REPORT TO THE

GOVERNOR

STATE OF IOWA

GOVERNOR'S COMMISSION ON AGING

1961

1962

GOVERNOR'S

COMMISSION ON AGING

PREFACE

Following the legislative session of the 59th General Assembly which failed to enact specific legislation dealing with the problems of the aged citizen, Governor Norman A. Erbe created by executive order a "Governor's Commission on Aging". Former Governor Robert D. Blue was designated as Chairman of the Commission, and private citizens of Iowa with an interest in the problems of the aged were requested to serve on the Commission.

On Sept. 6, 1961 the initial meeting of the Commission was held in the State House, Des Moines, Iowa with fifty-four members present.

The members were assigned to five sub-committees, and charged with the responsibility of studying the problems confronting the aged and recommending action in the areas of: 1) Housing & Institutional Care; 2) Education of the Elderly and Public Information; 3) Recreation, Leisure Time, & Income Maintenance; 4) Health Care; and 5) Cost of Care & Keep.

Numerous Commission and Sub-Committee meetings were held during 1961 and '62 with the members giving generously of their time, knowledge, and experience. The following report is the summary of the recommendations of the Sub-Committees and, in turn, the recommendations of the Governor's Commission on Aging.

SUB-COMMITTEE ON HOUSING & INSTITUTIONAL CARE

Leonard Wolf, Chairman

F. W. Pickworth, Vice Chairman

Louis Blair
Edward J. Herron
Rev. Virgil Hougen
Dr. Noble Irving
Arthur T. Gormley
Francis Messerly

Mrs. Eleanor Carris
Dr. J. K. Johnson, Jr.
Frank Wahrman
Dr. T. C. Coleman
Sanford W. Griffith

RECOMMENDATIONS OF SUB-COMMITTEE

On

HOUSING AND INSTITUTIONAL CARE

1) That the legislature establish a permanent Commission on Aging patterned along the lines of the Oregon law.

2) That consideration be given by the legislature of methods which would make it possible for people to remain in their own homes as long as possible. It recommends the following for consideration:

   a) The establishment at the local level with some help at the state level, of home nursing programs, day care, home-maker service and food programs.

   b) Increased homestead and income tax exemptions, with some means tests attached.

3) That the County Home Law be revised and that the County Home be recognized as a health facility, caring for chronically ill and aged persons, which is what it has now become, rather than a work house for the unemployed as it primarily was at the time the present law was written.

   In this connection it desires to point out that a high percent of the persons now being discharged from State Hospitals are being cared for in nursing homes and county homes. That the figures for the number of persons discharged from State Mental Hospitals have tended to create a false image in the public mind so far as the aged senile are concerned.

   It also desires to point out that only one county home is licensed as a nursing home and only eight have custodial home licenses.

   It is also important to point out that if county homes would

raise their standards and become recognized health facilities, that residents of county homes over 65 are now eligible to receive old age assistance grants. This has not been true in the past.

4) That the Mental Health Authority making a study of "Mental Health in Iowa" be requested to place emphasis on the care of older persons released from State Mental Hospitals.

5) That the laws relating to other public institutions providing care for the aged should be carefully studied and revised in accord with current acceptable standards and practices.

6) That allowances for housing old age assistance recipients be increased to meet current costs and that sufficient funds be appropriated by the legislature to carry out this recommendation.

7) That the regulations of the State Welfare Department be revised so that aged persons requiring medical or nursing care may have the old age assistance grant supplemented by funds from charitable organizations or public groups, as provided for by Iowa law and as is done in many other states.

8) That sufficient funds be appropriated to the Department of Health to enable it to properly carry out its function of licensing and supervising facilities giving care to aged citizens.

9) That a State Building Code be adopted that would control the construction of substandard buildings and maintenance of both private and public building.

   Attention is particularly called to the fact that the Fire Marshal has made recommendations for many improvements and safety repairs at various state institutions that have not yet been made.

10) That all facilities, both public and private, giving care to two or more unrelated older citizens be required to be licensed by the State Health Department. This would include:

    a) All Hospitals

    b) All Nursing, Custodial, and Retirement Homes.

    c) All Board and Room Homes, including residence hotels.

    d) All Foster Homes, including half-way houses.

11) That a State Chronic Illness Evaluation Center be established and financed in Iowa, and that the Center be in the vicinity of University Hospitals and be made available to physicians throughout the state.

12) That in appointing committees to consider problems of older citizens in Iowa, that special consideration be given to persons who have knowledge and experience in this field.

13) THAT IN VIEW OF THE MULTITUDINOUS ORGANIZATIONS NOW AUTHORIZED BY FEDERAL, STATE AND LOCAL GOVERNMENTS TO BUILD HOUSING FOR CARE OF THE AGED, IT IS IMPERATIVE THAT A STATE-WIDE PROGRAM BE AUTHORIZED BY THE LEGISLATURE AND THE NECESSARY LEGAL MACHINERY NECESSARY TO MAKE IT EFFECTIVE, BE ENACTED. IN THE ABSENCE OF SUCH A PROGRAM, SOME AREAS WILL BE OVER-BUILT AND OTHERS WILL BE UNDER-BUILT, AND MILLIONS OF DOLLARS POURED INTO CONSTRUCTION OF ILL-CONSIDERED AND ILL-LOCATED PROJECTS.

CRITERIA FOR DETERMINING NEED

FOR NEW NURSING & CUSTODIAL HOMES

No new nursing or custodial home (congregate living) shall be constructed in a community unless the following criteria have been satisfied. Sponsors of proposed projects shall submit a written program stating the precise methods of meeting these criteria.

1) The community must have a minimum of one practicing doctor of medicine or doctor of osteopathy residing within the community and willing to accept calls from the institution.
2) The community must have a public water supply with sufficient capacity available at the institution site in order to provide safe and adequate fire protection of the lives of the residents, and the institution shall be served by either a full-time or volunteer fire department.
3) The community must have an ambulance service available and located within the community for the prompt transfer of patients or residents when their medical needs indicate a transfer necessary.
4) A proposed custodial home shall have a written administrative agreement with a nursing home or homes and a hospital or hospitals of comparable capacity, and a proposed nursing home shall have a written administrative agreement with a hospital or hospitals of comparable capacity, establishing a preferential admission priority for patients who must be transferred from the respective home for appropriate medical care.
5) The community must have active churches and active service

clubs which are available to the residents. If the community does not provide other appropriate social, recreational and educational facilities such as theatres, libraries, adult educational programs, hobbycraft programs, etc., the appropriate facilities and organized programs shall be provided within the home.

6) The need for new or additional facilities shall be determined in the following manner:

a) The normal service area of the community shall be established by dividing the distance between the community in which the facility is proposed and adjacent communities of comparable size or larger. The population within the area circumscribed by this bisector procedure shall constitute the normal population served by the facility.

Exceptions:

1) In urban communities of 10,000 population or more, the minimum service area may be the community and the immediate suburban population, but in no instance shall a community establish a service area with a radius greater than 20 miles.

2) Sponsors of institutions operating with an admission program restricted because of race, creed, color, religious or fraternal affiliation and serving an area greater than the service area defined by 6 a) above shall define the area to be served and justify the proposed capacity of the institution in serving the

social and moral responsibilities to their membership.

b) The normal service area population multiplied by the ratio 3 custodial beds/1,000 population and/or 3 nursing home beds/1,000 population shall determine the total number of beds needed for the respective types of facilities. An additional 2 nursing home beds/1,000 population may be constructed in nursing homes designed and staffed to provide care for the senile patient. The bed ratio shall be re-examined annually and increased 1% per year if needs indicate, beginning in 1963.

c) Licensed beds in buildings which meet the structural requirements of a new building within the area shall be deducted from the total bed need as determined by 6 b) above.

Exception: Hospital-connected skilled nursing home units designed and staffed to provide diagnosis and treatment of chronic illness shall not be included in the total of existing facilities evaluated under 6 c), and shall not be deducted from the total bed need as determined by 6 a) and b) above.

7. The minimum size of a new facility shall be 30 beds. If the service area population does not indicate a need of 30 beds, the proposed facility is counterindicated. Only the number of beds indicated by the determination in (6) above shall be constructed.

Exception:

a) It is possible and desirable to combine custodial home,

nursing home, and nursing facilities for the senile in a single appropriately designed institution. However, if the proposed capacity of the institution exceeds 120 beds, the sponsors of the institution shall give special justification of the proposed capacity.

b) There shall be no minimum size of an addition to an existing fire-resistant facility.

This criteria shall not apply to resident facilities designed to maintain independent living, such as multi-unit cottages, apartment hotels, residence clubs, and similar facilities.

