NURSING HOMES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON NURSING HOMES

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

EIGHTY-SEVENTH CONGRESS

FIRST SESSION

Part 1.—Portland, Oreg.

NOVEMBER 6, 1961

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
78681 WASHINGTON : 1962

SPECIAL COMMITTEE ON AGING

PAT McNAMARA, Michigan, *Chairman*

GEORGE A. SMATHERS, Florida
CLAIR ENGLE, California
HARRISON A. WILLIAMS, JR., New Jersey
OREN E. LONG, Hawaii
MAURINE B. NEUBERGER, Oregon
WAYNE MORSE, Oregon
ALAN BIBLE, Nevada
JOSEPH S. CLARK, Pennsylvania
FRANK CHURCH, Idaho
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
EDWARD V. LONG, Missouri
BENJAMIN A. SMITH II, Massachusetts

EVERETT McKINLEY DIRKSEN, Illinois
BARRY GOLDWATER, Arizona
NORRIS COTTON, New Hampshire
FRANK CARLSON, Kansas
WALLACE F. BENNETT, Utah
PRESCOTT BUSH, Connecticut
JACOB K. JAVITS, New York

WILLIAM G. REIDY, *Staff Director*

SUBCOMMITTEE ON NURSING HOMES

WAYNE MORSE, Oregon, *Chairman*

CLAIR ENGLE, California
HARRISON A. WILLIAMS, JR., New Jersey
OREN E. LONG, Hawaii
ALAN BIBLE, Nevada
FRANK CHURCH, Idaho
EDWARD V. LONG, Missouri
BENJAMIN A. SMITH II, Massachusetts

NORRIS COTTON, New Hampshire
PRESCOTT BUSH, Connecticut
JACOB K. JAVITS, New York

NOTE.—Six hearings on nursing home were held and are identified as follows:

Part 1.—Portland, Oreg.
Part 2.—Walla Walla, Wash.
Part 3.—Hartford, Conn.
Part 4.—Boston, Mass.
Part 5.—Minneapolis, Minn.
Part 6.—Springfield, Mo.

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

	Page
Miss Geraldine H. Pearson, Institute of Gerontology, Mount Angel College, Mount Angel	4
Dr. Clinton S. McGill, chairman, Multnomah County Medical Society, Liaison Committee to Oregon Nursing Home Association	11
Dr. Harold D. Paxton, chairman, Multnomah County Medical Society, Liaison Committee to Multnomah County Welfare Commission	12
Dr. Eleanor B. Gutman, administrative assistant, clinical services, Oregon State Hospital, Salem	16
Sister Lawrence, St. Anthony's Hospital, Pendleton	19
Mrs. Anabel T. Allison, proprietor, Allison Nursing Home, and chairman, Nursing Home Accreditation Committee	20
Fred Stabler, representing Oregon Nursing Home Association	23
Walter Carte, county commissioner, Wasco County, The Dalles	27
Mrs. Hale Pragoff, medical social consultant, Oregon State Board of Health	31
Dr. Robert M. Heilman, director of licensing of care facilities and preventive medical services, Oregon State Health Department	33
Hon. Grace O. Peck, member of Oregon House of Representatives	37
Dr. James H. Stewart, director, Medical Division, Oregon State Public Welfare Commission	43
Dr. Morton J. Goodman, practicing physician, and former chairman of Medical Care Committee, Oregon State Welfare Commission	51
Mrs. Bertha Roth, administrator of Jackson County Welfare Department	53
H. J. Erickson, Department of Oregon Veterans of World War I	57
Mrs. Helen Zollinger, member of Legislative Council on Aging, moderator of radio series "The Challenging Years"	59
Merl E. Jones, vice president of Social Security Clubs of America, and vice president of Institute of Social Welfare	65
Mrs. Evon Crawford, Portland	65
A. R. Kirk, former member of Oregon Council on Aging, Portland	67
H. A. O'Neal, Portland	68
Mrs. Paul Conrey, administrator of Colonial Manor Sanitarium, Portland	70
Charles E. Woodward, Portland	71
Edward Day, member, legislative council, Veterans of Foreign Wars	72
Martin C. Day, Portland	73
Irene Waldo, member of State Board of Townsend National Pension Plan	74
May Conner, Sandy	75
Dr. Noren, Sandy	76
Claude Arrowsmith, president, Columbia River Pensioners Association of International Longshoremen's & Warehousemen's Union, Portland	78
Frank Hillman, Gladstone	80
Oral Love, Love Convalescent Hospital, Portland	80
Mrs. Sutherland	84

STATEMENTS

Allison, Mrs. Anabel T., proprietor, Allison Nursing Home, and chairman, Nursing Home Accreditation Committee	20
Arrowsmith, Claude, president, Columbia River Pensioners Association of International Longshoremen's & Warehousemen's Union, Portland	78
Carte, Walter, county commissioner, Wasco County, The Dalles	27
Amended statement containing additional information	30
Conner, May, Sandy	75
Conrey, Mrs. Paul, administrator of Colonial Manor Sanitarium, Portland	70
Crawford, Mrs. Evon, Portland	65

Page
Day, Edward, member, legislative council, Veterans of Foreign Wars---- 72
Day, Martin C., Portland---- 73
Diack, Dr. Arch W., Multnomah County Medical Society, Portland, Oreg., prepared statement---- 14
Erickson, H. J., Department of Oregon Veterans of World War I---- 57
Goodman, Dr. Morton J., practicing physician, and former chairman of Medical Care Committee, Oregon State Welfare Commission---- 51
Gutman, Dr. Eleanor B., administrative assistant, clinical services, Oregon State Hospital, Salem---- 16
Heilman, Dr. Robert M., director of licensing of care facilities and preventive medical services, Oregon State Health Department---- 33
Prepared statement---- 36
Hillman, Frank, Gladstone---- 80
Jones, Merl E., vice president of Social Security Clubs of America, and vice president of Institute of Social Welfare---- 65, 79
Kirk, A. R., former member of Oregon Council on Aging, Portland---- 67
Lawrence, Sister St. Anthony's Hospital, Pendleton---- 19
Love, Oral, Love Convalescent Hospital, Portland---- 80
McGill, Dr. Clinton S., chairman, Multnomah County Medical Society, liaison committee to Oregon Nursing Home Association---- 11
Noren, Dr. Sandy---- 76
O'Neal, H. A., Portland---- 68
Paxton, Dr. Harold D., chairman, Multnomah County Medical Society, liaison committee to Multnomah County Welfare Commission---- 12
Prepared statement---- 15
Pearson, Miss Geraldine H., Institute of Gerontology, Mount Angel College, Mount Angel---- 4
Peck, Hon. Grace O., member of Oregon House of Representatives---- 37, 82
Pragoff, Mrs. Hale, medical social consultant, Oregon State Board of Health---- 31
Prepared statement---- 32
Roth, Mrs. Bertha, administrator of Jackson County Welfare Department---- 53
Stabler, Fred, representing Oregon Nursing Home Association---- 23
Stevens, W. R., director, Maplewood Home for the Aged, Grande Ronde, Oreg---- 63
Stewart, Dr. James H., director, Medical Division, Oregon State Public Welfare Commission---- 43
Sutherland, Mrs---- 84
Waldo, Irene, member of State Board of Townsend National Pension Plan---- 74
Woodward, Charles E., Portland---- 71
Zollinger, Mrs. Helen, member of Legislative Council on Aging, moderator of radio series "The Challenging Years"---- 59

ADDITIONAL INFORMATION

Article entitled "Description and Procedures for Processing Welfare Grant Recipients From Oregon Mental Institutions," by Oregon State Board of Control, July 1961---- 120
Chart entitled "Factors in Payment Structures," inserted by Oral Love, Love Convalescent Home, Portland Oreg---- 81
Cost study by St. Mary's Hospital Nursing Home Annex, presented by Mrs. Bertha Roth---- 54
Goodman, Dr. Morton J.:
Biography of---- 45
Speech delivered to the Portland City Club entitled "Medical Aid for the Aged," on September 1, 1961---- 46
Leaflet entitled "Medical Assistance for the Aged in Oregon," issued by the Oregon State Public Welfare Commission, November 1, 1961---- 104
Letters to Senator Morse from:
Ankeny, G. W., Portland, Oreg., dated November 6, 1961---- 129
Byrne, Bertha G., R.N., executive secretary, Oregon Nurses Association, Inc., Portland, Oreg., dated October 3, 1961---- 91
Cavagnaro, Ray L., Sacred Heart General Hospital, Eugene, Oreg., November 15, 1961---- 132
Shepherd, Ruth, Eugene, Oreg., dated October 16, 1961, containing:
Enclosure 1.—Some questions about care facilities for the aged---- 86
Enclosure 2.—A proposal for planning directed volunteer assistance to nursing homes in Lane County---- 89

Letters to Senator Morse from—Continued
Page
Sister Mary Stanislaus, R.S.M., superior, Sisters of Mercy, Portland, Oreg., dated November 28, 1961 129
Williams, James J., Jacksonville, Oreg., dated November 8, 1961 129
Woodward, Charles E., Portland, Oreg., dated November 11, 1961 128
Zollinger, Helen, Portland, Oreg., dated December 2, 1961, containing memorandum from the Governor's Committee on Aging 60
Oregon State law entitled "Miscellaneous Veterans' and Servicemen's Benefits," inserted by Martin C. Day, Portland, Oreg 74
Preliminary report entitled "Preface and Introduction to the Nursing Home in Oregon," by William T. Lin, Ph. D., assistant professor of sociology, and Sheridan P. McCabe, Ph. D., associate professor of psychology, University of Portland 98
Study sponsored by Mount Angel College entitled "State Licensing Requirements for Nursing Home Administration" 93

NURSING HOMES

MONDAY, NOVEMBER 6, 1961

U.S. SENATE,
SUBCOMMITTEE ON NURSING HOMES
OF THE SPECIAL COMMITTEE ON AGING,
Portland, Oreg.

The subcommittee met at 10 a.m., pursuant to notice, in the grand ballroom, Multnomah Hotel, Senator Wayne Morse presiding.

Present: Senator Morse.

Committee staff members present: William G. Reidy, staff director and specialist on health and medical care; Miss Dorothy McCamman, expert on social security; Mr. John Guy Miller, counsel for the minority.

Senator MORSE. The hearing will come to order.

This is an official hearing of a subcommittee of the U.S. Senate's Special Committee on Aging. It is one of a series of hearings being held by similar subcommittees in over 30 cities throughout the United States within the next 2 months. Everything that is said here will be recorded, printed, and distributed to all Members of the Congress and to thousands of State legislators and scholars concerned with the problems that confront our older people in the United States.

This hearing and the one which I shall hold on Wednesday in Eugene are important to all of us here in Oregon. This is our opportunity to get our views on the record; our opportunity to let all the people who help write our Federal laws know just what the people of Oregon believe to be the problems that confront people growing old in our part of the country; what you think can be done about the problems besetting our older people and their children now and what can be done to see to it that these same problems do not confront the youngest person in this audience when he or she reaches the biblical three score years and ten.

For make no mistake about this. When we speak of the aging, we speak for ourselves. What we may do to, or for, or with those of our fellow citizens who are already aged we do, not only for them, but also for ourselves. What problems we solve for them, we resolve for ourselves also. That which we leave undone for them, may well be left undone for us.

This hearing is your chance to participate in the lawmaking process of our Government. The facts presented here, the ideas and opinions expressed here will be carefully studied and weighed against those voiced in other parts of the United States. All will be carefully analyzed and those which seem of national import will be translated into legislation and sent to the appropriate Senate committees for action.

That is why I insisted that hearings be held here in Portland and in Eugene. I want the voice of Oregon to be heard in the Halls of our Congress.

Here is how we shall proceed with this hearing.

Since I am chairman of the Subcommittee on Nursing Homes, this morning's session will be devoted largely to the testimony of expert witnesses discussing the nursing home picture here in Oregon. I wish to say that Senator Maurine Neuberger is a member of our Committee on Aging. She doesn't happen to be a member of my subcommittee, but we work together on the full committee, and I speak for her when I express to you her regrets that she could not be with us this morning because other commitments take her elsewhere, but I represent her here as I represent, of course, our entire delegation. As we go into this matter of the nursing home picture here in Oregon, there are some questions that we must necessarily ask. Do we have enough? Are they of the right kind? Do they provide all the services needed? Can the people who need them afford them? What are we in Oregon doing about nursing home quality which we can share with the Nation, of which we can be proud? Where are we falling short? Have we too much or the wrong kind of legislation? Do we need new or different legislation to assure those of us who some day may need care in nursing homes that in our time of need it will be available?

These and similar questions we hope will be answered here this morning, and we shall seek answers from all who are in a position to know—from State officials responsible for supervising nursing homes, from nursing home operators, from people whose job it is to try to find a nursing home bed with the needed services for an indigent or a middle-income person, and from people who have to worry about where the money is coming from to pay for nursing home care.

When we have heard from these expert witnesses—and I am sure their testimony will be of great value to us—we shall hear from representatives of such groups of senior citizens as have asked to be heard. They, of course, are also experts in a real sense.

Finally, this afternoon, we will hold a so-called town hall meeting of senior citizens where I hope the real experts, after all, our older people themselves, will speak for themselves as to what their problems are and what can be done about them. I hope, too, that out of their experience and wisdom they will tell us what we as a people and as a nation should be doing to make sure that these same problems do not exist 20 years hence.

Here with me today are Mr. William G. Reidy, on my right, our committee's staff director and specialist on health and medical care, and, in the presence of my constituency—and he can close his ears because he is a modest man and I don't want to embarrass him—I want to publicly thank Mr. Reidy for the wonderful cooperation that he has extended to me for many years in the Senate. He has worked with us on our Committee on Labor, Education, and Welfare, which included our health problems, for a long time. Time and time again I've gone to Mr. Reidy for the preparation of research memoranda on matters that involve health problems of vital interest to groups or individuals in my State, and Mr. Reidy has never failed me. I deeply appreciate his wonderful cooperation over the years, and I want to thank all three members of the staff who sit here on the

rostrum with me for the wonderful work that they have done in preparing, not only for this hearing, but hearings across the country.

On my left is Miss Dorothy McCamman, our expert on social security, one of the best versed people in this very troublesome field with whom I have become acquainted in my work in Washington; and John Guy Miller, who is the counsel for the minority, but let me say, on behalf of Mr. Miller and the members of our committee, on this committee there is no partisanship. We may have differences in point of view, but I want to say most respectfully and assuredly to you that we approach these problems, not as Democrats and Republicans, but as Senators and staff members who have the responsibility of finding the answer to the question: What are the facts? I happen to believe that once we have the facts, men and women of good will can find a public policy solution that will be in the public interest. It is with that spirit that we conduct these meetings and with that spirit and that objective in mind that we do the work on the committee.

Our first witness this morning will be Miss Geraldine H. Pearson, secretary of the Institute of Gerontology, Mount Angel, Oreg. Her testimony today will have a special value for these hearings because she will tell us of the new program in gerontology at Mount Angel College, the only program of its kind on the undergraduate level in the entire Nation.

Mount Angel College, because it is one of the few colleges in the country that has a nursing home of excellent quality right on the campus, provides a rare training ground for students who wish to qualify as professionals in nursing home administration and in social work with the aged. Programs, such as this, hold real promise for the welfare of our older citizens, particularly those who are nursing home patients. We are proud of this program and commend it to the attention of the rest of the Nation.

It gives me pleasure to call on Miss Pearson to now take the witness stand over to my left and proceed in her own way. As she takes the stand, may I say that we are all witnesses today in a way. I am appearing as a traffic officer. I have the job of conducting the hearing within the time limitation of which each witness has been notified in advance. Therefore, if I call time, you will know it's not because I don't want to hear you further, but because we are going to have to try to give everyone an opportunity to present part of their case at least. But let the record be perfectly clear, that any witnesses here are given the time to file with this committee full statements, much greater in detail than the limited time permits them on the witness stand. We will keep this record open for several weeks for the receiving of such statements, although we want you to get them in just as soon as you can.

Furthermore, those who are not witnesses will be given the opportunity to file statements. They will be given a preliminary review to make certain of only one thing, that they represent responsible approaches to the problem. Of course, I think you could well imagine that we could receive certain types of statements that would not be at all constructive to our record. That doesn't mean that we will not receive a good many critical statements, but only that they are responsible statements, and they will be made a part of this record as well.

Miss Pearson, you may proceed in your own way.

STATEMENT OF MISS GERALDINE H. PEARSON, INSTITUTE OF GERONTOLOGY, MOUNT ANGEL COLLEGE, MOUNT ANGEL, OREG.

Miss PEARSON. Thank you. On behalf of all those assembled here today, I should like to welcome to Oregon the Senate Special Committee on Aging. As a representative of the Institute of Gerontology at Mount Angel College, I cannot help but be impressed by the sincerity and interest of so many people who are attempting to discover a true picture of the problems of aging on a local and national level. I think it is up to each of us here today to gain as much information as we can to build upon the good work already done and to improve upon the entire nursing home situation.

We hope that the establishment of the Institute of Gerontology at Mount Angel College, a center for teaching, research, and service in the social and psychological aspects of aging, will in some way aid this endeavor.

I think that each of us should take a new look at old age. We cannot in truth separate one age of man from another. There are problems in being young, and there are problems upon reaching adulthood, there are problems involved in being a parent, and there are problems in growing old. But not everyone has difficulties at each of these times and difficulties do not always pile up at the end of life. Many of the older members of our society are invaluable to the rest of the population. We cannot, therefore, lump old age into one category and call it a problem.

The question under review today is the nursing home, that institution which has sprung into prominence in the last 15 years to care for those who need nursing attention; that institution which is crowded with older members of the population who are partially or totally infirm.

