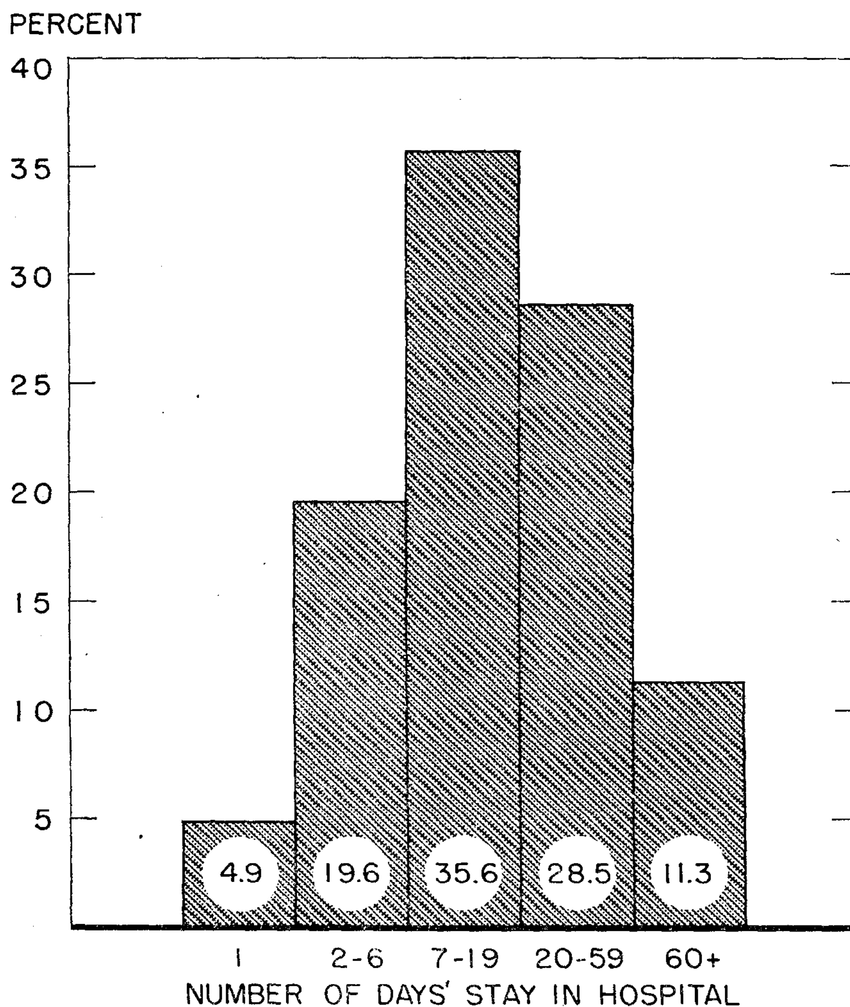
[1] Data for entire State or selected counties in State.
[2] Based on number of different cases receiving assistance during 6-month period.
[3] Excludes some cases receiving drugs supplied by physicians and cost of these drugs.
[4] Not computed; base too small.
[5] Data not available.
[6] Excludes routine monthly allowance of $1 for drugs and cases receiving only this service.
[7] Dental services not provided from assistance funds.

Nursing-home care, which includes maintenance costs as well as nursing and other medical services, is expensive even in homes that do not meet high standards. Unquestionably the homes in which recipients of old-age assistance were living ranged from those of acceptable quality as nursing-care institutions to homes that were poorly equipped and operated. For the 17 States the average monthly cost per case receiving nursing-home care was $65. In Connecticut the average cost was $118, and in Michigan it was $84. In only three States for which unit costs could be computed was the cost less than $50 a month—the maximum monthly payment in which the Federal Government can participate. Differences in monthly costs probably reflect differences in the types of services provided as well as in the quality of the services. Since 1946, costs of care in nursing homes have risen substantially.

The share of total expenditures for medical care going for nursing-home and convalescent-home care was relatively large, representing from 45 percent to 80 percent in five States—Connecticut, Massachusetts, New Hampshire, New Jersey, and Oregon. These States provide such care to relatively large proportions of cases.

The States reported that, although there is great need among aged recipients for nursing-home care, the high costs of the care put assistance agencies at a disadvantage in competing for the limited accommodations available.

Chart 5.—*Percent of all old-age assistance cases hospitalized, by number of days in hospital, 17 States,[1] during a 6-month period in 1946*



[1]Excludes Pennsylvania and Texas, which did not pay hospital costs from assistance funds, and Michigan, for which data are not available.

Drugs

Because of the extent of chronic illnesses among old persons, it is not surprising that a relatively large number of the cases receiving old-age assistance required drugs, frequently on a regular and continuing basis. These drugs were in addition to medicine chest supplies, which were frequently included in budgeting requirements. In most States the number of recipients for whom medicines were supplied and the number with physicians' visits were closely related. Usually more cases had physicians' services than had medicines, but in a few States the reverse was true.