GENERAL POLICIES

Each of the above requirements should be considered as minimal. The sponsor of any project which meets only the minimum requirement shall have a program whereby more adequate services than those listed in the various items above will be provided in the immediate years ahead.

In determining the adequacy of any requirement, those responsible for administering the above requirements shall be guided by existing facilities in the State, and shall keep in mind that it is appropriate to continually upgrade the facilities in the State for the care of the aged.

THE OREGON LAW ON STATE COUNCIL ON AGING

414.220 State Council on Aging created. There hereby is created a State Council on Aging. The members of the council shall be appointed by the Governor to represent the following groups, agencies or departments and shall be qualified as follows:

1) One member who is the State Health Officer or a member of his staff.

2) Two members representing the Department of Education: One, who is well versed in the recreational needs of the aging and one, who is well versed in vocational education.

3) One member who is the State Public Welfare Administrator or a member of his staff.

4) One member representing the Oregon State Employment Service.

5) One member representing one of the state hospitals for the mentally ill who is experienced in dealing with problems of the aging.

6) One member representing the Department of Higher Education who is qualified, because of his background and experience, to advise on extension and research and educational television.

7) One member representing the Oregon State Labor Council.

8) As many members of the general public who are sympathetic with the purposes of ORS 414.210 to 414.310 as the Governor deems necessary or proper to carry out the purposes of ORS 414.210 to 414.310.

414.230 Duties of Council. The council shall:

1) Investigate the problems of the aging people of this state.

2) Provide consulting service to local communities, including information on effective programs elsewhere in the state or nation for meeting the needs of the aging population.

3) Cooperate with, encourage and assist local agencies, both public and private, which are concerned with the problems of the aging people of this state.

4) Cooperate with officers and agencies of the United States and of this state in all matters affecting the problems of the aging people of this state.

5) Encourage the cooperation of private agencies in dealing with problems of the aging and offer assistance to private groups such as churches, unions and fraternal organizations in the fulfillment of their responsibility for the aging, within the spirit of ORS 414.210 to 414.310.

6) Make a report to the Governor biennially, before the third day of each January in which the Legislative Assembly regularly convenes,

concerning the work of the council for the preceding biennium. The report shall deal with the present and future needs of the aging people of this state with respect to employment, retirement, economic maintenance, housing and living arrangements, health, medical care and rehabilitation, education, recreation, personal adjustment, and such other matters as in its judgment are pertinent to the subject.

7) Make recommendations, in conjunction with its biennial report, for legislation dealing with the problems of the aging people of this state.

8) Recommend qualified citizens to the Governor for appointment to the council.

414.240 Terms and Expenses of Members.

1) Each member of the council shall serve at the pleasure of the Governor for a term of four years, except that of the members first appointed, the Governor shall appoint a portion of such members for terms of four years, a portion for terms of three years and a portion for terms of two years, so as to retain as many experienced members on the council at all times as is possible. Any vacancy shall be filled by appointment by the Governor for the unexpired term of the position.

2) The members of the council shall receive no compensation for their services as members but, subject to any other applicable law regulating mileage and traveling expenses for state officers, shall receive their actual and necessary traveling and other expenses incurred in the performance of their official functions. The expenses of members of the council who are state officers or employes other than by reason of their membership on the council shall be paid from the moneys appropriated to the agency or department which they represent or by which they are employed.

414.250 Meetings - Quorum - Chairman.

1) The council shall meet at least four times a year and as frequently as the proper and efficient discharge of its duties may require.

2) Seven members shall constitute a quorum for the transaction of business.

3) The council shall choose a chairman from its members who shall preside at its meetings.

414.260 Executive Secretary. The council may employ an executive secretary who shall:

1) Attend all meetings of the council.

2) Keep a record of the proceedings and transactions of the council.

3) Have custody of all books, papers, documents and other property

belonging to the council.

4) Be the administrative officer of the council.

414.270 Salary and Expenses of Executive Secretary. Unless otherwise provided in ORS 292.505 to 292.790, the council shall fix and determine the annual salary of the executive secretary. The executive secretary, subject to any other applicable law regulating mileage and traveling expenses for state officers, shall receive his actual and necessary traveling and other expenses incurred in the performance of his official functions.

414.280 Employment and Compensation of Other Employes.

1) Subject to the approval of the council, the executive secretary may:

a) Employ such other personnel as may be necessary to facilitate and assist in carrying out its functions; and

b) Fix and pay the compensation of such personnel.

2) The employment and compensation of such personnel shall be subject to any applicable provision of the State Civil Service Law.

414.290 Approval of Voucher Claims. The chairman of the council shall approve voucher claims for indebtedness or expenses incurred under the provisions of and payable from appropriations made for the purposes of ORS 414.210 to 414.310. The council may designate the executive secretary to approve voucher claims, provided that the indebtedness or expense has been theretofore authorized by the council. If the council so designates the executive secretary, it shall file with the Secretary of State a statement to that effect, together with a sample of his signature.

414.300 State Agencies to Cooperate With Council. All state agencies, boards, commissions and departments shall cooperate fully with the council in the performance of its duties.

414.310 Disposition of Moneys Received from Federal Government or Private Sources. The council may receive moneys from the Federal Government or from private sources, which moneys shall be deposited in the State Treasury to the credit of an account to be known as the "Council of Aging Account" and such moneys hereby are appropriated to the council for the purposes of ORS 414.210 to 414.310.

SUMMARY OF LONG TERM FACILITIES FOR THE AGED

FROM 1957 TO JULY 1, 1963

A. Construction Complete

86 Homes, incorporating 3,500 Nursing Beds and 1,137 Custodial Beds.

Total Beds - 4,637

B. Under Construction		Nursing Beds	Custodial Beds
1)	Wesley Acres, Heritage House, Atlantic	26	80
2)	Van Buren County Hospital Addn., Keosauqua	28	
3)	Western Home Addition, Cedar Falls	17	36
4)	Decorah Retirement Center, Decorah	82	
5)	Pioneer Memorial Home Addn., Orange City		20
6)	Shenk Nursing Home Addn., Wellman	20	
7)	Ramsey Memorial Home Addn., Des Moines	35	
8)	Fairfield Nursing Home, Fairfield	64	
9)	Twilight Acres, Wall Lake	50	
10)	Ballard Nursing Home, Ames	35	
11)	Cory Nursing Home, Morning Sun	50	
12)	Neighbors Nursing Home, Griswold	40	
13)	Bayard Nursing Home, Bayard	39	
14)	St. Monica's Nursing Home Remodeling, Sioux City	44	
15)	Newell Nursing Home, Newell	33	
16)	Peace Haven, Walnut		91
17)	Ossian Senior Hospice, Ossian	24	
18)	Greenwood Acres, Iowa City	52	

B. Under Construction (continued)	Nursing Beds	Custodial Beds
19) Lutheran Home for Aged Addition, Strawberry Point	19	___
Total - 19 Projects, 885 Beds	658	227

C. Projects Actively Planning. Plans Submitted to Department for Review.

1)	Southwest Iowa Senior Ctr, Council Bluffs	220	
2)	Oakview Home, Conrad	30	
3)	Elderhaven, Seymour	21	
4)	Glenhaven Home, Glenwood	80	
5)	Carest Nursing Home, Mason City	48	
6)	Glenn Custodial Home Addn., Minburn		16
7)	Crestview, Inc., West Branch	51	
8)	Residence for the Aged, Tipton		51
9)	Prairie View Home, Garner		96
10)	Greenwood Custodial Home, Jefferson		94
11)	Shea Nursing Home, Elkader	10	
12)	Clarinda Nursing Home, Clarinda	60	
13)	Long Nursing Home, Iowa Falls	40	
14)	Kater Nursing Home, Des Moines	30	
15)	American Geriatrics Foundation, Des Moines	64	
16)	Haywood Nursing Home Addn., Emmetsburg	20	
17)	Plair Custodial Home, Humboldt		19
18)	Webster City Nursing Home, Webster City	44	
19)	Northcrest Retirement Community, Ames	Approx. 100	
20)	Rock Valley Nursing Home, Rock Valley	41	

C. Projects Actively Planning - continued	Nursing Beds	Custodial Beds
21) Hutchison Nursing Home Addn., Des Moines	50	
22) Farlow Nursing Home, Winterset	48	
23) Van Wyngarden Nursing Home, Prairie City	39	
24) Home for the Aged, Davenport	100	
25) Concord Manor, Garner	20	
26) Denver Nursing Home, Denver	21	
27) Longview Nursing Home, Missouri Valley	55	
28) Cookson Memorial Home Addn., West Branch		14
29) Evangelical Free Church Home Addn., Boone	40	
30) The Custodian, Armstrong	39	
31) Coralville Nursing Home, Coralville approx.	100	
32) Americana Nursing Center, Des Moines	90	
33) Colonial Heights Home, Clear Lake	33	
34) Stofferan Nursing Home, Primghar	35	___
Total - 34 Projects, 1,819 Beds	1,529	290