At Mount Angel, we have a goal. This goal is to preserve the dignity of man. We are opposed to any institution or movement which threatens human dignity, whether it be communism or that attitude toward older infirm persons which considers them less than human beings.

Each nursing home administration, each supervisor, and each aid must take an honest look at himself and his attitude toward the patient. If this attitude is anything less than respect for the individual, we are in serious trouble.

It would be foolish to assume that we can measure or evaluate attitude absolutely. It is intangible, elusive and fleeting, and yet we know that this attitude can build or destroy at any time in man's life. An attitude which places the partially infirm into the ranks of the completely infirm can destroy as totally as any dread disease. An attitude that has in it respect for human dignity and hope for a better day, even if it is just a single day, will build. Nursing homes are not filled with a certain number of beds with spaces that legally correspond. They are filled with human beings, human lives which have been entrusted to their care. These human lives are in the hands of the members of the nursing home structure, in many cases, until the last moment of the person's life.

Studies conducted in the institute show that many homes in Oregon do give satisfactory nursing care. But the picture we are trying to get

here today is not of a nursing center—it is a nursing home. When the word "home" comes into the picture, it enlarges the focus to a place where the complete man is cared for. What are his needs besides nursing care? Should his spiritual life, his need of love, his need of rehabilitation, financial security, or his recreation be the concern of the nursing home? Is it the responsibility of the nursing home to preserve as a precious commodity those parts of the infirm man which are still active faculties? Or is the nursing home only a place where terminal care is provided? I would assume that the nursing home is more than this.

A question which can legitimately be asked of nursing home administrators is if they plan for death or for restoration—even partial restoration. Do they have facilities by which the patient might once again begin to look at himself as a contributing member of his community? And do their staffs have this kind of sympathy? If the patient one morning says, "I think I can tie my own shoes this morning," does the person helping him encourage this, or does he discourage it so that he can get the morning tasks over more quickly?

The attitude, atmosphere, and quality of the home is dependent on many things—physical plant and facilities, yes, but more than this. It depends on the attitude of the administrator and on his wisdom in hiring personnel. At Mount Angel, we are in the process of setting up a curriculum to train persons who wish to work with the aged, either as nursing home administrators or in one of the allied disciplines. We know that education can help to train professionals in this field. It can make them knowledgeable concerning everything in aging from philosophy to bedpan sanitation. But we are not naive enough to assume that education will be all this person needs. You do not "train" artists or poets, nor do we "train" a person to work intimately with human life. Educators can only build on the innate mystery which causes man to reach for a certain field of endeavor.

One of the questions we can answer today is the relative placement of Oregon with regard to nursing home administrative standards in the United States.

The study, "State Licensing Requirements for Nursing Home Administrators," by Dr. Carroll Mickey and Kathryn Beatty of the Mount Angel College Institute of Gerontology, has been submitted in full in the written version of this testimony. In this study (which is available through Mount Angel College) one finds that Oregon compares very favorably with the States in region 9 and with the Nation. (We used the Department of Health, Education, and Welfare breakdown of regions.) Though some of the Oregon laws seem very basic, one is surprised to learn that other States do not include them. To begin with, Oregon requires that the administrator be 21 years of age or older, where 5 of the 7 States in our region do not mention age as a qualification, and only 20 States nationally specify 21 as a minimum age.

Oregon is also one of 5 States out of 7 in region 9 that requires the administrator to have an annual physical examination, and one of the 29 States nationally that have this requirement. Oregon is the only State in this region that requires any form of reference for determining the character of the administrator, and is one of 8 States nationally that requires references. Good character is not even mentioned by 3 States in this region, nor by 18 States nationally.

Thirty-one States in the Nation and 5 in region 9 do not mention good mental health as a requisite for home administrators. Oregon does require good mental health, but does not state how this health is to be measured.

The administrator in Oregon is required to meet specific educational, training, and experience standards. In this respect, Oregon is leading this region and is among the most restrictive in the Nation. An administrator in Oregon must meet qualifications that include medical or nursing training, or higher education with course work in business administration or finance, or a number of years in nursing home administration, referred to as the grandfather clause.

Therefore, nationally, we compare very favorably. This we can be proud of as a good beginning. We do not consider it an end. For a more thorough examination of the situation in Oregon, I refer to a preliminary study done under the Institute of Gerontology titled, "The Nursing Home in Oregon"; here we find some problems. The purpose of the study was to describe role relationship among nursing home personnel in the State of Oregon. A total of 516 persons comprising a sample of those working in the nursing homes in Oregon cooperated in the study. The research was conducted by trained personnel who employed a structured interview technique.

The respondents were asked, among a number of questions, what they felt was the most basic patient need in the nursing home. Physical and general care were most mentioned by operators, nursing supervisors, and aids. The least mentioned need by operators was "social visits," by the supervisors "responsibility given to the patient," and by the aids "recreation." Although this paints a picture of perceiving patients as people who are primarily physically ill, the respondents felt that the most basic skills of those who care for patients were understanding and sympathy, kindness, gentleness, and love. The respondents, therefore, did not seem to feel that the most important skills were those that are needed to meet patient needs, or perhaps they actually do, in truth, feel that patients' needs extend beyond physical care.

Another important finding of the study was that in all three positions, there is a discrepancy between the roles actually performed and the roles that the respondent felt should be performed on a particular job. The specific discrepancies differed among different sized nursing homes.

As perceived by all other personnel, the role components of the aids seem to be better defined and hence less subject to dispute than are the role components of the supervisors. Nursing home operators' roles were least clearly agreed upon.

It was discovered that what is considered to be a legitimate part of one's job varies among those who have the same position, but who work in different sized homes. For instance, aids in the smaller homes actually visit and chat with patients more than they feel they should, whereas aids in the larger homes feel that they don't visit as much as they should. Operators, on the other hand, actually go with doctors on their rounds more than they feel they should in the smaller homes; in the larger homes, the situation is reversed.

This study leads us to ask further questions: Are many of the operators themselves nurses? Are there more or fewer operators who

are nurses in smaller homes than in the larger homes? Perhaps an operator who is a nurse has an especially difficult time defining her total role in the nursing home.

As compared with aids in both nursing homes and hospitals with nursing home operators, student nurses and hospital nurses, it is noteworthy that fewer registered nurses and supervisors in nursing homes faced a role conflict. Job satisfaction seems to depend not only on an absence of role conflict, but also on motivational factors for wishing to work in the nursing home. These observations lead us to hypothesize that the type of nursing home care, or rather, the atmosphere in which nursing care is conducted may be a function of the personnel structure in different sized homes. The size of the nursing home may then actually prescribe functions of various staff members. We can see that State law takes care of the quality of nursing care and, to some extent, of physical facilities. More intensive questions in this regard can be put forth and answered by others at this hearing and through future research.

Though there is not now any care or quality rating, per se, of homes in Oregon, it is my understanding that the Oregon Nursing Home Association, under the direction of the National Nursing Home Association, is setting up a standard accreditation program which will attempt to classify homes into four categories, the intensive care facility, the skilled nursing facility, the intermediate care facility, and the supervised living care facility. The gradation of qualification is, I believe, dependent upon the type and quantity of nursing care available for the patients.

There have been occasions when the resident of a supervised living home has fallen very ill and yet has not been transferred to a home that can more adequately care for him, such as the intensive care facility. There seems to be three main reasons for neglecting to transfer the patient. The operator decides that the patient would be unhappy by the move; the patient would not actually be helped by the move; a financial loss would be incurred by the operator. Oregon law states that, if the light-care patient is in bed for over 7 days, he must be transferred to a home which can give more adequate care.

County and State laws for welfare and like agencies protect patients who are receiving aid. These patients must be seen by doctors and/or nurses at regular intervals. It is my understanding that all welfare patients in need of heavy care receive this attention, and that welfare patients who are in homes in the other two categories receive regular visits from their social workers.

The problem of rates and services could best be gone into by one who is fully aware of the ramifications of cost-analysis research. However, a number of operators have indicated to members of the institute that welfare patients are carried on minimum or below minimum rates. Naturally, in this regard, the nonprofit homes, where a number of volunteer or low-cost workers are available, would probably feel less the financial burden of the welfare patient than would the profitmaking home.

Concerning the training of staffs of nursing homes, there seems to be some problem. Most training is done on the job; that is, the new employee assumes his duty either under the supervision of his immediate superior or simply by being given a number of duties to per-

form that gradually grow in complexity. Some attempt is made at some homes to do training during staff meetings, but generally the workload is too heavy to do this to any extent.

When questioned about the most valuable asset for a potential worker in this field, most supervisors state that the would-be worker must have a real love of older persons. It is also stated in "The Nursing Home in Oregon" that high percentages of persons take work in nursing homes because of intrinsic rather than extrinsic reasons. In analyzing these percentages, one must be warned that this is a publicly stated reason, and one should keep in mind that private reasons or underlying factors may be part of the motivation.

As far as financial remuneration for persons in this field, studies conducted by the institute have shown that, for their educational backgrounds and time spent on the job, salaries of nursing home personnel are comparable to other forms of employment.

Though questions of standards have been introduced here, a representative of the Oregon Nursing Home Association would be more qualified to discuss it. Accordingly, a member of the State board of health could more adequately discuss the problem of licensing.

Though we have reason to believe that payments for various types of special services available in nursing homes are relatively stable throughout the State, this again could only be ascertained through extensive economic research.

Again and again, we come to the same impasse. That is, that the questions we are asking can only be answered through more extensive study and research in the field. Mount Angel College currently has three grants pending with separate Government agencies. A grant for funds supplementary to the one we are now working with will enable us to answer some of the questions posed here today. We have also applied for a grant to determine the importance of fitting rehabilitation activities to the motivational patterns of chronically ill and disabled older persons. If this grant from the Office of Vocational Rehabilitation is received, it will enable us to prove what sorts of activities can best sustain health and attitude or reduce some of the psychological problems which are often brought on with old age and some ailments. A third grant pending with the Research Facilities Department of Health, Education, and Welfare will aid us in establishing a center for research in the rehabilitation of older persons and other disciplines concerned with old age. Personally we have found the National Government and State agencies most cooperative and deeply concerned with aiding those older persons who need help.

Senator MORSE. Miss Pearson, I would like to interrupt with this announcement, that I am pleased to advise you and those at the hearing that these grants, to which you refer, were strongly recommended by the Senate committee, and we received excellent cooperation from the Department of Health, Education, and Welfare, and, through that cooperation, made these grants possible.

Miss PEARSON. Thank you very much. We know that if we receive this aid from the Government for our proposed programs, we can make a considerable impression on the problems that face us here today.

If we could paint a picture of the ideal nursing home and surroundings, from the results of our research so far, we would include those

things which I will list. We should remember, before I do this, that, since the majority of nursing home patients are aged, with a set of sociomedical problems peculiar and specially pertaining to the older population in an industrial society, the problem of care is neither simply medical-therapeutic, nor merely custodial-familial. It is both.

We should bear in mind, however, that homes, no matter in which one of the four specialized categories they are, do have a wide range of care types. Homes set up for intensive care patients often do have active patients in need of minimum care but in need of maximum activity schedule.

Before painting a picture of what might be considered the perfect home, it should be remembered that good mental health is a requisite to good physical health, and that this particular age group is susceptible to poor mental health for a number of socioeconomic reasons.

The ideal home might incorporate the following: Certainly, skilled nursing care; clean and odorless physical facilities; physical and occupational therapy; a full, varied and well-scheduled recreational program; a religious program allowing services in the home and clergy visitation; encouraged community dining; some type of patient responsibility; liberal visiting hours to encourage, not only a close family relationship, but also a close relationship between administrator and family so that communication is maximum; adequate visiting time by members of State agencies, for example, social workers; opportunity for the patient to have personal belongings with him; personal appearance of patients maintained; privacy for the patients; an attitude of respect for individuals on the part of each staff member.

The home should be large enough to allow for the activities listed above and should have personnel that can adequately perform these duties. It should be remembered that good therapy can be done by relatively untrained persons in small areas with a minimum of equipment. All of the above suggestions can be adopted to some extent by the home. If the administrator and her staff are sympathetic with those things which can be done to better the atmosphere of the home, the home will come close to this perfect picture. If the suggestions listed here are not incorporated in the home, there must be a reason. Primary objections in most administrators' minds would probably be money and space. Why give a large room to therapy or recreation when it can be used for 10 more beds? Another might be the size of staff. Again, money. It costs to get specialists, but if on-the-job training is done to teach persons to administer medicines, could training not be done in other areas?

I think that many nursing home personnel are highly motivated and well intentioned. But the field and the profession has grown so rapidly that they are beginning to race ahead of the people who are in it. It is at once big business and a huge humanitarian responsibility. The rapid growth has caused a lack of professional attitude in many cases. The persons involved are so busy, and probably rightly so, keeping up with their daily obligations that they do not have time to see the full margins of the picture.

There is, I believe, a definite need for education in this field, but I want to point out again that this education will be of no good whatsoever without dedication on the part of the person who has chosen this field for his lifework.

A question which should be solved immediately is how the person wishing to enter a nursing home or those who are about to place a relative in a nursing home can be assured that their choice is a good one. This is a difficult question, and one which I am sure has caused endless numbers of persons real consternation.

I should like here to volunteer the services of the Institute of Gerontology at Mount Angel College to compose a brochure which could be distributed to interested parties. This brochure might indicate the things one should look for in selecting a home, the prices one should expect to pay, and suggest a number of questions which it would be feasible to ask of the administrator. We would like to invite the help of any group which feels they would like to participate in the production of this publication, either with their knowledge or their financial support.

If enough of us are concerned about the total picture, I am confident that Oregon can maintain its national reputation in the nursing home field and can, indeed, be a leader in progress.

I should like to thank Senator Morse and the Special Committee on Aging for this opportunity to testify on behalf of the institute and the State of Oregon.

Senator MORSE. Miss Pearson, in behalf of the committee, I want to thank you for your statement, which, it is clear to all of us, was very carefully prepared. Your institute has produced and you sent our staff two excellent studies on the nursing home problems. We would like the people throughout the country to have access to this fine work, if you have no objection. If you are not printing them for distribution on a large scale, we would like to have your permission to make those studies a part of this official record. Would that be acceptable to you?

Miss PEARSON. Yes, it would help.

Senator MORSE. We will do that.

(The studies mentioned above will be found in the appendix on p. 93.)

Senator MORSE. There are many questions I would like to ask you, but time does not permit. I have one problem, though, which I would like to raise with you. You would agree, would you not, that it is impossible for the operators of nursing homes to provide all of the very fine services and conditions that you point out in your paper, so long as the Government pays, as I believe it does in many States, only $55 or $65 a month to welfare recipients?

Miss PEARSON. I think it is slightly higher in Oregon. I couldn't go into the point system accurately, but I know that welfare does in some cases pay up to $192.

Senator MORSE. I am talking about the national problem. I wasn't talking about Oregon. There are quite a few States, you might be surprised, in which the allowance runs from $55 to $65 a month per recipient. So, if the nursing home is going to receive only this from the recipient, it has to have some foundation funds, or it has to have some other sources of income.

Would you agree with me that in those instances in which welfare recipient allowances are low, the nursing home operators have a pretty good point when they say to this committee, "It isn't that we don't want to provide this service, it's just that we don't have the means

to provide it"? Therefore, this committee has the responsibility in its final report to recommend very carefully on the facts what assistance ought to be provided, by both State and Federal Governments, in order to achieve what I think we all will agree are the fine objectives that you have set out in your paper?

Miss PEARSON. We discussed that at the institute, rather unofficially—that is, the fact that the nursing home, as an institution, gets a certain type, the middle ground patient. The very poor will stay home and die. The very rich will maintain themselves in a hospital or with private nurses. So, necessarily, there is a problem for the low and very low incomed older person.

Senator MORSE. Thank you very much. Our next witness will be Dr. Clinton S. McGill, a graduate from Oregon Medical School in 1945, interned at Henry Ford Hospital in 1945 and 1946, was a resident in Henry Ford Hospital in 1946 and 1947; practiced internal medicine beginning in 1948, and was part-time medical director with the Oregon State Public Welfare Commission. He is now chairman of the Multnomah County Medical Society Liaison Committee to the Oregon Nursing Home Association, 1961.

Doctor, I thought it was only right, with your excellent background and your wonderful qualifications, that we should tell these things to the audience before you proceed. You may now proceed.

STATEMENT OF DR. CLINTON S. McGILL, CHAIRMAN, MULTNOMAH COUNTY MEDICAL SOCIETY LIAISON COMMITTEE TO THE OREGON NURSING HOME ASSOCIATION

Dr. MCGILL. I appreciate the opportunity to make a brief statement to this distinguished committee which is studying the type of care our older people are receiving in nursing homes. As stated, my background includes 10 years as the part-time medical director of the Oregon State Public Welfare Commission. At the present time, I am serving as chairman of the Multnomah County Medical Society's Liaison Committee to the Oregon Nursing Home Association. This committee was formed at the request of the nursing home operators.

The purpose of the remarks is to acquaint this committee with the experience we have had in Oregon in the development of standards for nursing homes. Formal recognition of this problem dates back to 1947 and the passage of the Hospital Licensing Act in Oregon. This law charged the Oregon State Board of Health with the responsibility of setting minimum standards for nursing homes and related institutions. This, of course, required a system for periodic inspection. In the beginning, these standards dealt primarily with the requirements of the physical plant, such as sanitary facilities, minimum bed space, and the like. It soon became evident, however, that medical supervision was also needed, and a full-time public health physician was assigned to direct the program.

The State public welfare program has been concerned with nursing home standards from the beginning. The primary concerns were the standard of care given the recipient and whether the cost of such care could be kept within budgetary limitations. It was also felt that the rate of payment should somehow be related to the amount of care required by the individual.