In the 19 States for which such data are available, it is estimated that nearly 3 cases in 10 received medicines during the 6 months of the study (table 4). Maine included an amount for medicines in the budgets of two-thirds of the cases. Under policies in effect in this State in 1946, medicines were supplied either as prescribed by physicians or as requested by the recipient. The agency believed that there was widespread use of patent medicines, particularly in the more remote rural areas where there was a dearth of doctors. In Texas, 25 percent of the recipients had amounts budgeted for physicians' services, while the cost of drugs and medical supplies was included for 43 percent. Some items that usually were classified as medicine chest supplies may have been reported by Texas as medicines. In a number of States, the extent to which drugs were supplied may have been somewhat understated. In some instances, a single amount was included in the budget to meet the costs of physicians' services and medicines. Because this was the usual practice in Michigan, data for that State are excluded from table 4. The cost of medicines in Maine also is known to be understated because of this practice. To a lesser degree, data for other States may have also been

affected. Physicians undoubtedly administered or dispensed some medicines without making any separate charge for them.

The cost per case receiving drugs was in general higher in the States that included estimated amounts in the budgets of individual recipients to meet anticipated need for drugs. This procedure may account for the relatively high costs in Maine, Oregon, North Carolina, South Carolina, and Texas. An examination of county data for Maine, Oregon, and Texas indicates that medicines were supplied for relatively large numbers of recipients in all localities. In South Carolina the practice differed widely among the local agencies included in the sample. The data are heavily weighted by three counties that considered medicines a requirement for 26–41 percent of the recipients. In three other counties, medicines were considered a requirement for only 3 percent of the cases.

In Maine, medicines cost $2 per assistance case per month, and in Texas the cost was $1.70. In North Dakota, if the routine monthly allowance of $1 per case were included, the cost per assistance case would approach $2 a month, but the cost per case with a special drug allowance would, of course, be low. For the 19 States combined, the monthly cost was estimated at 77 cents per assistance case.

Dental Services

Policies or practices affecting the provision of dental services usually limited the types of care that could be provided or the conditions under which specified types of care could be supplied. In most States and localities, agency authorization was required, except in emergencies, before dental work was undertaken. Even in States that in general did not require prior authorization, certain services were subject to approval by the local or State agency, or by a physician, or, in a few instances, by an advisory committee.

In Illinois, for example, recipients could go directly to the dentist of their choice, but the need for dentures was subject to review by the county advisory committee except when, in the opinion of the caseworker, dentures were imperative for social or economic reasons. In Connecticut the recipient could go directly to the dentist but was required to discuss with the agency his need for nonemergency dental care before work was started and to obtain an estimate of the cost. Similar procedures were in effect in many of the States.

Even in States or localities with policies permitting a wide variety of dental services, relatively few recipients received this type of care. Limitations on funds and the expense of some dental procedures have doubtless led to close scrutiny of the need for this type of service. Some recipients may not have wanted as much dental service as they needed and could have received. Some localities did not have dentists, and in others there were undoubtedly too few dentists to meet community needs. In some places this scarcity may not have had much effect on the amount of services supplied to recipients; frequently communities poorly supplied with dental service are communities with low economic resources.

In the 19 States for which these data are available, 1.4 percent of the aged recipients had some dental care in the 6-month period (table 4). Monthly costs of dental services per case receiving assistance were 10 cents or more in five States and ranged from less than 1 cent to 7 cents in the other States.

Home-Nursing Service

Several localities reported that there were too few nurses—practical or registered—to meet community needs. The amount of service provided recipients in hospitals, nursing homes, or their own homes may therefore have represented less than was required even in States with sufficient funds to pay for such care. Assistance agencies participating in the study said that, because of the inadequate supply of nursing homes and the high fees, bedridden recipients in their own homes or in the homes of relatives frequently got inadequate care. They also said that more facilities in the nursing homes were needed for old men and women who were too infirm to get about in their own homes or to take care of their bodily needs and who could not get proper care at home.

The proportion of cases for which home-nursing services were provided was small in all States—about 1.0 percent of all assistance cases for the 18 States for which such data are available.

Other Services

Osteopathic services were supplied to some cases in 14 States. Three percent of the recipients in Maine and about 2 percent of those in Michigan and New Mexico had osteopathic treatment, and expenditures for this purpose represented approximately 4 percent of all medical expenditures, excluding those for nursing-home care. In other States, few recipients were served by osteopaths, and expenditures were correspondingly small. In 13 of the 20 States, some chiropractic services were made available to a relatively small number of recipients—usually from 0.1 to 0.3 percent of the caseload in the sample counties.

In Massachusetts and New Hampshire, approximately 5 percent of the recipients received eyeglasses during the 6-month period; in the other 16 States providing eyeglasses the proportions ranged from 0.1 to 3.6 percent. The number reported as receiving services of optometrists may be understated since a separate charge is not always made for this service. Charges for refractions or eye treatment by ophthalmologists or other medical doctors were included under physicians' services.

All States expended some funds to permit recipients to pay transportation costs to obtain medical services, but the expenditures for this purpose were small. In West Virginia, however, where medical services were provided largely to cases having emergency and acute illnesses, transportation costs amounted to 4.5 percent of total medical expenditures.