D. Towns Where Interest Has Been Shown, But Plans Not Yet Drawn or Submitted to the Department.

1) Oakland
2) Council Bluffs
3) Red Oak
4) Clarinda
5) Spencer (2 projects)
6) Sac City
7) Rockwell City
8) Guthrie Center
9) Sioux City
10) Creston
11) Fort Dodge
12) Jefferson (2 projects)
13) Boone
14) Adel
15) Lamoni
16) Mason City

17) Iowa Falls
18) Ames
19) Ankeny
20) Des Moines (2 projects)
21) West Des Moines (2 projects)
22) Swea City
23) Hartley
24) Corydon
25) Leon
26) Waverly
27) Cedar Falls
28) Waterloo (2 projects)
29) Oskaloosa
30) Ottumwa
31) Elkader
32) Dubuque
33) Oelwein
34) Cedar Rapids (2 projects)
35) Iowa City (2 projects)
36) Davenport
37) Wapello
38) Story City
39) Ackley
40) Newton

FINANCING PROGRAMS

There are many governmental financing programs designed to assist private, non-profit, and governmental agencies in the construction of housing and health facilities for the aged. Briefly, these programs are as follows:

Governmental Agency	Eligible Facility	Eligible Applicant	Financial Assistance
Federal Housing Adm.	Housing for Elderly	N P A	100% Loan
Federal Housing Adm.	N.H. for Elderly	Private	90% Loan
Housing & Home Finance	Housing for Elderly (Urban)	N P A	100% Loan
Farmers Home Adm.	Housing for Elderly (Rural)	N P A	100% Loan
Small Business Adm.	Housing and/or Nursing Home	Private	75 - 90% Loan
USPHS Hill-Burton	Nursing Home	N P A -Gov.	33 1/3 Grant
Public Works Acceleration	N.H. and Housing	Gov.	50 - 75% Grant
County	N.H. in conjunction with Hsp.	Gov.	General Obligation Bond
County	County Home	Gov.	General Obligation Bond
City	N.H. in conjunction with Hsp.	Gov.	General Obligation Bond

With this financial stimulus, it is evident that virtually every community in the state could build one or more facilities for the care of the aged with the very real danger of overbuilding, building in improper locations, and building facilities which do not meet the needs of the population served. It is, therefore, recommended that the needs for the various types of care facilities for the aged be studied with a view toward the development of a state-wide plan of construction. (See Criterion of Need.)

CLASSIFICATION OF FACILITY		Other Name for Same Facility	Other Name for Same Facility	Acute Treatment Facilities	Diagnostic - X-ray - Lab	Special Therapies, PT OT RT	Organized Medical Staff	24 Hour Nursing Supervision	Part-Time Nursing Service	Unskilled Supervision	Food Service	Maid Service	Shelter	Janitorial Service	
Nursing	ACUTE GENERAL HOSPITAL			X	X	(X)	X	X			X	X	X	X	
	CHRONIC DISEASE HOSPITAL				X	X	X	X			X	X	X	X	
	SKILLED NURSING HOME				X	X	X	X			X	X	X	X	
	INFIRMARY (SHORT TERM)							X	X		X	X	X	X	
	INFIRMARY (LONG TERM)								X		X	X	X	X	
	NURSING HOME								X		X	X	X	X	
Custodial	CUSTODIAL HOME									X	X	X	X	X	
	DOMICILIARY HOME										X	X	X	X	
Residence	RESIDENTIAL UNIT											X	X	X	
	INDEPENDENT LIVING												X	X	

IN-PATIENT FACILITIES FOR CHRONIC MEDICAL AND AGED

SUB-COMMITTEE ON EDUCATION OF ELDERLY AND PUBLIC EDUCATION

Mabel I. Edwards, Chairman

Ernestine Grafton, Vice Chairman

Walt Conway
Arthur T. Gormley
Ralph Shannon
Arthur Secor
Robert Sweany

Mrs. Mary Perkins Jones
Mrs. Walter Meads
A. P. Rankin
David Herrick
Mrs. Martin VanOosterhout

RECOMMENDATIONS OF SUB-COMMITTEE

On

EDUCATION OF ELDERLY AND PUBLIC EDUCATION

1) The creation by statute of a permanent Commission on Aging, following in general the Oregon pattern.

2) Recommends a program of driver education and in some cases, limitations for the elderly driver. The number of fatal accidents involving drivers over 70 is greater than that of teenagers.

Age Group	Number of Drivers Involved per 100,000,000 Miles
16 - 19	12.73
20 - 24	7.12
25 - 29	4.53
30 - 34	3.59
35 - 39	4.26
40 - 44	2.89
45 - 49	4.42
50 - 54	4.33
55 - 59	3.69
60 - 64	6.73

Age Group	Number of Drivers Involved per 100,000,000 Miles
65 - 69	6.86
70 - 74	14.46
75 and over	22.15

3) Recommends the adoption by all cities of an ordinance licensing door-to-door salesmen to protect the elderly from the unethical or fraudulent salesmen who mulct large sums, often life savings, by many schemes including such items as furnace repairs, roofing, house siding, water proofing, storm windows, tree surgery, pictures, magazines, insurance, fire extinguishers, etc.

4) Recommends a program of safety education for the elderly in connection with such hazards as stairways, fires, smoking in bed or overstuffed furniture, driving cars, shutting off gas stoves, use of throw rugs, etc.; and a health education program especially concerned with problems connected with aging.

5) That senior citizens be better informed by publicity, of adult education courses and extension courses offered at both the local and state levels.

SUB-COMMITTEE ON RECREATION

Rabbi Irving Weingart, Chairman — William Poorman, Vice Chairman

Jerry Corbett
Clarence Daily
Mrs. John Safly
Benjamin Shore
William Dreier
Marguerite Cothorn
Rev. Royal J. Montgomery
Lee Sanders
Mrs. Mary Perkins Jones

RECOMMENDATIONS OF SUB-COMMITTEE

On

RECREATION

1) The Committee finds that one of the biggest problems of aging is loneliness. That many Iowa communities are lacking in recreational programs for the aging. That the rural characteristics of Iowa create problems of financing, planning and coordinating such a program without aid.

2) The Committee recommends that a State Recreation Service be created.

3) Senior citizens should have opportunity to plan their own programs.

4) Each county should appoint a recreation committee.

5) Leadership training sessions should be held for senior citizens to provide effective leadership for their programs.

6) All "Homes for the Aged" should provide recreational facilities.

7) Communities should develop recreational programs for home-bound persons.

REPORT TO THE COMMITTEE ON HEALTH CARE

of the

GOVERNOR'S COMMISSION ON AGING

The cost of care for the aged in Iowa State Mental Institutes can be determined only on the basis of the number in these Institutes and the average cost per day.

The cost for care for those persons over 65 in Mental Health Institutes is as indicated below for the respective years:

Year	# of persons over 65	Total Cost	Per Cent
1960	1209	$1,639,490	$2,183.20
1961	987	2,671,957	2,707.15
1962	908	2,606,729	2,870.85

The accurate cost relative to county home inmate is not available for persons over 65 because the breakdown by age is not done except on mentally ill persons. The only figures available at this time from county homes are for 1959 and 1960.

Year	Total	Total Mental	Mental Over 65	Total Expense
1959	4251	2366	965	$4,380,174.52
1960	4378	2482	946	4,710,649.74
1961		2514	918	N A *
1962		2580	886	N A *

* N A - Not Available

A survey is in progress at the present to determine the number of mental ill in nursing homes who have been at a State Mental Health Institute.

The two enclosures are relative to discharged patients and to the setting to which they return:

#1 is a report of disposition of patients analyzed by over 65 and under 65 from Mr. Taylor, our statistician, to Mr. Henry, Member, Board of Control.

#2 is a report called Disposition of Discharged Patients and shows where the patients were released to by number and by percentage.

James N. Gillman, Consultant
Community and Hospital Administration
Board of Control of State Institutions

JNG:ms

SUB-COMMITTEE ON HEALTH CARE

Dr. Carroll Larson, Chairman	Morris Kahn, Vice Chairman
Dr. Charles H. Henshaw	Dr. E. G. Zimmerer
Dr. William Morrissey	Dr. Jason Lipkind
Dr. Holcomb Jordan	Mary Louise Smith
Leo Sanders	Arlo Myers
C. D. Myers	C. D. Daily
Dr. Walter Gower	Merrill Hunt

RECOMMENDATIONS OF SUB-COMMITTEE ON HEALTH CARE

1) Creation by Statute of a permanent Commission on Aging, following in general, the Oregon pattern.