To help solve this problem, the 1953 State legislature authorized the welfare commission to employ two qualified public health nurses. Their duties were to supervise the standard of care—I emphasize that point—being administered in nursing homes, and to assist the local welfare office in determining the proper rate of payment. Now, this payment schedule was determined in joint meetings with representatives of the Nursing Home Association.

During the early years of this complex program, many conferences were held among representatives of welfare, nursing homes, and public health. Participating parties discussed their problems, aired their grievances, and shared their experiences. While many problems were solved in this manner, it soon became apparent that those nursing homes which were run by qualified operators fit into the program with little difficulty. As a result, the Nursing Home Operators Licensing Act was passed, which limited the management of nursing homes to individuals with special training. Now, this series of events has served to provide a steady improvement in nursing home standards, and I am confident the standards will continue to improve.

To summarize, we now have developed proper standards for the physical plant itself and for the amount and type of nursing care. We now have an equitable payment schedule for welfare recipients (who occupy about one-half the nursing home beds), a system for regular medical inspections, management by competent operators, and excellent liaison between all interested parties.

The spirit of open and free competition which has characterized this program since the outset is perhaps one of the biggest single factors in the development of these high standards. The good homes flourished, the poor ones did not, just as in most business enterprises. The chronic "problem" home can exist only in an atmosphere where there are no other homes to move to. It is my considered opinion that such competition should be encouraged.

The next area for consideration deals with improved medical supervision by the physicians themselves. Considerable study has been given this point by the State and county medical societies, and this activity will be reported by Dr. Paxton, my colleague.

Senator MORSE. Thank you very much, Dr. McGill. The next witness will be Dr. Paxton, referred to by Dr. McGill. Dr. Paxton is a graduate of Johns Hopkins Medical School, 1948; interned at Albany Hospital, 1948–51; was resident at Barnes Hospital, St. Louis, Mo. in 1953–56; practices neurological surgery; and is a diplomate of American Board of Neurological Surgery and chairman of the Multnomah County Medical Society Liaison Committee to the Multnomah County Public Welfare Commission. We are delighted to have you here, Doctor, and you may proceed in your own way.

STATEMENT OF DR. HAROLD D. PAXTON, CHAIRMAN, MULTNOMAH COUNTY MEDICAL SOCIETY LIAISON COMMITTEE TO MULTNOMAH COUNTY WELFARE COMMISSION

Dr. PAXTON. Thank you, Senator Morse. I would like to thank you for this opportunity to appear before your excellent committee. As a practicing physician in this field, I have long been interested in the care of patients in nursing homes, and, in addition to this, as chairman of the county medical society's liaison committee to the welfare

commission, I have been particularly interested in the care of welfare patients in nursing homes.

Now, the magnitude of our problem here in this county might be expressed in the number of patients which are in nursing homes, this being some 1,600 welfare patients. This constitutes approximately half of the nursing home beds in this community, and it also constitutes about an expenditure of half of our funds for medical care in the welfare budget.

The medical society had a committee which did a study of nursing homes some years ago, and, in a number of respects, the report was quite derogatory. Since that time the caliber of nursing homes has greatly improved. As a part of that study, they pointed out that they felt that perhaps more medical supervision and care should be extended to the welfare patients in the nursing homes. In this county, up until last year, these patients were the responsibility of the county physician, and this, quite frankly, exceeded his capacity. Very often, such care was a matter of emergency and the routine care involved in transportation to the University of Oregon Medical School clinics. This was exceedingly expensive, to take an elderly patient perhaps by ambulance that distance to have his prescription refilled. It was exceedingly expensive and, moreover, it did not constitute good continuous medical care.

For this reason, we held a series of conferences with the medical director of the State public welfare commission and with the consultant for the county welfare. The consensus of opinion was that we felt that some degree of care should be extended to these 1,600 patients. Our solution to this problem was to hire physicians for the nursing homes. These individuals would be paid $5 a month per patient, and they were to accept the continuous responsibility. They were to visit the nursing homes at least once a week. They were to supervise and at least expedite whatever rehabilitation was possible. If an emergency arose or if the patient needed hospitalization, we would send them probably to the private hospitals here in the community and to the University of Oregon Hospital.

We agreed to poll the medical society, which we did, and presented it to them as a community service. We found ourselves in a rather happy situation by having too many people wanting to help, and we very nicely had to reject roughly half of the people who wanted the jobs. We were able to assign some of the outstanding members of our medical community to the nursing homes. This has been in effect now for approximately 1 year, and I would recommend it to any county welfare nursing home group anywhere in the country.

We have had a few complaints, but these have been minimal and by far and large have fallen away. We expect this in any human endeavor.

Now, as to cooperation, we actually have a key method. We are in close communication with the county consultant, county welfare department. We work very closely with the caseworkers and we invite them to be with us. Moreover, we have a feeling that we save money by what appeared to be initially an expensive venture, and, while we have not been able to get specific figures, there haven't been many complaints. When we get few complaints about the financial structure of such a program, we have the feeling that we are breaking

even and, in fact, have reason to believe that we are doing considerably better than that.

Now, on one of the problems, one of my associates of this liaison committee is Dr. Arch W. Diack, and he is doing something which is really very exciting to us. I would like to report on it in a few words, and I would like to submit his statement into the record, if I could.

Senator MORSE. His statement will be received into the record.

(The prepared statement of Dr. Diack follows:)

PREPARED STATEMENT OF DR. ARCH W. DIACK, MULTNOMAH COUNTY MEDICAL SOCIETY, PORTLAND, OREG.

At the suggestion of the Rehabilitation Committee of the Multnomah County Medical Society, arrangements were completed in May 1961 with Goodwill Industries of Oregon and the Wallway Nursing Home (Portland) to conduct a demonstration on the effectiveness of work therapy for welfare patients in the nursing home. It was felt that many nursing home patients could benefit physically by some type of gainful activity and at the same time increase their self-respect by earning a small amount of money. Such funds might be used in part to offset welfare expenditures.

In July 1961, Goodwill assigned five women a simple task at the Wallway Nursing Home which could be completed at their leisure. It was agreed that they would receive a small amount of money for completed work. On August 1, 1961, a total of $10.75 was paid to these women, of which $6.24 went to one individual. Subsequently, another small project was assigned to one woman, and the work was completed in about 3 weeks.

The total amount of money earned by these individuals was not large, but the favorable effect upon them is noticeable. Through this very limited study, it appears a number of persons in nursing homes are able and eager to undertake constructive activities. Still many more persons who have lost individual initiative because they have been inactive for long periods of time may be stimulated to participate, especially if they are given an opportunity to become even partially self-supporting.

This project definitely improved morale at the nursing home. It was interesting to note that when one woman was assigned a task, four other women, who previously refused to participate, became interested and asked for work.

We are certain that many patients could benefit from such a project. An activity of this nature is a natural undertaking for a voluntary service organization.

Dr. PAXTON. Dr. Diack has been working, as you know, on the theory that perhaps 70 to 75 percent of the patients in our nursing homes are older than 75 years. This means that they are not productive members of the community and there are very few circumstances where they might be. The Goodwill Industries—we don't like to see a man, who has worked all his life, who now finds himself in a nursing home looking out the window and almost effectively waiting to die—has gone into the nursing home on an experimental basis and has tried to direct some piecework to a few of these patients to give them some reason or some method by which they may be a value to society. Although it's very small, I think it has worked very well, and we are very enthusiastic about it. We think it is one aspect of the care of the elderly patient in the nursing home that has been neglected and very little has ever been done about it.

Senator MORSE. Doctor, I only want to say for the record that it should show that the Multnomah County Medical Society in this field, as you have just testified, is really doing something that isn't too common throughout the United States. Our hearings elsewhere brought out testimony to the effect that in many places we do not have the close liaison relationship between the nursing home and the medical society,

as such, as we have close relationship between the nursing homes and individual doctors. Here in Multnomah County, as you have just brought out, you have a society program that I think is wonderful, and, as chairman of this hearing, I want this record to show that you have the congratulations of this committee because we know about this work. In fact, I am going to put into the record your full statement which you prepared for the committee because you went into some other phases of this in your statement that you didn't cover in your extemporaneous remarks, and that includes some cost figures that you covered in your statement, and I want to thank you very much for your statement.

(The prepared statement of Dr. Paxton follows:)

STATEMENT OF HAROLD D. PAXTON, M.D., CHAIRMAN, MULTNOMAH COUNTY MEDICAL SOCIETY

It is a privilege to appear here today as a practicing physician interested in the medical care of our older citizens and officially as the chairman of the Multnomah County Medical Society's Liaison Committee to the county welfare commission.

About a year ago the Multnomah County Medical Society joined with the Multnomah County Public Welfare Commission and the Oregon Nursing Homes Association in a program to improve the medical care of some 1,600 welfare patients in local nursing homes.

A committee of the society had previously reported that private physicians needed to play a more important role in this regard. They found that patients without personal attention lacked some of the motivation required to get well and thus might remain in bed for longer than other persons with similar illnesses.

In addition to the fact that welfare patients were not receiving routine care in the home by qualified physicians, there was the disturbing factor that the county welfare commission was spending from $4,000 to $6,000 per month on transportation charges alone for welfare recipients who were referred to the outpatient clinic at the University of Oregon Medical School. Our studies revealed that these patients could receive better care at a saving to the taxpayers if physicians were assigned to see them right in the nursing homes.

Prior to the development of this new bedside program, the medical care for these people had been the responsibility of the county physician's office. The demand far exceeded the facilities, and direct medical attention was practically nonexistent. The objective was to provide a better service at a cost equal to or perhaps less than existed when all care was provided by the county physician's office.

A poll of the medical society membership produced more than enough volunteers to man the program. The medical director for the county welfare department selected 38 physicians from the list who were assigned to supervise the care of about 50 welfare patients each.

These men are required to make weekly rounds in the nursing homes. They visit each patient and leave appropriate instructions with the registered nurse on duty at the home. They also are responsible for full medical care at all times, such as for consultations with the nurse and in the event of emergencies.

When indicated, patients are sent to private hospitals as teaching cases or to the medical school for further diagnostic tests or hospitalization in the county hospital.

Our bedside service is provided at a cost to welfare of just $5 per patient per month. The result is a smoothly operating medical-community team approach to meeting the basic needs of the welfare patient. Although no figures have been made available to our medical society committee, there is every reason to believe that savings to the taxpayers have been realized, and many patients have been returned to their families as a result of this personal attention.

Today welfare patients in our nursing homes receive continuous and expert medical attention at a reasonable cost. Thanks to the cooperation of the welfare commission, nursing homes association, and practicing physicians, welfare patients in local nursing homes are not forgotten citizens. Their needs are being met in a manner far exceeding anything previously accomplished.

We strongly recommend this type of local cooperative program be developed in other communities.

Senator MORSE. Our next witness is Dr. Eleanor Gutman, a graduate of University of Oregon Medical School in 1930. Dr. Gutman interned in Connecticut; was licensed in New York State in 1932 and in Oregon in 1946; was certified by the American Board of Public Health and Internal Medicine in 1951, currently engaged in the practice of psychiatry and public health in Oregon State Hospital at Salem, Oreg. Her present position is administrative assistant, clinical services, and, in this capacity, she supervises geriatric services at Oregon State Hospital, among other duties. I am delighted to have this witness here this morning.

I hope you will not think me too personal, Doctor, when I have this record show my high esteem for the dedicated public service you have rendered us for many years.

STATEMENT OF DR. ELEANOR B. GUTMAN, ADMINISTRATIVE ASSISTANT, CLINICAL SERVICES, OREGON STATE HOSPITAL, SALEM, OREG.

Dr. GUTMAN. Thank you, Senator. I should like to comment on the relationship of State mental hospitals to nursing homes in Oregon.

For nearly 80 years, Oregon's mental hospitals have been the custodians of elderly individuals whose behavior appeared too disturbed or too eccentric to permit family or nursing home care. Until recently, mental disturbance in the elderly has been looked upon as a permanent and progressive state. Individuals, who exhibited confusion, memory impairment, tendency to wander away, or distortion of ideas, or deterioration of social behavior, were classed as senile dements and were committed to mental institutions, there to spend the remainder of their days. Little was provided beyond custodial care and little was expected in the way of improved functioning.

So, the elderly segment of Oregon's mental hospital population has gradually increased to now 40 percent of the total census, fed both by the extended lifespan of the population at large and by the relative readiness of communities to commit their aged to mental institutions for custodial care. Half of all the patients, aged 65 and over, at Oregon State Hospital have reached that age since coming to the hospital. A year ago, the patient population contained 9 individuals who had been hospitalized for over 50 years and 202 individuals who had lived there 25 years and more.

In 1960 the population of Oregon age 65 years and older was enumerated at 184,000 which represented 10 percent of the total population. In that same year State hospital admissions in this age group from Multnomah County was 19 percent of their 1,100 admissions. And at this same time 39 percent of patients at Oregon State Hospital had reached or passed the age of 65. Thus one sees that the elderly population at large was doubled with respect to hospital admissions, and quadrupled in terms of hospital residents.

One must inquire: Is the State mental hospital the best place to care for these 1,800 individuals who presently inhabit our three State institutions? Are these persons hopelessly mentally ill? Are they unsafe to be in family care, or in nursing homes, or foster homes? Are

they incurably fixed in their behavior, unalterably set in a pattern of deterioration? The answer is definitely "No." A large portion of mental illness in this age group is reversible, just as it is in younger mentally ill persons.

During the past 3 years, 242 elderly patients, some of whom have been hospitalized for many years, have been released from Oregon State Hospital to nursing homes. Fifty-two others are being processed for discharge. More could be released were it not for certain difficulties and limitations in placement. Some of these are economic, some personal on the part of patients or their families.

What of the clinical, the medical aspect of hospital versus nursing home care? I should like, if I may, to submit the experience of Oregon State Hospital during a year's study, just completed, of newly admitted elderly patients.

On October 19, 1960, the hospital established a separate admission unit for patients 65 years and older. From that date to October 19 of this year, 408 patients were admitted to the geriatric unit. This represented 12.5 percent of the 3,267 total admissions over that period. To date, 159 of these aged patients have been released, 142 of them remaining out of hospital, which is 35 percent of the total group. Those who have returned are not considered by us as treatment failures since our assumption is, as in any chronic illness, that many of these elderly persons will require intermittent periods of hospital care for their mental and for their physical ills.

One might question whether these patients, who were able to be released in 4 to 6 months, were justifiably hospitalized in the first place. In most instances, they were. One-fifth were admitted on voluntary commitment, the remainder by court commitment. Nearly all showed some degree of mental disturbance during their first weeks or months of hospitalization. Many of these elderly patients showed frank psychotic illness such as may be seen at any age. Many showed chronic brain changes which might or might not improve with care. A large number exhibited generalized physical illness which was only secondarily related to their mental state.

Now, of the 408 who were admitted to the geriatric unit, 80 have died within the year. This 20-percent death rate is far in excess of the 5.7 per hundred death rate for age 65 and over in our State at large. We have no figures for the age specific rate in nursing homes or general hospitals. These would be of tremendous interest. Notably, however, 41 percent of the deaths in our institution occurred within the first month of hospitalization and 14 percent within the first week. Obviously, many of those individuals were in terminal physical illness at the time of their commitment to the mental institution.

It is significant to note that much of the acutely disturbed behavior which precipitated commitment subsided within a few days or weeks of admission. Patients committed as unmanageable, assaultive, noisy, or uncooperative, appear to adjust rapidly in an environment of understanding and acceptance. Many of these elderly patients feel acutely rejected by families and bereft of friends. We see them deeply depressed or aggressively angry at the world. Many regress to childish habits of eating or soiling, or retire into noisy protest or mute negativism. Under treatment with medication, attitude, and

activity programs suited to their needs, these patients frequently show dramatic change to more acceptable behavior.

So, it is our belief that during the acute stage of mental illness these folk should be treated in the psychiatric hospital, as in the acute stage of physical illness they are to be treated in the general hospital. Otherwise, with proper supervision and consultation, the elderly, as well as the young, may be better cared for in their home community. When they are no longer acutely mentally ill, then they may live more comfortably in their own environments than in large institutions. We are convinced that nursing home care can provide a climate as effective, if not more so, than that of the large institution.

Senator MORSE. Thank you, Dr. Gutman. Your testimony presents a difficulty to me because I am not going to yield to the temptation of discussing it with you here publicly. I do want to have a personal conversation with you as to the significance of this testimony, because, as we conduct these hearings throughout the country, we are constantly finding the great neglect that we, the people, are guilty of in connection with our mentally ill in this country. Your testimony moves me to say, however, even though we are in the early part of these hearings, how much we owe those nursing homes in this country that are cooperating with mental hospitals in taking over some of the older mental patients who are quite fit and suitable for nursing home care. I don't think the public itself fully appreciates the public debt of gratitude it owes to the nursing home people in this country, both the nonprofit and the proprietary. Our committee has been very much concerned about this problem because it is really a shocking thing to find throughout the United States the number of people who are sent to mental hospitals who really could be sent to nursing homes or to proper psychiatric care with the cooperation of the psychiatrists in the area. As a people, we certainly must face up to this. The clear implication of your testimony is that a good number of these people would be much better if sent to nursing homes. That is why we have gone on record that this work has been partially successful, but not nearly as successful as it should be. We will see that it is more successful when we get the support back home—when I say "back home," I mean across America, State by State—to get the Federal appropriations that we have been asking for to help these fellow citizens of ours so that those who can't afford it can be sent to the nonprofit homes, and those who can make some contribution go to the proprietary nursing homes.

What I want to stress, and then I am through with this comment, is that I look upon the nursing home institution, both nonprofit and proprietary, really as a great human resource in this country to assist you people who operate our mental hospitals and the medical profession as a whole, to meet what I consider to be our moral obligations to the elderly.

I happen to be a strange bird, I guess, in politics. I happen to be dedicated to the proposition that we, in Government, have the duty to translate moral values into legislation, and the purpose of this hearing is to produce evidence and facts to show us what kind of Federal legislation ought to be adopted. At least, that is one of our purposes. I want to say that in this hearing, as far as I am concerned, I am going to continue to support the program that we have been

sponsoring in Congress. It is based upon the theory that the Federal Government has its share of responsibility to help these mental patients, especially through adequate appropriations.

I want to say to my fellow citizens that we ought to fear social injustice more than taxation in the United States. Thank you very much.

Our next witness will be Sister Lawrence, formerly director of the geriatrics wing of St. Elizabeth's Hospital in Baker, now in St. Anthony's Hospital in Pendleton. She will inform us of the service performed by her hospital. Sister, we are honored to have you, and you may proceed in your own way.

STATEMENT OF SISTER LAWRENCE, ST. ANTHONY'S HOSPITAL, PENDLETON, OREG.

Sister LAWRENCE. Senator Morse and distinguished committee, I hadn't intended to be here and I came here on very short notice. Right after noon yesterday, I was called and asked if I would come down to this meeting. I think the reason I was called here is that we, in Baker, Oreg., were the first general hospital that established a nursing home unit for the aged, and ours worked out very satisfactorily. In Baker, the population has not grown as in many places of the State, and we did have 50 beds to turn over to the nursing home, and it worked out very well. So, I think this is the reason for my being here today.

Since I didn't have time to prepare a statement, I will be happy to give you the benefit of my personal experiences in connection with the home. However, this morning before I left by plane from Pendleton, I did work up these few notes. At St. Anthony's in Pendleton, we just opened up an 80-bed new hospital. This will give us at least 30 beds to turn over immediately to a nursing home.

Well, after you spend over $2 million, you are very conscious of costs. So, when we reached the end of the year, I worked out the per diem cost per patient, based on 100 percent occupancy on a unit of 29 patients. Would you care to hear this?

Senator MORSE. Yes, indeed.

Sister LAWRENCE. Well, the per diem cost, not including any depreciation or building cost, will come to $196.13. I will break that down for you: one nurse supervisor at $18 a day; two practical nurses at $14 a day; three nurses' aids, which will come to $27 for the three of them per day; and an orderly for $14 a day. The total nursing cost for 1 day would be $87; in 30 days, it would amount to $2,610. As you know, 5 percent of that goes for employee benefits, and that amounts to $130.50. The total payroll for the full 29 patients will be $2,740.50.

The food and preparation of the food, I think, will be an average cost of $2 per person per day. The total food cost for a 30-day period would be $1,740; insurance, fire, medical, medical practice insurance, would be $100; janitorial service, maid, and cleaner, would be 3 hours a day, and at $1.58 an hour it would be $142 for 30 days; maintenance, repairs and so on, $130; light, heat and water, $175; phone service, $25; laundry averaged 50 cents a day, which comes up to $435; administration cost, which would be bedding, and so on, $200. The

total cost of caring for 29 patients would be $5,687.70, or a per diem possibly per patient of $196.13. This does not include building or depreciation, or anything else of like factors.

I am sorry I didn't have time to prepare anything more to give you and that this is all I have. If you have any questions you would like to ask, I would be very happy to answer them.

Senator MORSE. I can't begin to tell you, Sister, how excellent this kind of testimony is because we get very little testimony that gives us a factual breakdown of costs, such as you have given us here this morning, and we certainly welcome your making any supplemental statement for the record that you may wish to file with us in the next 30 days. I am very glad you put this in the record, because so many people just do not realize what the minimum costs are. Here we are not dealing with a profit institution; we are dealing with an institution that has certain inescapable costs in order to perform this nursing and medical service.

Mr. Reidy just said to me in a whispered conversation here that this is the kind of evidence that we need because without it we can't begin to deal with this matter of what should be considered to be Government's responsibility, National, State and local, in making contributions for the carrying out of what I referred to as our moral obligations. I am never going to lose sight of that because we, the people, have that kind of a moral obligation if we really mean it when we profess to say that we are our brother's keeper. You people who are doing this humanitarian work are just going to have to give us such hard, cold facts, as you have given us in this testimony, so that when we sit down before the Appropriations Committee of Congress we can say that these are the minimum costs, and this is what our expert witnesses throughout the country have filed with us. One of the best services you could render is to supplement what you have already said to this committee by additional financial data, so that we can say, "Here, at this hospital at Pendleton, we know this is what it costs," and we know that we will find this without exception throughout the country. Thank you very much indeed.

Our next witness will be Mrs. Anabel T. Allison, graduate of the University of Oregon in education and psychology, 1941–43, administrator of training, U.S. Air Force Portland Subdepot, Portland, Oreg.; since 1955 owner and manager of the Sandy Boulevard Sanitarium and Allison Nursing Home, both of Portland, member of the National Nursing Home Association, and chairman of the accreditation committee of the Oregon Nursing Home Association.

We are delighted to have you, Mrs. Allison, and you may proceed in your own way.

STATEMENT OF MRS. ANABEL T. ALLISON, PROPRIETOR, ALLISON NURSING HOME, AND CHAIRMAN OF NURSING HOME ACCREDITATION COMMITTEE

Mrs. ALLISON. Thank you, Senator Morse. My purpose in appearing here with you today is to acquaint you with the national program of accreditation of nursing homes and the progress that has been made in Oregon toward accreditation of nursing homes.

As stated, I am chairman of the accreditation program for the State of Oregon, and I feel it is of great importance that the public and your committee be made cognizant of this program, what it will do, and what it will mean to people seeking nursing-home care. The primary purpose of such a program, and by far the most important reason it is being instigated, is that of raising standards of nursing homes.

We, in Oregon, are very fortunate in that we have some of the highest standards in the Nation for nursing homes. We are also aware that we have some differences in the quality of nursing homes in Oregon. The premise of the National Nursing Home Accreditation Committee, as well as the Oregon Accreditation Committee, is that all homes must operate on an efficient, professional basis, with sound, meticulous nursing procedures, and the public is entitled to know which homes meet our standards, and it is our intention to bring about this situation. The origination of this particular program is probably of little interest to you with the exception perhaps of the fact that it has been carefully planned, involving in time almost 10 years. The execution, however, will prove to be of great interest to you, and we hope to be able to publicize our activities to such an extent that the public will easily follow this program.

Allied professions have been and are being of great assistance to us in this effort as an integral part of the committee of the advisory council. This advisory council is composed of one member each from the State medical association, State hospital association, State dental association, State league of nursing, State nurses association, State licensing agency and in Oregon this is the State board of health, the reimbursing agency or State welfare commission, the health insurance council, and one member from each category of the nursing homes. The advisory council will not only participate in an advisory capacity, but, from this group, a survey team will be elected. As you can readily ascertain, all personnel on the survey team will be persons well grounded medically, experienced, and capable of carefully weighing the activities of the nursing homes.

The survey team itself will include three members of the advisory council, one of whom is to be a nursing home representative, and automatically include the chairman of the State accreditation committee. The survey team is required to go into the nursing homes to examine and evaluate all departments of operation, including administration, medical care, medical records, nursing care, restoration activities, all activities in essential services. There are subdivisions under each of these headings, which are all-inclusive, thereby perpetrating an extremely comprehensive inspection, in turn demanding substantial, high standards in order to qualify for accreditation.

We in Oregon have decided to make the requirements even more stringent by adding a rating within the accreditation system. We will have three categories: Excellent, standard, and nonaccredited.

In order to be rated excellent, a nursing home must maintain a very high standard of proficiency, including a well organized program for personnel, good rehabilitation practices, and excel in emotional and physical care for the patients. The facilities must be maintained safely and be scrupulously clean. Our reporting and recording systems will fulfill a two-fold purpose: Not only will the accreditation or the lack of it be accomplished through this system, but we plan to

maintain close communication with municipal and State health departments, State welfare agencies, hospitals, and medical organizations. Through these mediums, trouble spots will be quickly recognized by inspection divisions. Welfare will have a guide as to which nursing homes are providing not only necessary but efficient services. Hospitals will know what homes to recommend to a patient being discharged but in need of further care, and doctors will have knowledge of where they can place their patients to the best advantage of all concerned.

We anticipate our reporting of the accreditation system as being an extremely important part of our plan. You will readily understand that, in order for the program to be successful, it is highly important that accurate, factual information be made available to those persons in need of our services, that you know from what sources to obtain such information, and that it be easily accessible to the public and that it be information upon which you can depend.

There are many problems arising as we progress in this program. One which has been foreseen and studied since the very inception of our activities is that of national standardization. Actually, this problem is no more acute to us than it was to the hospitals when they developed their accreditation program some 15 years ago. There is no such thing as perfection, and without effort, without foresight, and without a start at some arbitrarily chosen point, absolutely nothing can be accomplished. This is progress. It is a step in the right direction.

With proper controls, execution, and cooperation, a definitely ascertainable program can be in existence within a short time. Actually, the only fine point where we are not in complete accord right now between the States is where the State laws vary in their requirements. We, in Oregon, are most fortunate in that we have good laws, govering our nursing homes. Our facility requirements are good, and we are, as far as I know, the only State in the Union with an administrator's law which has been in existince since 1956. It is already beginning to have an elevating effect, due to the fact that people in the nursing home business must have experience, be of good moral character, and have business acumen.

With the assistance of your committee and the public's interest in our efforts, the accreditation program will be successful and will ultimately provide the type of uniform nursing care in our nursing homes which we all desire.

I thank you, Senator Morse, for giving me the privilege of speaking to you on the accreditation program.

Senator MORSE. Mrs. Allison, I want to say for this record that one of the tentative conclusions I have reached in connection with our hearings elsewhere is that, where you have a serious nursing home problem—one in which there is evidence of low quality—the problem appears to be due to these factors: First, they do not have the kind of policing, shall I say, within the nursing homes conducted by the nursing homes themselves as you outlined here this morning with your accreditation program. It is so essential, I think, that they have the kind of accreditation program that we have in Oregon.

For the benefit of those attending this hearing, I would say the record is pretty clear that our nursing homes are among the highest quality in the country. It is not true everywhere. It is not true, for

example, in the District of Columbia, where I serve in effect as an alderman. I have been the equivalent of an alderman in the District of Columbia for many years, and I am on the District of Columbia's Standing Committee. We have a serious nursing home problem there. The fault isn't in the nursing homes in my judgment. The trouble is they are only getting, from public assistance, around a hundred dollars a month. It's a very high-cost area, and on that the homes can't begin to maintain the standards which you maintain here.

We also have the problem of accreditation in the District, and I hope that we can do something about it when we open up our hearings here early next year. Thank you very much.

The next witness will be Mr. Fred Stabler, representing the Oregon Nursing Homes Association, with a degree in business administration. Mr. Stabler served in the Adjutant General's Department, U.S. Army, 1942 to 1946, was assistant superintendent of Multnomah County Home, 1948, is a member of the nursing home advisory council of the State board of health, and a member of the Educational Committee of the American Nursing Homes Association.

Mr. Stabler, we are glad to have you. You may proceed in your own way.

STATEMENT OF FRED STABLER, REPRESENTING THE OREGON NURSING HOMES ASSOCIATION

Mr. STABLER. Senator Morse and members of the subcommittee of the Senate Special Committee on Aging, the Oregon Nursing Homes Association appreciates this opportunity to appear before your subcommittee, Senator Morse, and discuss nursing homes in Oregon with you. We feel that a great benefit can result from this hearing.

In Oregon, the State board of health is charged with the responsibility of licensing nursing homes, assuming this duty in 1947 under the Hospital Licensing Act. Under the capable guidance of Dr. Robert Heilman, and the cooperation of the nursing-home owners and administrators, the standards set as licensing requirements are among the highest in the Nation. The 1961 session of the Oregon Legislature passed a measure which further safeguards the patients. The State fire marshal must now approve a home before the board of health will issue it a license. As a practical matter, this has been the procedure for years, but now it is law.

In 1955, following a bad situation in one of the nursing homes, the Oregon Nursing Homes Association sponsored and passed, with the assistance of the State board of health, an administrator's licensing law. It is worthy of note that the decision to sponsor such a law followed a meeting between members of the association and Dr. Heilman of the State board of health.

It is almost axiomatic that the finest nursing-home care occurs in those States where close cooperation exists between the State agencies and the nursing homes. This cooperation has reached a high level in Oregon over the past few years. The Oregon Nursing Home Association is proud of having secured the passage of the administrator's licensing law. We believe it indicates a professional attitude toward the patients in our homes for us to discipline our own members and act as a responsible organization.

Oregon's requirements for a nursing-home administrator's license are unique among the States. Until August of this year, one needed to be a registered nurse or have an education equivalent to a registered nurse in order to be eligible for an administrator's license unless, of course, a person had received his first license under the grandfather clause of the administrator's licensing law. There are additional requirements which another speaker will present to you today. It is now possible for a person to secure an administrator's license if he completes 4 years of college work with some training in accounting and business administration; also, if one has had 3 years of experience in a nursing home and has devoted 40 hours a week for 48 weeks in each of the 3 years which he worked in such home and passes an examination given by the State board of health. We are sure your committee will find that Oregon is far ahead of most States in its requirements as to licensing nursing homes and issuing administrator's licenses.

We believe that the State board of health has been particularly wise up to this point in being more concerned with the patient care rendered in a nursing home than in the physical plant of the home. We have found that marble halls are not a guarantee of a good nursing home. In fact, most patients who go to nursing homes prefer something in the way of surroundings more closely akin to the home they left. While the standards of care have been most closely watched, the board has moved steadily forward in its requirements concerning the physical properties of the nursing homes in this State.

In years gone by, the common conception of the nursing home was a facility similar to the county poor farm with all the stigma attached that this was the place to go to spend one's last days in a cold, bleak, unwanted environment. Today, this is no longer true. However, there needs to be a tremendous job done in public relations to acquaint the public with the new concept of the skilled-care nursing home which is taking on a whole new image. Unless one has had direct contact with the present-day nursing home through having a loved one in such a home, or has worked with a volunteer group, he has not had an opportunity to become acquainted with the new concept.

The nursing home of today is a comfortable, safe, and clean facility, arranged and equipped to give efficient, skilled nursing care. The doctor's orders are given to registered nurses who are delegated the responsibility of seeing that the orders are carried out to the doctor's satisfaction. Balanced diets and prescribed diets are prepared by trained kitchen personnel. Physical therapy is made available to the patient who has the potential for rehabilitation to daily living needs.

I might inject that the State board of health has employed a graduate physical therapist who will be working with the nursing homes throughout the State of Oregon with the development of the physical therapy program in the nursing home. Also, I might mention that a trained dietitian is available through the State board of health to assist in the nursing home in developing an efficient and skilled diet program. Realizing that the mind and the body need to work together in order to maintain emotional stability, the new trend in nursing homes is to provide, in addition to skilled nursing care, recreational activity, arts and crafts, and community participation through pro-

viding trained volunteers. Along with this new image of the modern nursing home comes the realization and need for better qualified and trained administrators. That is an insight into the new image of the nursing home. There are many nursing homes throughout the Nation that fit into this image now, and many more that will come into this image in the near future. A nationwide accreditation program for nursing homes is now just coming into being and will implement the development of better nursing homes providing better skilled nursing care. In Oregon, we will have an accreditation program in effect after the first of the year 1962.

Now, let us see how the nursing home fits into the progressive care picture. For example, let us take this hypothetical case. The patient with an acute illness is admitted to the hospital for intensive care. If this illness should be of a nature that could be chronic or long term and no longer in need of the intensive hospital care, but still needs skilled nursing care, the patient can move from the hospital to the nursing home where the skilled nursing care can be continued under careful medical doctor prescribing and professional nurse supervision carrying out the doctor's orders. In due time, many nursing home patients with the advantages of skilled nursing care, physical therapy, proper diet, and emotional stability maintained can progress to the point that they can be transferred to a supervised living-care facility, to the home of a relative, or even to their own private living situation again. This is what we are going to be hearing more and more about, progressive medical care.

One thing that I have not touched upon is the economic factor. This cannot be overlooked. We all know that intensive hospital care for the acutely ill is expensive and justifiably so, according to hospital cost studies. Here again, the nursing home comes into the picture with a cost considerably less than the hospital, but still needs to be high enough to insure skilled nursing care. This cost again must be based upon accurate cost studies made by competent nursing home administrators through their accountants. As the patient with the potential for rehabilitation arrives at the point where he no longer needs skilled nursing care, he can be transferred to an even less expensive care facility, or to his own home. These are the health services that are available to that segment of the aging that is faced with a long-term illness.

Now, let us explore the avenues of service that the community can provide to the aging that is in the nursing home. The nursing home has a responsibility to the community to provide an adequate facility, well administered, and provide skilled nursing care under professional supervision. Now, the community has the responsibility to the aging in the nursing home of providing trained volunteer workers. These volunteer workers can assist in caring for the spiritual needs of the patient, can work with arts and crafts, and can plan social and recreational activities which are all a part of caring for the whole individual, not the body separated from the mind. Also, it is hoped that the future will see more referral and information centers on the community level that can coordinate these resources available for the well-being of the aging.

As we are talking about rehabilitation of the whole individual, I cannot stress the word "happiness" too much. One person has de-

fined happiness as a firm conviction of being loved. I am sure that the aging person in our society is being loved just as much today as the aging were a hundred years ago, in spite of the fact that we hear to the contrary without taking into consideration that we are living in 1961 and not 1861. Sometimes children are criticized for not caring for their parents in the child's home as has been done in previous generations, but medical and social research has come to the conclusion that this is not always the best for the aging parent. So, again, I emphasize that we must live and think in 1961.