2) Appropriation by the legislature of sufficient funds to make the Kerr-Mills Law operative in Iowa.

3) Establishment of a Joint Study Commission to review and recommend changes in Iowa health laws. Many laws are not up to date and the Health Department is often unable to assist in developing local and area health services under present laws.

4) It is recommended that the status of the County Homes be studied and steps taken to bring their standards up to those of licensed nursing homes, hospitals or custodial homes. A change in Federal Regulations now makes it possible for aged persons residing in County Homes to receive old age assistance if the homes meet certain standards.

5) Consideration should be given to the possibility of retarding the mental and physical deterioration of the aged by community and institutional action developed by volunteer groups at the local and state level.

6) Job retirement ought not be based upon age alone. Greater effort should be made to integrate older persons into both the social and economic life of the community. That the existing restrictions which penalize individual earnings of the elderly, both with regard to old age assistance payments and social security payments, should be reviewed.

TO: Mr. Jim Henry

FROM: Mr. Ray Taylor, Statistician

SUBJECT: RELEASE OF MENTAL HEALTH PATIENTS

An analysis has been performed of all the patients released from the four Mental Health Hospitals under the Board of Control. This analysis consisted of a break-down of where the patients were released to at the time of discharge and was divided into two groups; namely, 1) those of 65 years of age and older, and 2) those under 65 years of age. The time period for this analysis was the following three periods.

1) July 1, 1959 to June 30, 1960
2) July 1, 1960 to June 30, 1961
3) July 1, 1961 to February 28, 1962

The following table is a break-down of releases of the age group for 65 years and older. The percentages are based on the total releases for each period.

	Periods Ending					
	6-30-60		6-30-61		2-28-62	
Released To	Number	Per Cent	Number	Per Cent	Number	Per Cent
Community Setting	283	52.9	213	39.0	137	41.3
County Home	87	16.3	87	15.9	42	12.6
Nursing Home	135	25.2	228	41.8	143	43.1
Vets. Admin.	22	4.1	11	2.0	8	2.4
Other Institution	8	1.5	7	1.3	2	0.6
Total	535		546		332	

The following table is for the age group under 65 years.

	Periods Ending					
	6-30-60		6-30-61		2-28-62	
Released To	No.	Per Cent	No.	Per Cent	No.	Per Cent
Community Setting	2034	79.5	2117	80.1	1406	79.8
County Home	330	12.9	281	10.6	189	10.7
Nursing Home	53	2.1	162	6.1	93	5.3
Vets. Admin.	79	3.0	47	1.8	30	1.7
Other Institution	64	2.5	36	1.4	44	2.5
Total	2560		2643		1762	

Combining the Two Tables would produce the following table on all patients released:

	Periods Ending					
	6-30-60		6-30-61		2-28-62	
Released To	No.	Per Cent	No.	Per Cent	No.	Per Cent
Community Setting	2317	74.9	2330	73.1	1543	73.7
County Home	417	13.5	368	11.5	231	11.0
Nursing Home	188	6.1	390	12.2	236	11.3
Vets. Admin.	101	3.3	58	1.8	38	1.8
Other Institution	72	2.2	43	1.4	46	2.2
Total	3095		3189		2094	

SUB-COMMITTEE ON COST OF CARE AND KEEP

Dr. Woodrow Morris, Chairman

Rev. Clarence W. Tompkins, Vice Chairman

Phil Irwin
Ralph J. Quackenbush
Dr. Homer E. Wichern
Robert Day
Lawrence Putney
Al Mensing
Dr. J. O. Cromwell

Dr. Earl C. Lowry
Dr. J. K. Johnson, Jr.
Paul Walter
Marshall C. Jewell
H. W. Saunders
Mrs. Lloyd Davis

RECOMMENDATIONS OF SUB-COMMITTEE on COST OF CARE OF THE AGING

1) That the legislature pass a bill creating a permanent Commission on Aging, following in general the Oregon law. Approximately 23 states now have such commissions.

2) That the legislature appropriate funds to make the Kerr-Mills Law effective in Iowa.

3) That a careful study be made of the adequacy of the old age assistance payments for care of indigent persons.

4) That a continuing study be made upon the effect of inflation upon the adequacy of the care given in the custodial and nursing homes.

5) That the State Social Welfare Department revise its rules which conflict with state law, in order to permit supplementation of old age assistance grants where medical or nursing care is required by the recipient.

6) Because of the fact that a very large number of people are involved as well as very large sums of money, the Committee recommends that a thorough study of the cost of the care of the aged be authorized by the Iowa Legislature.

7) The Committee especially calls attention to the wide range of the cost of care among the different institutions studied, but cautions that the quality of the care may be quite different, and suggests that a system of rating the kind of care be worked out by the Health Department and that old age assistance grants be based, in part at least, on the quality of care furnished.

REPORT OF COMMITTEE ON COST OF CARE OF THE AGED

Upon the organization of the present Commission on Aging for the State of Iowa, the Committee on Cost of Care of the Aged was given the following charge:

"The cost of care is one of the most important, most neglected and most controversial subject matters connected with the problems of the aging. The controversy over including medical care cost in the Social Security Program as opposed to the program set forth by the Kerr-Mills Bill involves not only the hotly debated question of socialized medicine, but also the less publicized question of who bears the cost.

"At the state level there are a number of agencies dealing with the caring for the aged and no study has been made to compare either the cost or the type of care provided by different agencies of government.

"While it will probably be impossible for this committee to completely explore this field, it can make a good start in studying care costs which should be helpful in not only informing the legislators of the problems involved, but would clarify the actions and policies of various governmental organizations working in this field."

In the first meeting of the Committee, it was decided to approach this charge by having various members of the Committee assume responsibility for providing information as follows:

1) A study of the cost of care of the aged in different state mental health institutes in Iowa, responsibility for which was assumed

REPORT OF COMMITTEE ON COST OF CARE OF THE AGED

by Dr. James Cromwell.

2) A comparative study of the cost of care in state and county operated homes, responsibility for which was assumed by Dr. James Cromwell.

3) The cost of the care of the aged in regular medical hospitals throughout the state, responsibility for which was assumed by Dr. Earl Lowry.

4) A study of the cost of care of the aged in University Hospitals, responsibility for which was assumed by Dr. W. W. Morris.

5) A study of the cost of care of aged persons in proprietary nursing homes in Iowa, responsibility for which was assumed by Mr. Ralph Quackenbush.

6) A study of the cost of care of the aged in non-profit nursing and retirement homes, responsibility for which was assumed by Reverend Clarence Tompkins.

7) A study of cost of care of the aged in home care programs.

This report will include the information provided from the above in the order outlined.

SECTION I: COST OF CARE OF THE AGED IN STATE MENTAL HEALTH INSTITUTES

The statistics available at the present time on the cost of custodial care at the Mental Health Institutes show it to be $6 - $7.50 per patient per day, varying according to the institution.

As of June 30, the average cost per month per patient in our 6 institutions (4 mental health institutes and 2 schools for the retarded) is $209.19.

The average cost per month per patient in the Iowa Soldiers' Home in Marshalltown is $216.00.

SECTION II: COST OF CARE IN STATE AND COUNTY OPERATED HOMES

From a report entitled "The Iowa County Home" prepared by Walter A. London, Iowa State University, it appears that the average age of all patients is 59.4 years. For those who were admitted to county homes as paupers, the average age is 63.1. Of the total number 31.2% (1,061) were over 65 years of age.

"In order to arrive at some estimate of the cost of maintaining patients, each of the officials in the respective county homes was asked two questions:

"1) How much does it cost to keep one person one year in the county home as reported to the state auditor?

"2) What was the actual cost to keep one person for one year, including cash expended, value of produce consumed, gifts, clothing, etc.?

"Of the 85 homes, 38 reported costs which were useable for analysis. The average reported cost (1) amounted to $519.00 whereas the

actual cost (2) amounted to $827.00 or almost 60 per cent more than the reported cost.

"In the state auditor's report for 1959 the weekly cost per patient in the 84 counties ranged from as low as 37 cents to $25.95. By using the average for the 84 county homes based on 52 weeks, the average annual cost came to $528.32 which is near the reported cost but still much less than the actual cost. In spite of the general estimates in these figures, both the reported and the actual amounts do give an overall idea of cost per patient.