Another way of expressing happiness is one who can enjoy the scenery when he is on a detour. For example, if you are traveling down a beautiful highway, enjoying the scenery, and all of a sudden come to a detour that takes you over a bumpy, dusty road, a good test of your happiness is whether you can still enjoy the scenery while you are on the detour, and a comparable analogy can be made for the happiness of the patient while he is on a detour in the nursing home as compared to the happiness he enjoyed when he was walking down life's highway, physically and mentally well. Time does not permit going into the various facets of the two-way process of coordinating the nursing home services with the community volunteer services, but I assure you from personal experience there are many.

As a nursing home administrator, I think that much can be accomplished in coordinating available resources for the well-being of the aging by the nursing home taking an understanding attitude toward cooperating agencies, medical care facilities, and other health services with which they work, rather than an attitude of condenmation. I cannot overemphasize that there must be a more adequate communication among all health services in order to insure the best service available to our aging population.

There is a great deal being said over the country about rehabilitation of the patients in nursing homes. It is the desire of good nursing home administrators to restore to the patient as much physical and mental activity as the capabilities of the patient will allow. Many homes in Oregon have practiced rehabilitattion for years within a limited scope. Here again, economics and trained personnel enter into the picture. Physical therapists and equipment must be available together with sufficient space in the home to carry on the program. Much is being done with simple devices to teach the patient some measure of self-care. Any intensive program with trained personnel must contemplate payment of rates commensurate with the services rendered. In Oregon, there is a study being conducted under realistic conditions which will prove very beneficial. The Multnomah County Medical Society, in cooperatiton with the Goodwill Industries and the Oregon Nursing Home Association, is conducting a program of rehabilitation in the Wallway Nursing Home located in Portland. The project has not been in operation long enough as yet to allow a comprehensive report. Early indications are, however, that much can be accomplished for the patient, not only by restoring some physical activity to him, but also by restoring his confidence and self-esteem. In a few months, this worthwhile project will be completed, and we will then be in a position to evaluate it and help install the program in other homes in the State.

In closing, I would like to say that Oregon is fortunate among the several States in having an alert board of health and an active nursing home association that have consistently worked together toward higher standards in the care and facilities of the nursing homes in Oregon. We have also been fortunate in having a State welfare commission that has sought to provide a high standard of care for welfare recipients within the limits of the funds available. These two State agencies, together with their staffs are, I believe, among the best in the Nation.

Senator Morse, we believe the elderly people of the State of Oregon are being provided some of the finest nursing home care available. If we all continue to do our part in providing tender, loving care for the aged, Oregon's elderly citizens will be among the best cared for in the Nation.

Senator MORSE. Thank you very much, Mr. Stabler, for your very helpful statement. If you wish to enlarge upon it by filing a supplemental statement within the next 30 days, we will be very glad to receive it. I am sure that your statement is very helpful to us.

Our next witness will be Mr. Walter Carte, county commissioner of Wasco County. Mr. Carte attended schools in Idaho, graduated from the School of Pharmacy of Idaho State College in 1939, moved to Oregon in January 1949, now operates a retail pharmacy in The Dalles, Oreg., was appointed county commissioner in 1957, and elected for another term in 1958. Wasco County is one of the few taxing bodies which operates a nursing home. His testimony will, therefore, lend insight to one of the facets of the nursing home problem.

Commissioner, we are very glad to have you.

I understand from Mr. Reidy that there have been some comments from the audience in regard to our very valuable helpmate, who is sitting in the middle of the hearing room on the platform. He is not a man from Mars. He is our official reporter. Mr. Montgomery will travel with us in the Northwest. This is my first experience also with this method of transcription. It shows at least that times are changing. I will be very much interested in the results of this fascinating transcription. I want to publicly thank Mr. Montgomery for giving his assistance to this committee.

Commissioner, you may proceed in your own way.

STATEMENT OF WALTER CARTE, COUNTY COMMISSIONER, WASCO COUNTY, THE DALLES, OREG.

Mr. CARTE. Senator Morse and staff, this is a statement from Wasco County to the Senate Committee on Aging.

In the early 1900's, this nursing home was built as one of the buildings of a county fair. In approximately 1922, the building started operating as Wasco County Poor Farm, caring for the indigents in the area, at which time they produced large amounts of their own farm products, including meat. In the 1930's, it came into operation to supply food to needy families. During these years, WPA workers built the basement and the second floor, and during this time it was renamed as the Wasco County Hospital and doctors were employed. Some time during the late 1940's, the hospital was licensed as a nursing home for some 30 patients, nearly all of whom were elderly patients.

The patient load remained static for several years and then starting in 1956 it has increased greatly, and this has continued to the present, and a remodeling program has been carried on. At the present time, the nursing home is licensed for 56 patients. Since there are no privately operated nursing homes in this county, nor in four adjoining counties, the name was changed in 1957 to Columbia Basin Nursing Home, which more nearly indicates the area usage of the facility. Also, it shows the desirability of a home for the older citizens in their home areas so that they can be visited often by their relatives.

At present, a partial survey shows that the facilities should be doubled in size from what we now have. To aid in the general solution of this pressing problem, we have appointed three men, Mr. Ivor Davies, Mr. Leo Hammil, and Mr. D. S. Elwood, to work as an advisory committee. We have been working with the Oregon Public Health Department to see if it is possible to procure Hill-Burton funds to help us build another or add to our present plant. May we add that the extremely high cost of construction of a good nursing home is a serious problem. It is approximately $11,000 per bed.

In the operation of the nursing home at present, we have a licensed floor space of 1,652 square feet on the first floor, and 3,045 square feet on the second floor. Yearly, we are inspected by the Oregon State Board of Health on licensing, and the State fire marshal also makes his inspection and recommends any corrections necessary. The building has a fire alarm, fire extinguishers, and a complete automatic sprinkler system. At present, we have 25 full-time employees, including a registered nurse as the superintendent, and another registered nurse, one of whom is always on call. The registered nurses administer all medications and supervise all the other employees. Each patient has his own doctor. One local clinic sends a doctor to the home daily who is advised of any medical problems. If a patient becomes critically ill, he is transferred from the nursing home on the doctor's order to a hospital.

Senator MORSE. Commissioner, if you don't mind my interrupting you, in your report in the very heart of your testimony you discussed your inquiry as to whether or not Hill-Burton funds would apply to the Wasco County Nursing Home. The chairman is pleased to advise you that you will be eligible for such funds if you meet the terms and conditions of the act. I think you will be pleased to know that on the recommendation of this committee we have increased the funds from $10 million to $20 million for nursing homes, with a caveat in the amendment that stresses the desire of the Congress to have special consideration given to homes that take care of the elderly. That is at least a step forward, and it will help to some extent those nursing homes which qualify under the other provisions of the act, to seek some funds. So, the record should show that you are at least eligible to apply for funds under Hill-Burton.

Mr. CARTE. That is good news, Senator. The number of patients treated from July of 1958 to July of 1959 was 504; the next year 600; and the following year 672. Our charge for a private patient is $7.75 per day, and if they receive physical therapy, we charge them 50 cents for the treatment made. The public assistance patients are evaluated upon admission by the caseworker and the administrator as to the classification of treatment and these are now paid for by rates

of $145, $169, or $192 per month, depending upon the amount of care necessary.

The physical therapy program is one that was installed in January 1961, with a registered therapist, Miss Marcelle Montgomery, of the Oregon State mobile unit in charge. She visits the home regularly, instructs the aged, and cares for those who receive physical therapy. We now have about 20 patients who receive physical therapy weekly, plus a few outpatients who receive treatment as designated by the doctors, and the treatments are for both public assistance and private patients equally.

The State of Oregon has compounded our space problems by sending us people out of State care homes, and we have a large number of them in our home. Some of these people have had their original homes in other counties, and we receive many people from Columbia Park Home, the geriatric home. The State mental hosiptals have also, by use of new drugs, become able to discharge many more patients, and some of these will become nursing home patients. Many of our patients are mentally disturbed people whose care requires a great deal of our time.

We are enclosing a financial statement of our last 3 years of operation. Approximately 50 percent of our patients are on public assistance roles, and the nursing home has received some $50,000 for care in the last fiscal year. The other half of the patients, whose care is paid for by private sources, have paid some $79,000. In our financial statement, you will note that the nursing home has been able to show a modest surplus at the end of each year of its operation, a surplus which is possible by reason of the extremely efficient management of the superintendent. Also, the rates for private patients are considerably less than would be charged for by a privately owned nursing home.

In all fairness to the privately owned nursing home, we must point out that our nursing home has many economic advantages which they do not have. We are able to buy surplus foods, are able to buy on county bids, and are exempt from taxes.

We thank this committee for the opportunity of informing it on the operation of our nursing home. We hope that our experience in our particular locality will be of some assistance to the committee. Our major concern is to properly care for senior citizens so that they may enjoy their last years in comfort and dignity, no matter what their status financially.

Senator MORSE. The chairman would like to make one request, if you can accommodate us and if you would prepare it. It would be helpful to us if you would submit a supplemental financial statement, showing your breakdown on cost per patient.

Mr. CARTE. That we can do.

Senator MORSE. That is really what we need, in addition to this general cost statement. We need to collect all the evidence we can on what it is costing these nursing homes per patient, because, when we get before the Appropriations Committee, they will get down to the lowest possible base calculated figure. I am positive they will say, "Senator, what did you find was the cost per patient?" When they start to consider recommendations of this committee for additional appropriations. I haven't any doubt that this committee will recom-

mend additional appropriations for the nursing home program, but we are going to have to prove our case. So, I am asking you to help me prove our case.

Mr. CARTE. We will be glad to do it.

Senator MORSE. Thank you. Your financial statement will be made a part of the record.

(The financial statement referred to above follows:)

(Mr. Carter's amended statement included the following additional information:)

The cost per patient per day is $5.43. This cost is the same for private and public assistance patients. It does not include any depreciation schedule of buildings or equipment other than remodeling work done during the current year.

In light of the testimony given by witnesses during the hearing we submit that nursing homes operated by tax-supported bodies such as Wasco County have many advantages and should be given serious consideration for assistance from the Federal Government.

Wasco County, Oreg., Columbia Basin Nursing Home—Expenditures and revenues

	Actual for year ended—			Budget, 1961–62
	June 30, 1959	June 30, 1960	June 30, 1961	
Salary, supervisor	$6,000.00	$5,000.00	$5,400.00	$5,700
Nurses	23,834.03	29,410.77	36,010.18	44,000
Other employees	19,065.09	21,870.90	26,967.97	25,300
Total, salaries and wages	48,899.12	56,281.67	68,378.15	75,000
Housekeeping supplies	1,590.00	2,084.86	2,343.23	2,500
Kitchen supplies	9,556.43	8,999.60	14,103.61	13,500
Medical supplies and services	1,292.39	1,261.52	1,042.89	2,000
Building maintenance	3,728.63	5,138.20	1,966.73	3,500
Equipment maintenance			567.51	
Fuel oil	813.52	953.71	1,800.65	1,500
Electricity	1,840.34	1,736.60	1,896.66	1,620
Water and sewer			700.56	700
Laundry, housekeeping services	111.65	15.60	153.60	500
Telephone	180.00	180.00	180.95	180
Social security	3,566.53	3,600.00	3,600.00	3,700
Industrial accident insurance	437.12	641.23	896.62	1,000
General insurance	352.82	485.83	761.40	650
Miscellaneous expenses			87.95	
Total operating expenses	72,368.55	81,378.82	98,480.51	106,350
Capital outlay	4,606.54	2,641.98	11,059.99	58,000
Total expenditures	76,975.09	84,020.80	109,540.50	164,350
Revenues	96,491.47	99,444.30	129,585.61	140,000
Margin	19,516.38	15,423.50	20,045.11	24,350

Senator MORSE. Our next witness will be Mrs. Hale Pragoff, medical social work consultant, who received her B.A. and master of social work degrees from the University of Minnesota. She took additional graduate training in social work at Tulane University, the University of Southern California, and the School of Social Work, Columbia University, and Yale. She has been a medical social worker at the Charity Hospital in New Orleans, La., and the Veterans' Administration hospital at Minneapolis, Minn.; also, assistant director of hospital service of the midwestern area of the American Red Cross, medical social consultant of the Arizona State Department of Health and Oregon Public Welfare Commission. She is a member of various community committees and boards and has contributed to professional

journals. She now is the medical social work consultant with the Oregon State Board of Health.

With these wonderful qualifications, Mrs. Pragoff, I am delighted to invite you to the stand. You may proceed in your own way.

STATEMENT OF MRS. HALE PRAGOFF, MEDICAL SOCIAL CONSULTANT, OREGON STATE BOARD OF HEALTH

Mrs. PRAGOFF. Senator Morse and your committee, I am particularly grateful and happy to explain the following activity for we believe it is a new innovation as far as most States are concerned—or, the development of coordinated citizen participation through communitywide volunteer activity programs over a State.

The Oregon State Board of Health has joined with a group of representative community organizations and agencies to further stimulate and help in providing more citizen participation in communitywide volunteer activity programs in nursing homes and in homes for the aged in Oregon. These groups, having a feeling of responsibility for improving the physical, the social, and the emotional well-being of our senior citizens residing in these homes, requested the State board of health to assume the leadership in this endeavor.

Following this request, the Portland Community Coordinating Committee on Volunteer Services was developed. This included representatives from State, local, and county organizations, agencies and groups, such as the Oregon Council of Churches, various church groups, the women's auxiliary of the State medical society, the American Red Cross, Salvation Army, the chaplain's organization, senior craftsman, the Portland Visitation Group, which is sponsored by the Federation of Women's Clubs, and the women's forum, and the State council on aging. Also, this included administrators from the Oregon Association of Nursing Homes and Homes for the Aged, and representatives of the Oregon State Public Welfare Commission, the Multnomah County Public Welfare Commission, and the Oregon State Board of Health.

The purpose of this project is to encourage over the State of Oregon the development of citizen participation to help cover some of the unmet social and emotional needs of residents in these homes through providing activities that would make life more meaningful for them. These activities would offer something to these senior citizens that money cannot buy—friendship, personal interest, and thoughtful attention by someone who cares and who is not paid to care. This group could provide a program of visitation, including recreational and craft activities and help to those oldsters who are lonely and who are lost to life's warmth because they are unable to keep up contacts outside these homes. Or, they may feel too useless or unwanted to offer themselves as friends to others or to carry on some of their former interests and activities. Through this offer of friendship and true concern, volunteers would help residents regain their sense of worth and prove to them they still count in someone's world. This would not only bring more personal and social enrichment to the lives of these older people, but would also vitally contribute to protecting and improving their physical and mental health and to preventing further deterioration.

The ways and means of achieving this needed humanitarian project is being facilitated through four procedures: One is the development of a manual or guidebook on volunteer services in such settings. Its aim is to assist communities, organizations, agencies and groups, nursing homes and homes for the aged, to better understand the use and value of volunteer services, and also ways in which they can further effectively extend and strengthen, develop, coordinate, and maintain such activities.

The second procedure is to hire a State cordinator of volunteer services, who would explore and assist in the development and maintenance of a coordinated communitywide volunteer program throughout the State.

The third is the application and testing of the contents of this manual through its application in pilot programs in four selected nursing homes and one home for the aged in Multnomah County, before services are developed elsewhere.

The fourth procedure is the establishment of a research project which would contribute to better understanding the voluntary social welfare services particularly needed by the aged in nursing homes and homes for the aged, and effective ways of providing them. Data in this way would be obtained for more effective short- and long-range planning in the utilization and further development of community resources for this group. Such research could make an important contribution in the development of more comprehensive, coordinated communitywide volunteer activity programs for the aged in nursing homes and homes for the aged, not only here but elsewhere.

(The prepared statement of Mrs. Pragoff follows:)

PREPARED STATEMENT OF MRS. HALE PRAGOFF, MEDICAL SOCIAL CONSULTANT, OREGON STATE BOARD OF HEALTH

MOTIVATION FOR PROJECT

The Oregon State Board of Health has joined with a group of representative community organizations and agencies to stimulate and help in providing more citizen participation in communitywide volunteer activity programs in nursing homes and homes for the aged in Oregon. These groups having a feeling of responsibility for improving the physical, social, and emotional well-being of our citizens residing in these homes requested the State board of health to assume the leadership in this endeavor.

Following this request, the Portland Community Coordinating Committee on Volunteer Services was developed, including representatives from State, local, and county organizations, agencies and groups such as—

1. The Oregon Council of Churches, various church groups, the women's auxiliary of the State medical society, the American Red Cross, Salvation Army, chaplain's organization, senior craftsman, the Portland Visitation Group, sponsored by the Federation of Women's Clubs and the women's forum and the State council on aging.
2. Administrators from the Oregon Association of Nursing Homes and also home for the aged.
3. The Oregon State Public Welfare Commission, the Multnomah County Public Welfare Commission, and the Oregon State Board of Health.

PURPOSE OF THE PROJECT

The purpose of this project is to encourage the development of citizen participation to help cover some of the unmet social and emotional needs of residents in these homes through providing activities that would make life more meaningful for them. These activities would not only bring more personal and social

enrichment to the lives of these older people, but would also vitally contribute to protecting and improving their physical and mental health and to preventing further deterioration.