"The table shows the average reported and actual costs are classified by rural and urban counties for the 7 rural counties and the 5 urban counties. The actual costs in the two groups of counties showed very little difference - rural, $767.00 and $768.00 for urban counties."

TABLE *

COMPARISON OF REPORTED COST AND ACTUAL COST OF KEEPING ONE PERSON ONE YEAR IN 38 COUNTY HOMES IN IOWA -- 1961

County Group	Reported Average for Counties	Actual Average per County
Rural (7)	$424	$767
Small Town (11)	575	867
Large Town (10)	504	838
Small City (5)	460	860
Large City (5)	615	768
Total (38)	519	827

It would appear that the important figures in the above would be those pertaining to actual cost per patient since this represents the amount actually spent.

* Taken from Walter A. London's report "The Iowa County Home".

SECTION III: THE COST OF THE CARE OF THE AGED IN REGULAR MEDICAL HOSPITALS THROUGHOUT THE STATE.

The data in this report is furnished from the files of Blue Cross, Hospital Service, Inc. of Iowa. Four tables are included: Table I covers all classifications of enrollment (in-patients only); Table II covers similar data for group contracts; Table III covers similar data for individual contracts, and Table IV covers data for group conversion contracts.

From the tables two things are apparent. First, that the charge per case increases with age from a minimum of about $123 for patients under the age of 21; to approximately $195 for patients in the age group 21 to 44; to approximately $270 for patients in the age range 45 to 64; to approximately $320 for patients over the age of 64 (Table I - 1961 data). Second, while there is relatively little variable in the charge per day, the average length of stay increases with age as follows: Less than 5 days for patients under age 21; to approximately 6 days for those in the age range 21 through 44; to about 9 days for those in the age range 45 to 64; to about 12 days for those who are 65 or over (Table I - 1961 data).

It should be noted that the charge per case indicated above and in the tables is the amount paid by Blue Cross for a semi-private room with all extras. It does not include the physician's charges which generally stand in the ratio of 8:5 hospital:physician charges respectively.

Additional information was supplied to the committee from data from a survey of two Cedar Rapids hospitals. This study was concerned with financial aspects of health care for aged in a dissertation by Mr. Larry Pugh. A summary of the findings follows:

BLUE CROSS Hospital Service, Incorporated, of Iowa - Des Moines

TABLE I

1960 - 1961
UTILIZATION DATA BY AGE OF PATIENT
FOR ALL CLASSIFICATIONS OF ENROLLMENT
IN-PATIENTS ONLY

	1960						1961					
	Total Cases	% of Total Cases	% of Total Charge	Charge Per Case	Charge Per Day	Average Length Stay	Total Cases	% of Total Cases	% of Total Charge	Charge Per Case	Charge Per Day	Average Length Stay
Under 21	28,777	27.15	16.31	114.59	24.42	4.69	27,534	26.45	15.87	123.40	25.92	4.76
21 - 25	9,070	8.56	6.74	150.24	30.03	5.00	10,459	10.04	7.77	159.04	32.33	4.92
26 - 30	8,516	8.03	6.69	158.72	30.12	5.27	8,651	8.31	6.93	171.55	32.39	5.30
31 - 35	7,462	7.04	6.43	174.08	29.38	5.93	5,798	5.57	5.27	194.47	30.90	6.29
36 - 40	6,928	6.53	6.64	193.70	28.84	6.72	5,959	5.72	5.86	210.43	30.99	6.79
41 - 45	6,216	5.86	6.35	206.65	28.65	7.21	5,920	5.69	6.34	229.43	30.40	7.55
46 - 50	6,403	6.04	7.24	228.58	28.09	8.14	6,633	6.57	7.34	236.87	29.62	8.00
51 - 55	6,391	6.03	7.57	239.41	27.97	8.56	6,338	6.09	7.71	260.48	29.71	8.77
56 - 60	6,613	6.24	8.35	255.16	26.87	9.50	6,397	6.14	8.22	275.23	28.91	9.52
61 - 65	6,344	5.98	8.47	270.00	26.72	10.11	6,321	6.07	8.49	287.72	28.55	10.08
66 - 70	5,769	5.44	8.05	282.02	26.24	10.75	5,779	5.55	8.01	296.65	28.12	10.55
71 - 75	3,962	3.74	5.79	295.33	25.05	11.79	4,300	4.13	6.22	309.84	27.30	11.35
76 - 80	2,341	2.21	3.51	302.83	24.54	12.34	2,498	2.40	3.77	323.17	25.87	12.49
81 - 85	877	.83	1.33	305.93	23.32	13.12	1,116	1.07	1.56	300.33	25.19	11.92
86 - 90	267	.25	.41	309.96	21.26	14.58	341	.33	.51	320.13	24.39	13.12
91 - 95	76	.07	.12	313.61	21.45	14.62	76	.07	.12	336.03	22.92	14.66
96 - 100	3	--	---	209.11	23.23	9.00	5	--	.01	458.10	40.18	11.40
TOTAL	106,015	100.00	100.00	190.65	27.00	7.06	104,125	100.00	100.00	205.64	28.81	7.19

BLUE CROSS Hospital Service, Incorporated, of Iowa

TABLE II

1960 - 1961
UTILIZATION DATA BY AGE OF PATIENT GROUP
IN-PATIENTS ONLY

	1960						1961					
	Total Cases	% of Total Cases	% of Total Charge	Charge Per Case	Charge Per Day	Average Length Stay	Total Cases	% of Total Cases	% of Total Charge	Charge Per Case	Charge Per Day	Average Length Stay
Under 21	18,646	29.77	18.58	115.60	24.20	4.78	17,854	29.45	18.38	125.17	25.80	4.85
21 - 25	6,201	9.90	8.02	149.89	30.36	4.94	6,718	11.08	8.94	161.95	32.81	4.94
26 - 30	5,738	9.16	8.00	161.76	30.32	5.33	6,392	10.55	9.06	172.48	32.80	5.26
31 - 35	4,887	7.81	7.59	179.99	29.85	6.03	3,707	6.12	6.11	200.65	31.29	6.41
36 - 40	4,536	7.24	7.75	198.12	29.30	6.76	3,913	6.46	7.07	219.94	31.29	7.03
41 - 45	4,080	6.52	7.35	208.78	28.68	7.28	3,832	6.32	7.44	236.12	30.60	7.72
56 - 50	4,171	6.66	8.40	233.47	28.45	8.21	4,227	6.97	8.43	242.60	29.72	8.16
51 - 55	3,957	6.32	8.33	244.08	27.95	8.73	3,912	6.45	8.57	266.74	29.96	8.90
56 - 60	3,800	6.07	8.52	259.86	27.11	9.59	3,533	5.83	8.26	284.60	29.50	9.65
61 - 65	2,897	4.63	7.02	280.85	27.27	10.30	2,956	4.88	7.32	301.45	29.13	10.35
66 - 70	1,877	3.00	4.91	303.41	27.84	10.90	1,718	2.83	4.74	335.75	29.01	11.57
71 - 75	995	1.59	2.98	347.23	25.10	13.83	1,052	1.72	3.18	368.37	28.53	12.91
76 - 80	526	.84	1.58	348.66	26.48	13.17	507	.84	1.62	387.80	26.56	14.60
81 - 85	212	.34	.67	367.62	24.36	15.09	219	.36	.62	347.22	25.79	13.47
86 - 90	67	.11	.23	406.66	20.83	19.52	56	.09	.21	456.93	23.56	19.39
91 - 95	23	.04	.07	345.03	21.98	15.90	17	.03	.05	375.22	29.95	12.53
96 - 100	--	--	--	--	--	--	--	--	--	--	--	--
TOTAL	62,613	100.00	100.00	185.19	27.53	6.72	60,613	100.00	100.00	200.77	29.44	6.82

BLUE CROSS Hospital Service, Incorporated, of Iowa

TABLE III

1960 - 1961
UTILIZATION DATA BY AGE OF PATIENT
INDIVIDUAL
IN-PATIENTS ONLY

	1960						1961					
	Total Cases	% of Total Cases	% of Total Charge	Charge Per Case	Charge Per Day	Average Length Stay	Total Cases	% of Total Cases	% of Total Charge	Charge Per Case	Charge Per Day	Average Length Stay
Under 21	8,857	26.50	15.67	110.97	24.68	4.50	8,514	25.16	14.80	118.74	25.91	4.58
21 - 25	2,368	7.09	5.56	147.24	28.73	5.12	3,260	9.64	7.16	149.95	31.21	4.80
26 - 30	2,367	7.08	5.59	148.21	29.40	5.04	1,877	5.55	4.49	163.37	30.60	5.34
31 - 35	2,175	6.51	5.51	159.08	28.28	5.62	1,772	5.24	4.73	182.03	29.91	6.09
36 - 40	1,962	5.87	5.63	180.14	27.97	6.44	1,734	5.13	4.76	187.44	30.12	6.22
41 - 45	1,804	5.40	5.63	195.90	28.29	6.92	1,730	5.11	5.37	212.06	29.93	7.08
46 - 50	1,774	5.31	6.07	214.80	27.15	7.91	1,979	5.85	6.46	222.84	29.24	7.62
51 - 55	1,878	5.62	6.74	225.12	27.77	8.11	1,935	5.72	6.94	244.70	29.26	8.36
56 - 60	2,167	6.48	8.39	242.91	26.13	9.30	2,158	6.38	8.29	262.11	28.06	9.34
61 - 65	2,453	7.34	10.28	262.90	26.21	10.03	2,493	7.37	9.88	270.61	27.63	9.79
66 - 70	2,481	7.42	10.73	271.43	25.12	10.80	2,640	7.80	10.65	275.31	27.41	10.04
71 - 75	1,667	4.99	7.50	282.48	24.49	11.54	1,898	5.61	8.21	295.19	26.71	11.05
76 - 80	948	2.84	4.45	294.33	23.50	12.52	1,134	3.35	5.13	308.70	24.86	12.42
81 - 85	351	1.05	1.54	276.13	22.44	12.31	493	1.46	2.11	292.01	24.56	11.89
86 - 90	126	.38	.54	268.14	19.85	13.51	169	.50	.80	321.61	24.30	13.24
91 - 95	37	.11	.16	273.47	20.73	13.19	42	.12	.19	315.06	20.37	15.50
96 - 100	2	.01	.01	269.89	26.99	10.00	3	.01	.03	593.33	43.41	13.67
TOTAL	33,417	100.00	100.00	187.78	26.18	7.17	33,831	100.00	100.00	201.77	27.89	7.23

BLUE CROSS HOSPITAL SERVICE, INCORPORATED, OF IOWA - DES MOINES

TABLE IV

1960 - 1961
UTILIZATION DATA BY AGE OF PATIENT
GROUP CONVERSION
IN-PATIENTS ONLY

	1960						1961					
	Total Cases	% of Total Cases	% of Total Charge	Charge Per Case	Charge Per Day	Average Length Stay	Total Cases	% of Total Cases	% of Total Charge	Charge Per Case	Charge Per Day	Average Length Stay
Under 21	1,274	12.76	6.79	124.89	25.86	4.83	1,166	12.04	6.29	130.42	27.88	4.68
21 - 25	581	5.02	3.61	168.70	32.04	5.27	481	4.97	3.58	179.97	32.99	5.46
26 - 30	411	4.12	3.10	176.85	31.13	5.68	382	3.95	3.10	196.11	34.27	5.72
31 - 35	488	4.01	3.13	183.40	29.24	6.27	319	3.30	2.53	191.63	31.61	6.06
36 - 40	430	4.31	3.83	208.87	27.84	7.50	312	3.22	2.82	218.68	31.51	6.95
41 - 45	332	3.32	3.39	238.96	29.99	7.97	358	3.70	3.58	241.70	30.34	7.97
46 - 50	458	4.59	4.64	237.42	28.24	8.41	427	4.41	4.33	245.18	30.27	8.10
51 - 55	556	5.57	6.04	254.41	28.69	8.87	491	5.07	5.54	272.81	29.45	9.27
56 - 60	646	6.47	7.41	268.60	27.85	9.65	706	7.29	7.84	268.48	28.45	9.44
61 - 65	994	9.95	10.86	255.87	26.31	9.73	872	9.01	10.47	290.11	29.07	9.98
66 - 70	1,411	14.13	16.41	272.19	26.05	35.87	1,421	14.68	17.00	289.02	28.20	10.25
71 - 75	1,300	13.02	15.10	272.07	25.80	10.55	1,350	13.94	15.91	284.83	27.01	10.54
76 - 80	867	8.68	10.52	284.26	24.44	11.63	857	8.85	10.78	304.08	26.81	11.34
81 - 85	314	3.14	3.99	297.38	23.45	12.69	404	4.17	4.76	285.06	25.61	11.13
86 - 90	74	.74	.93	293.62	24.64	11.92	116	1.20	1.21	251.95	25.37	9.93
91 - 95	16	.16	.25	361.25	22.06	16.38	17	.18	.24	347.16	23.61	14.61
96 - 100	1	.01	--	87.55	12.51	7.00	2	.02	.02	255.25	31.91	8.00
TOTAL	9,985	100.00	100.00	234.57	26.66	8.80	9,081	100.00	100.00	249.65	28.43	8.78

THE TWO HOSPITALS ARE DESIGNATED AS HOSPITAL "Y" & HOSPITAL "Z"

1) In Hospital Y the aged comprised 12.07% of total admissions during calendar year 1959; in Hospital Z, aged admissions were 11.85% of total admissions.

2) In Hospital Y, male and female admissions were approximately equal (50%); in Hospital Z, female admissions were much higher than male admissions (65.3% and 34.7% respectively).

3) In general, female admissions of the entire age range exceed male admissions.

4) In general, the aged patients at both hospitals used more hospital services (laboratory, drugs, surgery, X-ray, blood, etc.) than younger patients. In this regard also the aged male used all services, except surgery and X-ray, more often than the aged female. The only medical service used to a greater extent by the younger patients (below age 65) was surgery.

5) Costs of medical services were higher for aged males than females in all respects except, again, surgery and X-ray. Since the cost to aged patients was greater, it is obvious that their utilization of these services is also greater. This may correspond to the fact that their need for these services was greater on the average than the younger patients.

6) The median length of stay for patients aged 64 or less was around 5 days while the median length of stay for older patients was about 7 days. A greater percentage of the aged patients stayed 10 days or more. At both hospitals, almost 85% of the patients in the younger age group stayed 9 days or less but only 60% of the aged stayed so short a time. One per cent of the younger patients stayed 30 days or more as compared with 11.6% of the aged in hospital Z and 4.9% of the aged at hospital Y.

"Average" length of stay of patients was: (a) age 64 or less -- 6.44 days at both hospitals, and (b) age 65 or more -- 13.13 days in hospital Z and 11.45 days in hospital Y.

7) The aged patient's total bill was much greater than the younger patient's bill. At hospital Z, the average bill of the patient aged 64 or less was $188, and the average total bill of the aged patient was $340. At hospital Y, the average total bill of the younger patient was $160, and the average total bill for the aged patient was $280.

8) For younger patients at hospital Z, 45.6% paid for hospital charges by Blue Cross; 34.8% by commercial insurance; 18.6% by cash (self); .7% charity; .5% government (medicare, county, state or federal), and .4% by "other" means. This method of payment is different from the

method employed by the aged since 49.5% paid by cash; 28.4% by Blue Cross; 18.9% by commercial insurance; 2.1% by charity; 1.1% by government and 1.1% by "other". In hospital Y, the greatest percentage of younger patients paid their charges by Blue Cross (45.7%); 28.4% by commercial insurance; 23% by cash; .7% by charity; .6% by government and .8% by "other". Again, in this hospital, most of the aged paid their charges by cash (51.2%); 32.7% by Blue Cross; 23.9% by commercial insurance; 3.3% by charity; 1.1% by government and none by "other" methods.

9) The percentage of aged admissions to hospitals is greater than their respective proportion in the population, and the average daily census of aged patients is much greater proportionately than their respective ratio in the population.

Dr. Lowry also provided a general statement on the estimated cost of care of the aged in private general hospitals in Iowa. The statement follows:

> "Incident to the recent national interest in programs for the aging, Blue Cross and Blue Shield both nationally and locally have developed a great deal of data and estimates. Locally in Iowa, Blue Shield and the two Blue Cross Plans have developed contracts that are in keeping with the basis benefits developed on a national basis and endorsed by the American Medical Association, the National Association of Blue Shield Plans and the Insurance Industry.
>
> "These basic benefits include, for any one illness or injury, 70 days of hospital care with a 90 day interval before benefits can again commence. The Blue Shield contract adds, in addition to this, 13 weeks of nursing home care while the Blue Cross contract will permit to be substituted two days of nursing home care in lieu of one hospital day; that is, if a patient had 40 days of hospital care, he would be entitled to 30 additional hospital days or 60 days of nursing home care. The basic benefits are, semi-private room, hospital facilities and the usual customary services normally covered by Blue Cross and Blue Shield covers surgical, medical, radiology and pathology services.
>
> "Based on the best figures we have available, the cost of such benefits are: $12.25 per person per month (single) or $24.35 per family per month to include dependent children. If additional benefits not covered under the above program were to be added, such as, dental care, dentures, appliances, glasses, etc., obviously the cost of these items would have to be added to the above budget."