WAYS AND MEANS FOR ACCOMPLISHING THIS PURPOSE

It was decided ways and means of achieving this needed humanitarian project could be greatly facilitated through—

1. The development of a manual or guidebook on volunteer services in such settings. Its aim would be to assist communities, organizations, agencies, and groups, nursing homes and homes for the aged, to better understand the use and value of volunteer services and ways in which they can further extend and strengthen, or develop, coordinate, and maintain such activities.
2. The hiring of a State coordinator of volunteer services who would explore and assist in the development and maintenance of a coordinated communitywide volunteer program throughout the State.
3. The application and testing of the contents of the manual through its application in pilot programs in four selected nursing homes and one home for the aged in Multnomah County, before services are developed elsewhere.
4. The establishment of a research project which would contribute to better understanding the voluntary social welfare services particularly needed by the aged in nursing homes and homes for the aged and effective ways of providing them. Data would be obtained for more effective short- and long-range social planning in the utilization and development of community resources for this group. Included would be the scope, amount of services, and the approach that appears to be needed. Such research could make an important contribution in the development of more comprehensive, coordinated communitywide volunteer programs for the aged in nursing homes and homes for the aged here and elsewhere.

Senator MORSE. Thank you very much, Mrs. Pragoff. That is very helpful to us.

The next witness will be Dr. Robert Heilman. Dr. Heilman is a native of Nebraska. He received his M.D. degree from the University of Nebraska in 1938. He interned in St. Luke's Hospital in Denver, Colo. He has an excellent background. At the present time, he is director of licensing of care facilities and chronic disease of the Oregon State Health Department.

We are glad to have you, Doctor. You may proceed in your own way.

STATEMENT OF DR. ROBERT M. HEILMAN, DIRECTOR OF LICENSING OF CARE FACILITIES AND CHRONIC DISEASE, OREGON STATE HEALTH DEPARTMENT

Dr. HEILMAN. Thank you, Senator Morse, members of the committee, ladies, and gentlemen. The law governing the licensing of nursing homes, as you have heard today, was enacted in 1947. At that time, we had 230 homes for the aged that were licensed under the home for the aged law. During the fall and winter of 1947, rules and regulations were formulated and adopted by the State board of health. Now, since that time, there have been repeated amendments made to the rules and regulations, all for improving the safety of patients and raising the quality of care.

Conditions have steadily improved in nursing homes over the years. Many old nursing homes have been replaced by new modern facilities. As an example, since 1951, we have had 64 new nursing homes constructed; 17 existing nursing homes have added new additions, and 8 nursing homes have been completely remodeled or modernized. Four nursing homes currently are ready for construction. A great

many of our nursing homes now have automatic sprinkler systems or automatic supervised fire alarm systems. We have 74 nursing homes with automatic supervised fire alarm systems today and 24 nursing homes with sprinkler systems that are automatic. The remaining nursing homes have manual fire alarm systems.

Now, this report was based on a letter submitted to us by the State fire marshal in July of 1960, and since that time, it has been estimated that 20 additional nursing homes have now installed either automatic supervised fire alarm systems or automatic sprinkler systems.

All nursing homes have registered nurse supervision, the amount commensurate with the size of the facilities. In 1960, according to our annual reports, 52 nursing homes in Oregon had over 41 hours of registered nurse service per week, 67 nursing homes had over 40 hours of registered nurse service per week, 13 nursing homes had 32 hours of registered nurse service per week, 30 nursing homes had 21 hours of registered nurse service per week, and 13 nursing homes had 8 hours of registered nurse service per week, which is the minimum.

In 1952, there were 1,603 nursing home beds in 132 licensed nursing homes. Today, there are approximately 6,000 beds in 171 licensed nursing homes.

The inspections of nursing homes are made by deputy State fire marshals, county sanitarians, State plumbing inspectors, and public health nurse licensing advisers of the State board of health. Since 1954, annual education and training courses have been held for all nursing home administrators and their personnel. These courses have included every phase of nursing home operation. As an example, in 1955, we started our training courses for nursing home personnel involving the basic fundamentals of nursing home operation, including sanitation, fire safety, nutrition, nursing care, building safety and maintenance, bookkeeping, medical and nursing records, insurance, and liability. We repeated this course in 1956. These courses were conducted in cooperation with Portland State College. In 1957, we conducted training courses in nursing care and techniques in Portland, care of mental patients in Salem, sanitation and nutrition courses in Eugene. In 1958, we stressed rehabilitation, and that course was conducted here in Portland. In 1959, courses in rehabilitation were conducted in Portland, Eugene, Medford, and Pendleton. In 1960, we again stressed rehabilitation in courses at Portland. We had courses in nutrition conducted at Grants Pass, Klamath Falls, Astoria, Portland, La Grande, Medford, Eugene, and Pendleton. Currently, this year, we are holding courses on nutrition at Salem and are to start courses in rehabilitation at McMinnville.

With the addition of a physical therapist to our staff, we are going to change our training techniques a bit and take the training into the nursing homes. In the past, we have had the nursing home personnel come to one central place in the city for these courses at an institute for 1 to 3 days. It is now our plan to take the inservice training right into the nursing home and working right with the personnel.

Educational opportunities for the nursing home personnel have been instrumental in raising the quality of care in the nursing home. We have a working relationship with the Oregon Nursing Homes Association, which has been excellent. The Oregon Nursing Homes Association has a representative on our advisory council for facility licensing and licensing of nursing home administrators.

The medical department of the State public welfare commission and the license section of the State board of health cooperate in the solution of problems related to nursing home operation. Since the inception of the licensing program, improvements have been progressive and dramatic. As an example, in 1960, according to annual reports submitted by the nursing homes, we found that 105 nursing homes in 1960 had made improvements. Now, these included the following: 25 nursing homes established physical therapy and/or outpatient care in home facilities; 13 nursing homes remodeled and established better recreational facilities, sitting rooms, solariums, and dining room facilities; 39 nursing homes completely refurbished their institutions, purchasing new equipment, painting, and things of that nature; 71 nursing homes made improvements relating to safety of the buildings, such as putting new wiring in, conduit, furnace safety, and things of that nature; 4 nursing homes improved their facility by developing a new method of recordkeeping.

A continuing program of such operations will further raise the standards of care and safety for patients in our nursing homes. Recently we conducted a sample survey in Multnomah County, visiting 55 nursing homes, comprising approximately 2,400 patients, and we found that this is a fairly representative sample when applied to most of the State. The average age of a person in a nursing home in Oregon, construed on this basis, would be 75, the median 79, and the mode 81. The average length of stay was 22 months in Multnomah County, and the welfare recipients stay on the average, I believe, 2 months longer than the private cases. The average occupancy rate is around 96 percent for Multnomah County, and about 95 percent for the rest of the State.

In 1960, according to our annual reports, we had 6,611 new admissions to our nursing homes. These new admissions, for the most part, replaced the following: 146 patients that were transferred from the nursing homes to the mental hospitals; 2,192 patients that died; and 4,126 patients that had been discharged either to their homes, other nursing homes, boarding and rooming houses, homes for the aged, motels, hotels, and other facilities. Fifty-eight percent, approximately, of all patients in our nursing homes in Multnomah County are welfare; 42 percent are private. The female-to-male patient ratio is almost 2 to 1, almost twice as many women patients as men.

On July 1, 1961, according to our most recent report, 150 nursing homes in Oregon are proprietary; 17 homes are voluntary nonprofit, such as church and lodge groups; and 6 homes are run by county government. We have 271 licensed nursing homes administrators. Many man and wife teams are operating homes and both are licensed as nursing home administrators.

At the present time, the board of health is in the process of revising rules and regulations relating to the licensing of nursing homes. We have conducted about 20 to 25 meetings on this matter, and are concerned with establishing standards with which we can measure the quality of care and treatment that the patients receive. It is something new for us, and I know a lot of the other States in the country are doing the same thing, trying to develop some set standards or a set of standards whereby the quality of care and treatment can be measured.

These committees that we have are representatives of the State board of nursing, Oregon health officers associations, State council on aging, Oregon State Board of Health, Multnomah County Commissioners, Oregon Osteopath Association, Oregon Nursing Homes, Oregon State Board of Medical Examiners, Oregon State Medical Society, the State public welfare commission, Oregon Nurses Association. We are sincerely working hard, endeavoring to come up with something that will prove of benefit in providing the quality care and quantity care to our patients in our nursing homes. Thank you, Senator.

(The prepared statement of Dr. Heilman follows:)

STATEMENT OF DR. R. M. HEILMAN, DIRECTOR, CHRONIC DISEASE AND LICENSING OF CARE FACILITIES SECTION, OREGON STATE BOARD OF HEALTH

The law governing the licensure of nursing homes was enacted during the 1947 session of the Oregon Legislature. At that time 230 homes for the aged were licensed under the home for the aged law.

During the fall and winter of 1947, rules and regulations were formulated and adopted by the Oregon State Board of Health.

A majority of the existing homes for the aged were able to meet the original standards for nursing home licensure, and were licensed as such.

During the years up to the present time, the rules and regulations for nursing homes were amended repeatedly. These amended rules and regulations were all directed at improving the safety of patients and raising the quality of care.

Conditions have steadily improved in nursing homes over the years. Many old nursing homes have been replaced by new modern facilities. A great many of our nursing homes now have automatic sprinkler systems or automatic fire alarm detection systems. All nursing homes have registered nurse supervision; the amount commensurate with the size of the facility.

In 1952, there were 2,603 nursing home beds in 132 licensed nursing homes. Today, there are 6,000 beds in 171 licensed nursing homes.

Inspections of nursing homes are made by deputy State fire marshals, county sanitarians, State plumbing inspectors, and public health nurse licensing advisors of the State board of health.

Since 1954, annual educational and training courses have been held for all nursing home administrators and their personnel. These courses have included every phase of nursing home operation. Educational opportunities for nursing home pesronnel have been instrumental in raising the quality of care in our nursing homes.

Working relationships with the Oregon Nursing Home Association have been excellent. The Oregon Nursing Home Association has representation on our advisory councils for facility licensing and for licensing of nursing home administrators.

The medical department of the State public welfare commission and the licensing section of the State board of Health cooperate in solution of problems related to nursing home operation.

Since the inception of the licensing program, improvements have been progressive and dramatic. Continuing program operation will further raise the standards of care and safety for patients in our nursing homes.

At the present time, the board of health is in the process of revising the rules and regulations relating to licensing of nursing homes. Serving on committees in assisting the board of health in this activity, are the following individuals:

Miss Virginia Hildebrand, R.N., Oregon State Board of Nursing
Willard J. Stone, M.D., Oregon Health Officers' Association
Mrs. Coe McKenna, State Council on Aging
Julia Dickinson, M.D., Oregon State Board of Health
Randall White, M.D., Multnomah County Commissioners
D. J. Hildreth, D.O., Oregon Osteopathic Association
Edison McBride, Oregon Nursing Homes, Inc.
George H. Lage, M.D., Oregon State Board of Medical Examiners
George Louis Freeark, M.D., Oregon State Medical Society
Mrs. Clara Dawes, State Public Welfare Commission
Eva Schadt, R.N., Oregon Nurses Association
Miss Bernice Peterson, R.N., Oregon State Board of Health

Senator MORSE. Thank you very much, Dr. Heilman, for your statement. We have time now for one more witness this morning. Dr. Stewart, I am going to ask you to be our first witness this afternoon. I will begin the session this afternoon and insert in the record, which Dr. Heilman and others will be interested in, certain information which was prepared for the committee by the staff, with the assistance of various Federal agencies, in regard to old-age problems in the State of Oregon, that I think will be of great interest to you. In addition to the material that I want to make part of the record this afternoon, I hope those who have testified will doublecheck and file with us any supplemental statements you may wish to make with regard to data that will be helpful to the committee. I will offer them for the record at the beginning of the session this afternoon before Dr. Stewart testifies.

We will close the hearing this morning with the testimony of the Honorable Grace Peck, member of the Oregon House of Representatives, and one of our legislators who has worked especially in this field of the aged. I am sure that her contribution will be very beneficial to this committee.

Representative Peck, you may proceed in your own way. We are always delighted to have you testify in regard to these problems, which I like to describe as involving a challenge to us to practice the great teaching of man's humanity to man. You may proceed in your own way.

STATEMENT OF HON. GRACE O. PECK, MEMBER OF THE OREGON HOUSE OF REPRESENTATIVES

Representative PECK. Thank you, Senator Morse, members of the committee, ladies and gentlemen. I will try to rush this through.

The administrator's license has been referred to several times this morning, and I would suggest to this committee that they take cognizance of this and think seriously of requiring all States to have such an administrator's license so that not only in the State of Oregon can the people be assured of good care, but all over the United States it should be, too. We have heard of our State's program having certain qualifications and it doesn't seem to me that there would be anything

wrong in requiring all States to have a good administrator's license law so that you will know that people in every State in the Union are getting the proper care.

Reference has been made to getting some money for a new county institution. Now, I have made the remark, and this has come up over the past few years, that over my dead body, while I am in the legislature, will we have any county or State nursing homes. I heard in California a couple weeks ago that they were planning a couple of new type of county nursing homes, which made me sick. I felt that I had been kind of asleep and I came home and learned that we have about six county homes in Oregon, and not all being used by the counties; some are leased out. Then I learned that Wasco County was seeking information as to whether or not they would get funds to either modernize or build a new county home.

This, to me, is like going back in the Dark Ages because, no matter how good a public institution is, it is a public institution, and in my sense, it in no way carries out the meaning of the words "nursing home." We have good State institutions that I am proud of. We even have a new women's institution, thank goodness, and all of our State institutions will be good institutions, but I hope the day will never come when we will start a program of county nursing homes, which, no matter what you put into them, are more or less glorified poor farms, and we have this feeling about people going into county or State homes and institutions, which I think is a long time in the past.

I think that nationally there should be some attention paid to the budget of the State to see what they take in, and I think nationally an interest should be taken in the budget, particularly as it pertains to the health of the people who are being paid for through these funds, such as the nursing homes; their allowance for wages is not adequate. They cannot, although some of them do without other things themselves, personally, pay a high scale for nurses aids and the other help that is in the nursing home. Some of them are not in a position to do this. It's a sad thing. We have had some real good nursing homes picketed because they weren't paying nurses aids or someother help, other than the licensed practical nurses, what they thought they needed to be taken care of, and these are good homes and they are on the unfair list right now in the labor temple here, and it's too bad because these are good nursing homes. However, they are unlike the butcher who can raise the price of meat because he has to raise the wages. These people care for as much as 80 or 90 percent of people who are welfare people. They have a closed-end budget. There is no way that they can get any other money. Some of them are reluctant to try to subsidize their home by taking in private patients for a much larger fee. Some of these people want to care for the needy people or the welfare people. They not only make their living in the nursing home, but they also feel that it is a privilege to do something to serve their fellow man, and I think this is very important.

We took this up a little bit in the legislature last year, in the last session, with some of the labor leaders present. Believe me, I respect organized labor, and I can see why they want these people to get more money, but the budget isn't such that the people can get more pay,

there isn't enough allowed. This is serious. I think, because this is a field that offers opportunities to women of all ages and because it also—and I know this to be true because I know I have helped some of these people to get work in nursing homes—it offers a job for someone who has been in a State hospital, who is out and considered able to go back into the community. They look to these homes. Now, I have been able to get some mentally retarded high school children into the nursing homes, to learn to do some of the work that is available so that they can eventually take their proper place in society. To close the doors to these people is terrible, but in the payment to the nursing home, there must be enough of a payment allowed for wages for the help, to see that they can pay the proper wages to the nurses aids and these other people. I think this is something that our committee here should consider.

There will be a certain amount paid for the people who go into the nursing homes on the medicare program. This will be just a definite amount. They can't raise that either. So, they're going to have a lot of patients and they are told how much they can give for them.

We have a pretty good point system now, and we are trying to figure another point in there because we feel there is something inequitable in it, but, for the most part, Oregon is doing a pretty good job because we are a State that has to stay in the black. We can't pay as much as some of our neighbors pay who operate in the red, but we have to do that.

Now, there has been reference made to the people that are being taken out of the State institutions and going to nursing homes and homes for the aged, and such. I will hand this book over to you a little later. I happen to have an extra copy, which shows an outline of our new program in Oregon. We appropriated $471,000 last session to be handled by welfare to take out people in the State hospital, who are there and who would die there because there is no one to take care of them, and now there is money in the welfare and health budget to take them out. We now have started a program that is well underway. I happen to have an extra one of these, so I am going to leave it with you.

Senator MORSE. The report will be made part of the record.

(The report referred to above will be found on p. 104.)

Representative PECK. We have talked about cooperation between the doctors—one of the doctors mentioned this—and all people concerned. I think this is wonderful. We do have good cooperation with the Welfare Department and the nursing homes. I think that this has come about because of a very fine Oregon Nursing Home Association, which they have here. They have worked with us at the legislature, they have suggested these administrative laws, they have come down there to work on other things, and they are a good group. All of the nursing homes do not belong to the association, but they should belong to it, and I think this is important because they are responsible.

This administrator's law came about originally at the request of the nursing home operators themselves, and when I started working in this nursing home operator program and nursing home program, I felt, if I was to know anything about nursing homes, I should visit them. I have had the privilege of going in and out of nursing homes

early in the morning and late at night, and I know that most of them are very good nursing homes, and if there is something wrong that is called to their attention they correct it. The day has long gone by when Oregon had nursing homes that people could be ashamed of and fearful of putting their people in.

I think that the fact that there is training going on is fine. I had the privilege of presenting legislation on the floor that created our Committee on Aging, and one of the strong talking points for this was that people should be trained to take care of the aged just as they are trained to take care of babies, or for certain types of diseases, and all this, and people should be trained to take care of the aged and their problems without just grouping them and saying, "Well, it's a problem with the aged," and I think this is coming about, and people are wanting to specialize in care of the aged.