Additionally, Dr. Lowry supplied information on cost estimate of insuring the aged in Iowa, as follows:

> "During the year 1961 Iowa Medical Service was exposed to an

average of 6,758 Senior "65" contracts. Hospital Service, Inc. of Iowa was exposed on 4,171 contracts.

"The Blue Shield incidence of usage was 1.073 claims per 1,000 members at $33.32 per claim, while Blue Cross experienced 309 cases per 1,000 members at an average cost of $162.95 on each case.

"On this basis a monthly premium structure of $3.55 per member for professional services and $5.10 per month for hospital services would be necessary, or a total monthly premium of $9.60.

"According to the 1960 census there are 327,685 people in Iowa who are 65 years of age or older. If all these people were insured under the Senior "65" program, the total monthly premium would be $3,031,086.00. This likewise would constitute the cost for rendering hospital and medical services to this group in accordance with the benefits in the above quoted contracts."

SECTION IV: A STUDY OF THE COST OF CARE OF THE AGED IN UNIVERSITY HOSPITALS

This study is derived from three separate analyses: (1) a study of 100 consecutive discharges of indigent patients from University Hospitals during the fall of 1961; (2) a study of the utilization of University Hospitals by patients 65 years of age and older during the months of May and June, 1960; and (3) a study of the utilization of University Hospitals by indigent patients 65 years of age and older during the eleven month period from June 1959 through July 1960.

(1) ONE HUNDRED CONSECUTIVE DISCHARGES

(a) Older patients (those 65 years of age or older) represented 26% of the 100 consecutive indigent patient discharges November 28, 1961. Of these 10% were males and 16% were females. The actual distribution by ages is as follows:

Ages	Males	Females	Total	Ages	Males	Females	Total
65	0	0	0	77	1	5	6
66	0	0	0	78	1	1	2
67	0	1	1	79	1	0	1
68	0	0	0	80	2	1	3
69	0	0	0	81	0	1	1
70	1	0	1	82	0	0	0
71	0	1	1	83	0	0	0
72	0	2	2	84	1	0	1
73	2	1	3	85	0	0	0
74	1	0	1	86	0	1	1
75	0	1	1	87	0	1	1
76	0	0	0				

Thus, most of the aged patients in this group are over the age of 70; the average age for the group is approximately 77 with little difference between the average ages of the men and women.

The distribution of the total sample follows:

Age Group	Percent Male	Percent Female	Percent Total
Under 21	13	18	31
21 - 44	5	16	21
45 - 64	14	8	22
Over 64	10	16	26
Total	42	58	100

(b) These 100 patients used a total of 1493 patient days in the hospital. The older age group used 37% of this total; the middle age group (45 - 64) used 27% of the total patient days. This means that 48% of the patients used 64% of the patient days.

(c) Average length of stay in the hospital increases with age as follows:

Patient Age-Group	Average Days of Hospital Stay
Under 21	12
21 - 44	13
45 - 64	18
Over 64	21

(d) The average cost of hospital services also increases with age from about $122 for the youngest age group to $311 for the oldest. The standard charge for room and board in University Hospitals is $18 per day. Total costs are shown in the following:

Patient Age-Group	Room and Board	Hospital Services	Total
Under 21	$262	$122	$384
21 - 44	238	180	418
45 - 64	334	206	540
Over 64	384	311	695

(e) The room and board costs of the oldest age group were 37% of the total and their hospital service charges were 40% of the total; the costs for the middle age group were -- room and board, 22% and hospital services 27% of the total. Again this means that these patients, representing 48% of the total, incurred 60% of the room and board costs and 67% of the hospital services costs.

(f) Only 11% of these patients had any insurance coverage while they were in the hospital. The distribution of this coverage was as follows:

Patient Age-Group	Percentage With Insurance
Under 21	4
21 - 44	1
45 - 64	5
Over 64	1

This finding may be compared with findings concerned both with in-patients and out-patients in the next section and also with the finding that 58% of clinical pay and 77% of private in-patients have some form of insurance coverage. (This refers to all patients, regardless of age.)

(II) UTILIZATION OF UNIVERSITY HOSPITALS BY OLDER PATIENTS (MAY-JUNE 1960)

(a) Patients 65 years of age and older represented 30% of the total hospital admissions. This involves 1174 males and 1121 females or a total of 2295 aged patients.

(b) These patients used about 29% of the total patient days in the hospital.

(c) These patients were distributed by patient categories as follows:

Patient Categories	Percent of Older Patients
Indigent Patients	37
Clinical-Pay Patients	24
Private Patients	19

(c) (d) These patients were admitted to the hospital possessing insurance programs as follows:

Patient Categories	Percent of Older Patients With Insurance
Indigent Patients	6
Clinical-Pay Patients	28
Private Patients	55

(e) About 75% of the aged patients were return patients; that is, patients who had previously been patients in the University Hospitals -- the other 25% were being seen for the first time.

(III) UTILIZATION OF UNIVERSITY HOSPITALS BY OLDER INDIGENT PATIENTS (JULY 1959 - MAY 1960)

(a) The oldest age group represented 41% of total indigent admissions; 34% of the total patient days in the hospital; and 33% of total out-patient registrations.

(b) This group of patients incurred 35% of the hospital charges.

(c) Fifty-four percent (4919) of the older indigent admissions were males; 46% (4165) were females.

(d) Seventy-five percent of the aged patients were return patients; while 25% were new.

(V) A STUDY OF THE COST OF CARE OF AGED PERSONS IN PROPRIETARY NURSING HOMES IN IOWA

The Iowa Nursing and Custodial Home Law was enacted in the 1957 Legislature. The rules and regulations incident thereto can be called among the best in the nation from a facility, care, and fire safety standpoint.

At present there are 412 licensed nursing homes with 10,343 beds and 329 licensed custodial homes with 5,635 beds. No county in the state is without a licensed home. From a health care standpoint it is unreasonable as well as unfair for a department of the state to give official recognition to unlicensed homes.

Sixty-eight additional projects, contemplated or under construction, will provide 3,756 additional beds.

Since 1957, there has been no loss of life by fire. The very few fires that have originated have been of a minor or confined nature.

In view of the investments made by licensed homes to meet the law and rules and regulations, it is unfortunate and unfair that many such homes should be regarded as unsuitable or replaceable by the Iowa Report -- An Integrated Program for Hospitals and Related Health Facilities.

Rules and regulations call for a minimum space of 80 square feet

in single rooms and 60 square feet per bed in multiple rooms. As with present hospitals, some homes have wards. A survey of persons per room reveals these figures: 9.7% one to a room; 36.1%, two; 25.2%, three; 14.1%, four; 7.9%, five; 2.4%, six, and 5.4% over six to a room. Again, as with hospitals, newly constructed facilities consist primarily of semi-private rooms with some private rooms and some providing up to four persons.

Every nursing home is required to have either an R.N. or L.P.N. in relation to the number of beds for which the home is licensed. As with hospitals, many of the care services are rendered by nurses aides. Each patient is, by rule and regulation and by desire, cared for under the direction of the individual's personal physician or one selected by the patient's guardian or relatives or, in an emergency, the administrator of the home.

Educational opportunities for administrators and staff are increasing each year in greater depth and bringing into practice new techniques for improved care and rehabilitation. In fact, since the inception of the Iowa Nursing Home Association in 1950, there has been a yearly education institute. Educational presentations have also been made at each year's convention. The five districts of the Association have also had educational programs at many of their monthly meetings. Workshops have also been conducted at the State's Mental Health Institutes and by staff members from these facilities. Personnel from the Institute of Gerontology, College of Nursing, Psychopathic Hospital and others of the State University of Iowa have also made educational contributions. Since the end of 1961 the State Department of Health has through its Nursing Home Care Improvement

Program issued 766 certificates to nurses aides, nurses, and administrators for completing the Nurses Aide courses. As of October 1st, a Physical Therapy Consultant has been added to the program.

Nursing homes do not aim or plan to compete with hospitals except in one area -- the personal, tender loving care given their patients.

It is of interest to note that present licensed homes represent an investment of some 24 million dollars and new facilities planned, another 20 million.

Nursing home costs are rising at a rate of about eight per cent a year. About 45% of all persons in licensed homes are old age assistance recipients. This raises serious question over the Department of Social Welfare's 1963-65 budget request of $12,400,000 - $350,000 less than their current budget for OAA cases. Present average operating costs exceed the average now paid for the care of OAA recipients. Again, the Department's decision not to use the federal grant of $4.20 to the church, fraternal, community and proprietary homes in meeting their economic needs should be a health care concern.

Mr. Quackenbush states, in regard to his figures on rates for patient care in proprietary nursing homes, the following:

> "This information, like that submitted by Rev. Tompkins on non-profit homes, we believe, must be recognized as the best information now available and that it serves merely as a guide as to the Cost of Care and Keep. By reason of continuing changes in the various elements entering into the operating cost of homes, especially of wages, the cost figures may have been fairly accurate at the time gathered, but by the time they are published may not be a true picture of costs. We believe it essential that this be made very clear lest the figures be misleading to those seeking care in a home for themselves or loved one and also unfair to homes because their costs have risen by reason of wages, supply and equipment costs, higher standards of facility and care and the continuing demand for more and better services, none of which are to be quarreled with, but which must be understood as

cost raising contributors.

"The report should also make clear that actual charges made by a home are subject to all of these cost factors plus the one of care which may be required for the resident or patient as well as the changes in the patient's condition which may take place with the passing of time.

"Following is a table of private patient rates as of 12/31/61:

	LOW	HIGH	AVERAGE
Range of Rates	$105 - $180	$150 - $300	$140 - $234
Average Range of Rates	146.56	199.11	168.36
Non-Profit Homes *	110.00	183.33	157.16

* Inserted as additional information on Non-Profit Homes.

Comparison of Change in Percent of Cost for First Six Month Periods:

1960 vs 1959 - - - - - - + 5.72% 1962 vs 1961 - - - - - + 7.93%
1961 vs 1960 - - - - - - +12.19% 1963 vs 1962 - - - - - + 6 to 8%"

As previously stated by Mr. Quackenbush, "approximately 45% of nursing home patients are OAA recipients." The average OAA payment for September was $150.33 which, when related to average rates or to the average actual operating cost, figures $144.05 as of December 31, 1961 (now about $155.47)-represents a growing lessening ability to care for OAA recipients - no matter how altruistic the home management may be. In new homes - whether proprietary or non-profit - the condition is more accentuated.

Then, when the Board of Social Welfare is unwilling to permit supplementation and in addition is making an OAA budget asking for the biennium ending July 1, 1965, in the face of rising operating costs, less than the current one, the question may well be raised of the need of a complete review and study of welfare payments for the care of the aged in nursing homes by the Department of Social Welfare in cooperation

with those rendering the service.

(VI) A STUDY OF COST OF CARE OF THE AGED IN NON-PROFIT NURSING AND RETIREMENT HOMES

A study of 12 Iowa non-profit custodial homes was completed, and 16 Methodist homes with the following findings concerning range of cost per month per patient:

		Per Month	
12 Iowa homes	Range	$ 50 - $296	(Median $120)
16 U.S. Methodist homes	"	$100 - $165	(Median $140)

VII COST OF CARE OF THE AGED IN HOME CARE PROGRAMS

The Committee was unable to find any comprehensive home care program operating in the State of Iowa. There is one home care program in Polk County which seems to be giving more emphasis to home maker services than to comprehensive home care, including all the range of services from home maker through skilled medical service.

Where comprehensive home care programs have been developed, there is evidence to support the idea that they are very worthwhile indeed. It would appear that the better and more comprehensive programs are those either based in a general hospital or closely affiliated with one. For example, a careful study has been made of the home care program sponsored by Jewish Hospital in St. Louis. This program was developed in such a way that the Home Care Department is a regular department of the hospital along with the Division of Rehabilitation and the Chronic Disease Division. It has the same status in medical departmental organization as the major specialty divisions of Medicine, Surgery, Obstetrics and Gynecology, etc.

The staff is headed by a Medical Director who is responsible for proper supervision of the service, for its personnel, for the annual budget, and for record keeping and statistics. The Medical Director is assisted by 5 part-time physicians, medical consultants as required, medical social workers, visiting nurses, physical therapists, occupational therapists, and housekeepers.

Through this program patients could be discharged from the hospital directly to a home care program where the full range of medical and auxiliary health care could be provided in the patient's home using members of the above listed staff people and, in addition, using the patient's own family as members of the health care team - they having been given some training and orientation.

One of the most cogent arguments advanced in support of home care is the markedly lower cost per day when compared with care in the hospital. Per diem costs in other typical home care programs across the country have ranged from less than $2 to over $5. In 1952, the extensive home care service of the Department of Hospitals of the City of New York operated at a cost of $1.58 per day. A report in 1954 of the Council of Jewish Veterans and Welfare Funds of 5 home care programs that it surveyed shows per diem expenditures of $ .94, $1.42, $2.83, $3.64, and $5.49.

In the St. Louis program, by any basis of comparison, cost per day in the home is considerably lower than care for equivalent patients would be in the general hospital. Cost of care for acute general hospital patients in 1958 averaged about $24 per day, for chronic patients, between $15 and $18 per day. The detailed break-down of expenses over a 5 year period of operation indicates that average costs

range from $2.88 to $3.30 per day in the home. It was estimated that other costs of the household allocable to the patient, such as food, rent and utilities, made an average additional $3 per day.

SUMMARY

As it turned out, the business of estimating the cost of care of the aged is an extremely complicated problem. It is the opinion of the committee that the foregoing data are really only preliminary and, at times, superficial. Without any funds by which to carry on detailed studies in depth, this is all a volunteer committee could hope to accomplish.

It is clear from the report that a wide variety of facilities are available for the care of the aging in Iowa. These range all the way from general hospitals, University Hospitals, to custodial type homes and care in state and county institutions. The range of costs are in general highest in private general hospitals and apparently lowest in state and county institutions. Between these two extremes the order of cost would appear to be: Next highest, University Hospitals; then proprietary nursing homes and non-profit custodial homes. While there are no comprehensive home care programs in Iowa, it would appear that the establishment of some, providing they could be hospital-based, might provide high quality care at a relatively low cost.

That there is concern among the aged with regard to health care was made clear in the 1960 survey entitled "Life After Sixty in Iowa". For example, while about half of the respondents in that survey believed they could afford a $1,000.00 emergency medical bill, about 30% believed they could not. This latter group extrapolated to the

population of Iowa would mean that an estimated 120,000 persons, aged 60 and over, probably could not afford such an emergency cost. Furthermore, inability to meet such a cost increases with increasing age.

The present findings make clear certain conditions which one might well regard as obvious but nevertheless seem worth restating. It would appear from the data from general hospitals and University Hospitals that there is not only more illness among the aged, but that once ill, their length of hospital stay is longer, and seems to increase with age. Since hospital costs vary in part by length of stay, the costs are consequently higher with increasing age. Furthermore, it would appear to follow that these patients would require more medical care with consequently higher medical care costs. In addition, it would appear that as age increased, less and less individuals have health care insurance to assist in covering their costs.

This Committee is particularly concerned with the fact that hospitals and nursing homes have been in the recent past, and probably will continue to be, affected by increased costs and that this fact should be taken into consideration by the next Legislature and particularly by the Department of Social Welfare when appropriations to that department are considered for the next biennium.

The Committee is also concerned that the Kerr-Mills Bill which was passed at the last session of the Legislature carried no appropriation of funds. The desired and necessary information has not been compiled to assist the Legislature in determining appropriations which should be recommended and made available to support the Kerr-Mills Bill.

In a letter from the State Board of Social Welfare, Mr. Lawrence

Putney states:

> "The State Board of Social Welfare would welcome a complete review and study of care of the aged in nursing homes in Iowa, especially the nursing homes where payments are being made by our Department. When payments are being made on a statewide basis in the same amounts, excessive payments may be made in some instances and homes giving better services may be penalized. We would suggest that a cost study be made in all homes in a like manner. This would probably mean that the study should be made by an accounting agency. At the same time we think it would be necessary to conduct a study on care given realizing that cost may not always relate to better patient care. We believe that the care should be studied by a team consisting of a doctor, a nurse, a hospital or nursing home administrator, and a social worker. Preferably, these persons should not be personally acquainted with the operator or patients involved in the home under study. If such studies could be made and co-ordinated, it would give the Department justification for paying for care on an individual basis and at the same time comply with the rule and regulation on uniform treatment throughout the State. We realize that such a study might be expensive, but believe that it is the only way that payments can be made on an individual basis. Homes would then be rated as to physical facilities, care given by the home, and efficiency of administration. We do not believe that payment alone will solve the problem of nursing care for old age assistance recipients or for other citizens in the State of Iowa."

The work of this Committee has focused almost entirely on all aspects of care except medical expenses, but it is difficult to separate medical care from other aspects of care for the aged. This Committee, therefore, should frame its recommendations jointly with such other committees as the Committee on Medical Care, the Committee on Housing, etc.