I think the accreditation plan is fine except I feel that I differ in one thing. I don't think there should be three accreditations. I think it should be patterned after the hospitals in a certain way. Dr. Heilman can correct me if I'm wrong, but it seems to me that hospitals are either accredited or not accredited, and I think, at least in the beginning, nursing homes should be accredited or not accredited. Various classifications could be set up under the accreditation program. I ask you to give serious thought to this because there is the thought in my mind that this could create ill feeling and discord among the nursing home operators themselves because they feel that this committee, which has in its membership some of the other home operators, could do something against them, and I think that this would tear down instead of build up a better feeling among them, and I think everyone would seek to be accredited. I don't think anyone wouldn't want to be accredited, and I think that this would be good.

I can't say enough about the nursing homes, as I find them, in the time I've had to say, and I am speaking of the private nursing homes versus county and State nursing homes. We are all aware that the private home pays taxes, pays property tax, personal property tax, they contribute to the industrial accident fund, unemployment and employment programs, and they shop locally with the little local butcher and grocer. So, they not only contribute to the economy of the State but they also take a personal interest in their home and in their people.

The doctors come into this accreditation plan, and that is one of the reasons the liaison committee was first set up with the doctors. I know that many years ago I was in a doctor's office after I had a serious accident, and I heard the doctor saying he wanted all of his patients to go to a certain syndicated nursing home. It was new and it was smart, and that is where he wanted them to go, instead of one of the older homes. I sort of jumped him about it. I thought this was unfair, that he should look into some of these other homes, and they did set up a committee to look into this, and I think the doctors have cooperated fine. The plan of the doctors sending their patients to nursing homes in Multnomah County, I think, originated through Dr. Ennis Keizer in our interim committee studying welfare in 1959. This, I think, has brought the doctors into touch with each private nursing home, some of them in old buildings, but good homes, and they have become aware that there is good care in these homes.

Now, if you were to accredit as "excellent," "standard," and so on, and so forth, perhaps some doctors, new doctors who can't look back and see the good in the older homes, would want to all send their people to "excellent" homes, and this would create trouble, I think, and the welfare patient has the choice of going to any home he or she wants to and can move from that home to another home if they're not happy there. So, we all want to look at this accreditation.

I know I am more or less bunching this up, but I know I was only supposed to have a few minutes. I hope I have contributed something, and I am going to accept your invitation to send in a written statement later.

Senator MORSE. Thank you very much, Representative Peck. We will welcome your supplemental statement, and I want to thank you for the statement you have made to this committee.

I want to say to all of you in attendance that I hope you will come back this afternoon. We will adjourn now until 2 o'clock this afternoon, at which time we have a few more expert witnesses, following which I want the senior citizens themselves, in what we call a town hall program, to give this committee the benefit of their own experiences and their own observations and feelings in regard to what the committee ought to do in connection with this whole matter of care for the aged.

Thank you very much. We will recess until 2 p.m.

(Whereupon, at 12:10 p.m., a recess was taken until 2 p.m., of the the same day.)

AFTERNOON SESSSION

Senator MORSE. The hearing will come to order. I have here a report by the staff, with the assistance of State and Federal agencies, on current facts about Oregon's older people. I shall make them a part of the record, and I make them a part of the record because I want the witnesses, who have already testified and others who may testify, to feel and know that I invite any memoranda on these facts and figures by way of rebuttal or modification. I think that you should know that, when we come to meet with the Appropriations Committee in the Senate, they are going to ask the question: "Well, what are some of the statistical facts in regard to the problems of the older people in the State of Oregon?" We shall, of course, supplement these figures on the basis of the evidence that is presented in hearings, but I am putting them in the record now so they will have some standing.

This is a very able research group that has worked on them. If there is any error in regard to them, I can assure you it's not because of the research work, but because the basic data contained errors. So, I will read the material as follows, and this is entitled "Some Current Facts About Oregon's Older People":

Their Growing Numbers: Between 1950 and 1960, Oregon's population 65 years and older increased 38 percent, slightly more than the Nation's average. The change in the very oldest age group, those 85 years and older, was dramatic for their numbers increased 55 percent in only 10 years. The total population over age 65 in Oregon, 183,653 persons, now constitutes over 17 percent of the Oregon adult population, those 21 years and older. In 1950, the aged made up only 13

percent of the adult population. That is a very significant vital statistic, which shows a steady increase in the number of aged people over 65 in our State.

Now, as to the income of our older group, more than 71 percent, 102,527, of Oregon's older population received social security benefits at the beginning of this year. The average old-age benefit paid to retired workers was $74.58 per month, only 44 cents more than the national average. Of those receiving social security retired workers benefits, 18 percent received between $26.40 and $44.90 per month, 48 percent received between $45 and $89.90 per month, and 34 percent received between $90 and $120 per month.

Some 16,591 persons needed assistance from Oregon's old-age assistance program in July of this year, more than one-third of them to supplement social security benefits. The average old-age assistance monthly payment was $84.06, of which $31.46 represented payments made directly to doctors, hospitals, and others for medical care.

Nursing Homes: As of the first of this year, the Hill-Burton hospital and medical facilities survey of nursing homes in Oregon showed a serious need. I want to emphasize that this survey was made not by our staff, but by the Hill-Burton hospital and medical facilities group, and they have presented these findings. As your Senator and chairman of this subcommittee, I have to work from these findings, and I think the only objective and fair thing is for me to present the findings in this record, so it will be a matter of public record, and invite your supplemental memoranda or comments on them, or modification thereof, if you think the facts warrant their modification. This Hill-Burton hospital and medical facilities survey states that with a total of 6,127 nursing home beds, 3,042—50 percent—are rated "nonacceptable." The nonacceptable classification is made by the State on the basis of fire and health hazards.

In contrast, of the 14,165 Washington State nursing home beds, only 28 percent are rated as "nonacceptable."

Oregon has about 9,000 aged persons in nursing homes and homes for the aged. Two-thirds of these people are public welfare recipients. There are some 175 nursing homes and 112 homes for the aged. The aged in these facilities make up approximately 5 percent of Oregon's aged population.

Now, what about their housing situations? A 1959 housing survey in Portland of some 500 persons receiving old-age assistance found that 75 percent, 376 units, were "substandard." The Portland Housing Authority then indicated that it could meet less than 3 percent of the need for low-rent housing for the elderly in Portland. The utilization of Federal housing programs for the elderly thus becomes of particular interest. Since 1956, only 2 public housing projects with a total of 190 units have been approved for Oregon. These are in the preconstruction stage.

Under the FHA mortgage guarantee program, 7 projects with a total of 1,011 units are in an active stage. Two of these projects with 361 units are in Portland, 1 in Eugene with 89 units, and 1 in Salem with 119 units. The direct loan program, just getting underway, now has two active applications from Oregon with 273 units to be built if these projects are approved. These projects, one for Salem and one for Newberg, are in the preliminary review stage.

May I say that you cannot work with data such as I have just read, without knowing more. Very frequently, you have to get behind the statistics. You have to look at other factors besides just cold figures. I want to say that my position is, of course, one of public trust in presenting the evidence as presented to me. I will repeat what I indicated very clearly this morning and, as I told the press during the noon hour: My tentative opinion, based upon such evidence as this committee has obtained here and in other States, is that we have every reason to be proud of the general level of our nursing home care and facilities in the State of Oregon. That does not mean that we haven't a long way to go in order to reach the accomplishments that all working in this field recognize ought to be considered as a bare minimum.

The purpose of hearings, such as this, is to try to find out what the State problems are, give the State officials an opportunity to correct any misinformation that the committee may have and may be working upon, and also to reach a final conclusion. As far as your chairman is concerned arriving at this final conclusion is the primary interest that I think the committee should have. We are searching to decide what, if any, legislation on the Federal level should be recommended by the committee to the Senate of the United States and, through the Senate, to the Congress by way of Federal assistance to our nursing homes, Federal assistance to our institutions that are seeking to carry out what I said this morning in my judgment is our clear and moral obligation to the elderly.

I think much good will come of this, and I think the evidence and material developed here in the hearings in Oregon are going to be of great assistance, legislativewise, when we come to make our recommendations at this next session of Congress. I put this material in the record with the clear caveat on my part that I have not accepted it as final, but it lays out, in the absence of any rebuttal evidence, a prima facie case with respect to the needs of the State of Oregon.

We shall now proceed with the taking of further testimony, and I am pleased to call as our first witness this afternoon Dr. James H. Stewart, presently director of the medical division, Oregon State Public Welfare Commission, formerly administrative veterans consultant, Oregon State Division of Vocational Rehabilitation.

We are glad to have you, Doctor, and you may proceed in your own way.

STATEMENT OF DR. JAMES H. STEWART, DIRECTOR, MEDICAL DIVISION, OREGON STATE PUBLIC WELFARE COMMISSION

Dr. STEWART. Thank you, Senator Morse. Members of the subcommittee staff, ladies, and gentlemen, I appreciate the opportunity to make a brief statement here about current use and experience of the State public welfare commission and its provision of nursing home service for aged persons on the recipient roles of the State.

The State public welfare commission is the single largest purchaser of nursing home services in Oregon. In the month of August 1961, which I think could be taken as representative of recent experience, there was a total of 3,313 welfare recipients resident in the licensed nursing homes in Oregon. Of this number, 2,672 were recipients of old-age assistance, that is, were over the age of 65.

78681—62—pt. 1——4

The State public welfare commission has worked closely with representatives of the Oregon Nursing Home Association in developing a classification and rate structure. At the present time, three levels of payment are established according to the classification which the patient receives on a special rate form that awards points for items of service and supply required in the patient's care; $145 per month, $169 per month, and $192 per month are the welfare rates, and include routine drugs and medications, such as aspirin, rubbing alcohol, laxatives, and the like. Special individually prescribed medications are purchased by the welfare department for the welfare patient in the nursing home for any drug covered by the State public welfare commission's drug plan and properly ordered by the attending physician.

The efficient use of nursing home facilities has been a major concern of the welfare agency. Welfare caseworkers are responsible for classification of patients. Physicians are urged always to use and recommend the type of living situation which will most economically serve the patient's medical needs. Move the patient from the hospital to the nursing home as soon as his medical condition will permit; transfer him from the nursing home to a home for the aged, or to a private home, as soon as he no longer needs the special care resources of the nursing home.

A particular case in point in relationship to efficient utilization of facilities is the program currently underway to effect transfer of suitable patients from the State hospitals to their own communities. Dr. Gutman mentioned this briefly this morning in her testimony. By selective screening on the part of the State hospital staff and by selective placement in community hospitals and community facilities, the State hospital system expects to reduce its resident population of persons over age 65 by approximately one-third in the 2-year period ending June 30, 1963. The welfare agency plans to place approximately 300 former State hospital patients in this age group in nursing homes. There will be additional welfare placements in home for the aged and private home settings, probably in a number of approximately half of that mentioned for the nursing home placements.

Physician supervision for the nursing home patients is a matter of importance in achieving adequate and satisfactory care. The welfare agency and the Multnomah County Medical Society have entered into a joint project for all nursing homes in Multnomah County. A physician is assigned the responsibility for the welfare recipients in each nursing home and works very closely with the nursing home staff and with the welfare caseworker for good cordination of medical and social planning. This project has been in effect for somewhat over a year now and it has resulted not only in a better level of care for the patients, but also in substantial savings on transportation costs, which were formerly involved in transporting these patients to distant clinics or other centers for care and supervision. In other parts of the State, formal arrangements of this kind have not been thought necessary up to this time since it is our observation that community physicians are conscientious in giving needed services to welfare recipients in congregate care facilities in our less populous counties in the State.

Our agency has developed extensive manual material, relating to case services for aged persons in nursing homes. Casework efforts are being supplemented by volunteer services and visitations, which in

some communities have been carefully organized by the public health agency. It is recognized that there is a real problem in trying to keep the patient, who is in a nursing home or a home for the aged, in contact with his family, with his friends, and with the mainstream of life outside the institution in which he is resident.

I would like to mention too informally that nursing home care for persons who are recipients of medical assistance for the aged will also be included in the package of benefits which have been adopted by the State commission for that program. This has been arranged initially on an exchange basis for hospital days with nursing home days being made available for each day of hospitalization that is unused by the patient or unneeded by the patient under this plan. It is hoped by this means to make available necessary and longer institutional care for persons who are MAA recipients or in the hospital and can use this additional time to their advantage in the convalescent phase of their illness. Thank you.

Senator MORSE. Doctor, I have one question. I try to keep my questions to a minimum, but this has come up in some of our other hearings. I wonder to what extent we in Oregon have developed the so-called home care services? Our committee has found that this program appears to be a very fine program in some States. Under this program elderly people are kept in their own homes, near friends, but they get some home care services. Apparently this is economical from the standpoint of reducing hospital load.

Do we have anything similar in Oregon?

Dr. STEWART. We have plans, well-advanced plans for the development of this, Senator Morse, and I think you will hear some discussion of that Wednesday in Eugene. I believe one of our representatives will be prepared to give testimony on that phase.

Senator MORSE. Thank you very much. As I say, we will welcome any supplemental statement you may wish to file with the committee, particularly in connection with any of these reports as to what the situation is in Oregon.

The next witness will be Dr. Morton J. Goodman, graduate of the University of Oregon Medical School. Dr. Goodman interned at San Francisco Hospital, University of California; was health officer and resident physician at Johns Hopkins Hospital, Baltimore, Md., in 1930 to 1932, assistant in medicine and research fellow at Johns Hopkins Medical School and Hospital, 1932 to 1934. Dr. Goodman has been in private practice in internal medicine from 1934 to the present. He is assistant clinical professor of medicine at the University of Oregon Medical School and belongs to a number of professional societies, the names of which will be incorporated in the record at this point.

(A biographical sketch of Dr. Goodman follows:)

BIOGRAPHY OF DR. MORTON J. GOODMAN

Born: Portland, Oreg., June 10, 1905.

Graduate of the University of Oregon (BA), and the University of Oregon Medical School (MD), 1929.

Intern: San Francisco Hospital (University of California Service), 1929–30.

House officer and resident physician in medicine: Johns Hopkins Hospital, Baltimore, Md., 1930–32.

Assistant in medicine and research fellow: Johns Hopkins Medical School and Hospital, 1932–34.
Private practice of internal medicine, 1934 to the present.
Assistant clinical professor of medicine, University of Oregon Medical School.
Diplomate of American Board of Internal Medicine.
Diplomate of National Board of Medical Examiners.
Board of Trustees of Boys and Girls Aid Society.
Past president of University of Oregon Medical School Alumni Association.
Formerly member of Oregon State Public Welfare Commission, chairman of subcommittee on medical care.
Author: Many articles in professional journals on subjects pertaining to my specialty of internal medicine.
Member of numerous professional societies, including:
American Medical Association.
Oregon State Medical Society.
Multnomah County Medical Society.
North Pacific Society of Internal Medicine.
American Society for Clinical Research.
American College of Chest Physicians.
American Heart Association.
American Society of Internal Medicine.
Portland Academy of Medicine.
Sigma Xi (honorary scientific society).
Alpha Omega Alpha (honorary medical society).

Senator MORSE. Doctor, with your distinguished record of service to your profession and to the people of our State—I don't want to embarrass the doctor, but I want to pay my personal high commendation for the great service that I think he is rendering in this field of health.

I will also incorporate in the record what is in my opnion a magnificent speech he delivered to the Portland City Club on September 1, 1961, on medical care for the aged. I think it is a speech that all members of my committee should have for ready reference.

(The speech referred to above follows:)

MEDICAL AID FOR THE AGED: THE CASE FOR THE SOCIAL SECURITY APPROACH

(By Morton J. Goodman, M.D.)

Mr. Beatty, members of the City Club, and guests, it is with humility and some trepidation that I stand at this rostrum of the City Club of Portland. I have been a member of this distinguished organization for 20 years. I have listened here, to some of the great scholars, some of the outstanding personalities of my generation. I have never before presumed that I would have anything constructive to contribute to the thinking of this group. I must say at the outset that I am not well informed in many of the fields which relate to the topic which I would like to discuss with you. I am not a student of government; I have no talent in the field of political philosophy or economics. I am no expert on insurance. I am a physician, and I feel that I am somewhat knowledgeable in the field of medical care. Furthermore, I have had 4 years of experience on the State welfare commission and as chairman of its committee on medical care, I have learned something about the medical needs of our older citizens and how they are being tragically neglected today. I hope that you may be interested in my comments on suggested remedies to meet those needs. As some of you may be aware, my position is somewhat less than popular with many of my colleagues, and in order that I not be misunderstood, or misquoted, I ask your indulgence if I adhere rather closely to my manuscript.

Every student of the subject knows that the provision of better health care for the aged is a serious and rapidly growing problem. Thanks to medical progress, the number of the aged is increasing rapidly. In 1930, there were 6 million people in the United States over the age of 65. Today, there are over 16 million and by 1970, there will be over 20 million. For many of these older men and women, longer life has meant shrunken incomes, increased sickness, loneli-

ness, and fear that costly illness will force on them the indignity of seeking public charity. Over half of these people have an income of less than $1,000 a year. Over 12 million of them have an income of less than $2,000 a year and these figures include those who are still working. Most of those in this age group have little or nothing in the form of liquid assets to fall back on in case of illness. The medical and hospital needs in this group are much higher than those of younger people. They go to the hospital more often, they stay longer than their younger neighbors, and their illnesses are far more costly. Most of them cannot afford meaningful health insurance. A third of them have some type of coverage, to be sure, but in most cases, it is very limited and inadequate. These older people represent a high cost, high risk, low income group. For them, insurance premiums are prohibitively high and the benefits are very restricted. Many of them have chronic health problems and they can't get any insurance at all. How do these people get by? The answer is that they barely do. Most of them live marginally with barely enough for the necessities of life. Even those that do have some security and moderate resources which have been built up in their working years are in constant danger of having these reserves wiped out by illness or hospitalization, forcing them to turn to their children or to public charities for aid. The issue is not is there a problem, but how to meet the problem.

Two major approaches have been developed to solve the problem of medical care for the aged. The President, in his health message to the Congress, recommended that a program of hospital insurance and other benefits be included under the social security system. This has been implemented in the King-Anderson proposal which is now before the Congress. Organized medicine is outspokenly opposed to this plan. It supports, on the other hand, the Kerr-Mills law which offers Federal matching funds to the States to expand their welfare programs. This is designed to offer health services to the "near needy," or the "medically indigent," as they are called. I hope that I am successful in keeping these two general approaches clearly in focus for you so that we can consider briefly the merits and the shortcomings of both plans.

On the one hand, the social security approach, or the King-Anderson bill, or what I like to call the Kennedy plan; on the other hand, the tax-supported welfare approach of the Kerr-Mills law.

What, in brief, is the Kerr-Mills program? This is the law which was passed by the last Congress which extends the tax-supported welfare program. The Federal Government offers generous matching grants to the States to supply limited medical care to those who are medically indigent, those who have just enough for food and shelter and clothing, but who are not able to take care of their medical needs. Each State may set its own standards, determine its own benefits, or it may choose not to enter the plan at all. The Kerr-Mills plan is financed entirely by Federal, State, and county taxes. It is a program designed to help older people after they have become dependent, after their resources have been depleted, requiring them to turn to public assistance.

How many States have adopted the Kerr-Mills bill? Even though the bill went on the statute books almost a year ago, in October 1960, only eight States have a program in effect and four more have submitted the plan for approval of HEW. The program is in legislative process in nine other States and no action is anticipated in 1961 in almost 30 others.

It has been repeatedly stated by supporters of the Kerr-Mills bill, as we were told 2 weeks ago, that "it will guarantee to every American who needs it the health care that he requires." This is virtually impossible. Most of the States are too poor even to fill out their current welfare programs up to their own minimum standards, let alone amplify them under the Kerr-Mills formula. In spite of the very generous matching grants, in some cases 4 Federal dollars for every State dollar, a number of State legislatures in the past year have passed up the offer because the State funds just weren't available. From my experience on the welfare commission, I have learned of the desperate plight of the welfare programs in many of these States. Seven or eight of the large manufacturing States in the country, and those States which have offshore oil rights are solvent. Most others can't afford any meaningful increase in State taxes to take advantage of the Kerr-Mills law. Some of the States are almost bankrupt and their Kerr-Mills plans are meaningless. In Kentucky, for instance, the Kerr-Mills plan allows only 6 days of hospital care and doctor services only for acute life-endangering emergencies. In Oklahoma, the Kerr-Mills plan permits two doctor visits per month, and then only for sight or life-saving illnesses. Some of the State programs exclude everyone with incomes over $1,000 a year, or $1,500 for a couple.

Oregon has a fair plan and it will go into effect November 1. Its benefits, however, are very limited. It supplies limited hospital and nursing home care, some X-ray and laboratory service, no drugs. To make it actuarilly sound, deductibles had to be inserted. The patient must pay, for instance, the first $50 of his doctor's bill. This places a very unfortunate barrier between a needy person in this age group and medical care. Most of these people who are medically indigent don't have $50 to pay for their doctor bill if they become ill. If they do, the supermarket, the rent, and the fuel bill take priority. The result is that they neglect and delay much-needed medical care until their situation becomes desperate or incurable. The Kerr-Mills plan, in my opinion, doesn't begin to meet the medical care needs of the large group of our older citizens. It swats flies instead of draining the swamp.

I was astonished to hear from this rostrum 2 weeks ago, the suggestion that if the City Club would send Rudy Wilhelm down to Salem with appropriate instructions, we could add drugs, dentures, spectacles to our Kerr-Mills program and increase the income ceiling from $1,500 to $3,000. I am sure that we all have the greatest respect for one of our ablest and most effective legislators, but Rudy isn't a magician. I am no expert in finance, so I asked one of the State tax experts for an estimate of what these increased benefits would cost. Our present budget estimate for a biennium for this program is $12 million. The estimate for the inclusion of the benefits which I have just listed would be a minimum of $35 million, and probably closer to $40 million. Where would this money come from? I am informed that it would mean a huge increase in the property tax and a substantial increase in our State income tax. Medical care is expensive and is becoming more costly all the time. To expand health care for the aged to any meaningful level under the Kerr-Mills formula would put a fantastic drain on the State treasuries.

I would like to say one more thing about the Kerr-Mills law which isn't generally appreciated. In order to qualify for help under the Kerr-Mills program, every applicant must take a means test. This is the pauper's oath. He must submit to an elaborate investigation of his needs and resources and, in many cases, his children must do likewise. It is degrading for our citizens who have been financially independent all of their lives to have to go, hat in hand, to a welfare agent in order to prove poverty or that one's children cannot, or will not, support them.

Having pointed out what I feel are the limitations and shortcomings of the Kerr-Mills approach to the medical care for the aged, I must say in all fairness that some type of legislation of this sort is needed to take care of the small group, approximately 1½ million, who cannot qualify for social security, or those under the social security program with incomes and resources that are so marginal that they will need this additional welfare type of assistance.

What about the Kennedy plan, the social security approach, as implemented by the King-Anderson bill? It is a modest, conservative approach which is fiscally sound and I cannot understand why any reasonable person who has read the bill and understands it doesn't favor it. It makes good sound sense. It is an insurance program under the social security system. It is aimed to meet the needs of those millions of Americans who want to pay their own way and don't want to receive care at the taxpayer's expense. These are the people whose savings and reserves can be completely wiped out by a large and crushing hospital bill, forcing them to go to their children or to the charities. The benefits of the Kennedy plan are substantial. Briefly, it will pay for 3 months of hospital care for any one illness; up to 6 months of nursing home care; for out-patient diagnostic services, including X-ray and laboratory studies, with a small deductible to discourage overuse and malingering. The plan will also pay for visiting nurses care and homemakers services which will enable many people to get care in their own homes without requiring costly hospital facilities. The benefits will be available for all persons over 65 who are eligible for social security. It is estimated that 14½ million people will be eligible for this program by January of 1963. It is to be financed by a small increase in the social security tax for each worker and employer and a slight broadening of the taxable base. It is a plan which would do very much like what Blue Cross has been doing for a number of years; it would pay for the hospital bills without interfering with hospital operations. In fact, the whole program could be administered through the existing Blue Cross mechanism, as suggested a few weeks ago by the American Hospital Association.

How can this generous type of health insurance be financed with such a small

increase in the social security tax? The answer is, of course, that while everyone that is covered by social security, virtually the whole working force of the Nation, will contribute, not everyone eligible for benefits becomes sick. In this respect, it is like fire insurance—many contribute but not everyone's house burns down. Another reason this type of insurance can be purchased so cheaply is that the social security system is one of the most efficient operations in our national history. The administrative cost is only 2 percent of benefits paid out. The Kerr-Mills plan will run about 8 percent administrative cost. Our welfare commission operates at 11 percent. Most private insurance companies operate on a 15–20 percent "loading factor," as they call it; some as high as 25 percent or even 30 percent.

How much will it cost? About $1½ billion during the first year, and it will go up to $2 billion in 1970. The Kerr-Mills bill, incidentally, fully implemented, will cost about the same. To keep this figure in perspective, let us remind ourselves that in this country we spend $4 billion every year for face creams and deodorants, $7 billion on tobacco, and $12 billion on liquor.

Under the Kennedy plan there is no degrading means test. Everyone who qualifies for social security is eligible for the care. It is entirely in keeping with the dignity of the individual. Each person is entitled to the benefits he receives because he has paid for them over his working years. His medical care thus becomes a right and not a dole.

Let us leave the figures for a moment, and talk about people. Mr. and Mrs. C., let's call them Clark, have been patients and good friends of mine for a good many years. Mr. Clark is now 72 and his wife is 70. He had a good job in a wholesale grocery firm. Their own needs and the responsibility of paying $150 a month for the care of Mrs. Clark's aged mother in a nursing home prompted Mr. Clark to take all of his assets a number of years ago, plus a loan, and buy a small family-type grocery store. The mother died 3 years ago at the age of 92. He and his wife operated this store successfully, and they were able to save a little and maintain some private hospital insurance. Two years ago, a large supermarket was built near his store. His business dwindled and he sold out at a considerable loss. Last year he had a prostrate operation and a cancer was found. He had a surgical complication and was in the hospital for 5 weeks. Total medical and hospital cost, largely hospital, was $2,600. His insurance covered only $700 of this and the policy was canceled when he left the hospital. The Clarks have now an income of $86 social security and $50 a month from rooms which Mrs. Clark rents out. Mrs. Clark has disabling arthritis and caring for roomers is becoming more difficult. Each month they dip into their rapidly dwindling reserves, now less than $3,000. Mr. Clark faces progressive deterioration and death within 2 to 3 years. Much of this time will be spent in the hospital or in a nursing home as his wife is unable to care for him. How will they afford this care?

A 71-year-old widow, we will call her Mrs. Wilson, had been a nurse prior to her marriage. Mr. Wilson was the office manager of a department store. When he died 10 years ago he left a $10,000 insurance policy, equity in their home and $6,000 in Government bonds. She gets $78 a month social security. Mrs. Wilson has been living modestly, has supplemented her income by renting out a room, but over the years her principal has dwindled. Eight months ago she fell and broke her hip. She had two operations and was in the hospital for 6 weeks and in a convalescent home for over 3 months learning how to walk again. Total medical and hospital costs, again largely hospital, $3,200. She had two sickness and hospital insurance policies; one was canceled when she had pneumonia 3 years ago; the other expired when she reached the age of 70. She tried to have it renewed but the new premium was prohibitively high. Her only present income is the $78 social security check. Her assets are rapidly shrinking as she must maintain a part-time housekeeper. She has a daughter who herself is ill and is unable to help. She called to see me a few weeks ago and asked for my best estimate of how long she would live. She has a bad heart and will probably need some type of hospital or nursing home care soon. She was specific and insistent. "I will never go on welfare," she said, "and I want to make my plans." I have known her for many years and I know exactly what she means. Neither she nor I had to spell those plans aloud. When her funds run out, rather than turn to charity, she intends quietly and unobtrusively to take her own life. She is a former nurse and knows how to do it.

I have chosen these two examples of the Clarks and Mrs. Wilson from my very current experience, as these people are average, decent, responsible Americans who have been successful in building up some moderate security and reserves

for old age and because in each instance they had private hospital and health insurance when they entered the retirement period. In both instances, catastrophic hospital bills and sickness reduced them to near indigency. Every physician can supply many similar cases from his own files. What about the thousands, the millions of people who have been less fortunate and who through no fault of their own, have little or no reserves and cannot afford any meaningful sickness and hospital insurance? These are the millions who are living on their small social security checks and on other small incomes such as pensions, or are being helped by their children. What happens when they become ill and need costly hospital care? These are some of the urgent problems to which the richest country in the world must address itself. These are the problems to which the King-Anderson bill, the social security approach to health insurance, offers a reasonable, a conservative, a modest solution.

I would like to comment briefly on some of the other aspects of these plans. It has been claimed repeatedly that the Kerr-Mills program is a voluntary program and that the social security program is compulsory. This is not true. All taxes are compulsory. Kerr-Mills funds come from compulsory taxes which all of us pay to the Federal, State, and county governments. The social security tax is paid for by the potential beneficiary himself, during his working years. What is wrong with it being compulsory that a man insure himself against the needs of his old age? Why shouldn't a person earning a good salary be made to set aside a small amount each month so that when he becomes 65 he doesn't have to have his hospital bills paid for by his children or by public welfare funds?

It has been claimed that the King-Anderson bill will "destroy free choice of physicians." The social security plan has nothing to do with the physician. It has nothing to do with medical care. It is merely hospital insurance and actually I think this is one of its major shortcomings. I think the bill is not inclusive enough, and that the program should pay for physicians' services, drugs, and certain other forms of medical care. And here I am delighted to find myself in agreement with the speaker of 2 weeks ago, and I quote from his tape, "The King-Anderson bill does not in any sense of the word provide total medical care. It makes no provision for the payment of doctor bills; it makes no provision for the payment of expensive drugs; all the bill provides is a limited period of hospitalization and nursing home care, and diagnostic outpatient services." (Nine months is not so "limited.") I agree that he has called attention to a major defect of the bill. I think it should provide for the payment of doctor bills, and especially for diagnostic services in the doctors' offices. The hospital outpatient departments couldn't possibly handle this load. And I think the plan should include payment for certain drugs. The speaker 2 weeks ago vigorously criticized the bill because it didn't contain these features. I would like to ask "If these extra benefits were added to the bill, would he then support it?" "And did he report these major shortcomings of the legislation as he sees it to the congressional committee as he reported them to us?" I would like to see these benefits inserted into the plan and think the bill should be amended in this direction, and I would welcome his support.

The irony of the situation is that these benefits were in the original program as it was first outlined 3 to 4 years ago, but were removed because of the opposition of organized medicine.

Let me make it clear, in justice to my society, that the record of the American Medical Association in scientific and public health areas is brilliant—in improving the standards of medical education, in closing the diploma mills, in its relentless war on medical quackery, in sponsoring laws for purer food and which is fiscally sound and I cannot understand why any reasonable person who has read the bill and understands it, doesn't favor it."

He exposed—and disposed—of two false charges made against the measure:

1. That is would destroy free choice of physicians. "This bill has nothing to do with the physician. It has nothing to do with medical care. It is merely hospital insurance and I think that is one of its major shortcomings. I think the bill is not inclusive enough," Dr. Goodman declared.

2. The charge that it would result in "socialized medicine" he called a "smokescreen designed to frighten the American people and the doctors."

"This is not socialized medicine, nor will it lead to it," he told the City Club. The Marine and veterans' hospitals, State and Federal tuberculosis and psychiatric hospitals—these are good examples of socialized medicine. "The University of Oregon Medical School hospital, to which our Governor is rushed when he becomes ill, practices pure socialized medicine," he said.

Spokesmen who make these charges against medical care for the aged under social security "do not speak for me," Dr. Goodman told the audience. Nor, he added, do they speak for a great majority of those physicians engaged in research or as teachers, nor for the rapidly increasing number of younger doctors.

Do they speak for the majority of the country's doctors? Or is it time for the AMA to make an agonizing reappraisal and move into the 1960's?

Senator MORSE. Doctor, we are glad to have you here, and you may proceed in your own way.

STATEMENT OF DR. MORTON J. GOODMAN, PRACTICING PHYSICIAN AND FORMER CHAIRMAN OF MEDICAL CARE COMMITTEE, OREGON STATE WELFARE COMMISSION

Dr. GOODMAN. Thank you, Senator Morse. Members of the committee, ladies and gentlemen, I am Dr. Morton Goodman. I am a physician, specializing in internal medicine. I have practiced in Portland for over 25 years, and during the past 4 years, up until July 1, I have been a member of the Oregon State Public Welfare Commission and have served as chairman of its committee on medical care. I have maintained a close and critical interest in the problems of medical care of the aged in nursing homes and related institutions.

I would like briefly to address myself to three general topics: (1) the present standards of care in nursing homes, (2) some basic defects in our present approach to congregate care of the chronically ill patient, and (3) some suggestions for study of new methods to meet present and future needs.

In the past three decades, there has been great improvement in the standards of medical care in nursing homes and related institutions in this area. Better licensing laws and regulations, improvement in the caliber of nursing home administrators, the efforts of the State board of health, and particularly the medical division of the State public welfare commission, the dedicated efforts of a few enlightened nursing home operators to raise their own standards, have all had salutary effects on the caliber of the care in these institutions. But much, very much, remains to be done.

From my own personal contacts, inspections and contacts, I am disturbed about abuses and violations in some areas which still exist. There still remains in some institutions overcrowding beyond license limits, substandard food, inadequate and incompetent nursing personnel, administration of drugs by unqualified employees—all violations which defy detection by anything short of continuous supervision. It is virtually impossible for the limited number of inspectors, competent and devoted though they are, to do an adequate job. They are able to visit and spot check some of the homes no oftener than once or twice a year, and the nursing home statute, as presently operative, make the efforts to correct the abuses often clumsy and difficult. Weeks or months of hearings and litigation often threaten to obstruct the correction of minor violations.

In many of the homes, there is no interest whatever in rehabilitation efforts which could salvage many of the unfortunates. Recreational and emotional needs are completely ignored. Many of the operators look at their patients as so many beds, and each bed represents income.

In some of these bleak establishments, the patients sit and wait for death to relieve the dreary monotony.

Improvement of standards through regulatory compulsion has long been an uphill battle. Mrs. Allison is to be commended for her efforts to introduce an accreditation program for nursing homes, but her task is a lonely and difficult one.

It is for these reasons that I look with great interest at the possible benefit in this direction by legislation on the national level. If the President's plan for hospital and medical care insurance for the aged within the social security framework becomes law, as outlined in the King-Anderson or Morse bills, high standards for skilled nursing home facilities for the care of those who qualify under this program would be spelled out clearly. Substandard homes would not be forced or legislated into altering their standards, but, if they wished to participate in the national plan, they would have voluntarily to meet the requirements of the statute and under Federal supervision. This, in my opinion, would be one of the many bonuses, one of the adjunct benefits of this type of legislation, which I strongly endorse.

The difficulties in coping with today's substandard nursing homes are precisely the same as those which plagued the operation of privately owned hospitals 40 years ago. In the early part of the century, hospitals operated by private individuals for private profit displayed all the built-in potentials for abuses in the medical care of sick people that we see today in the nursing home setting. Now that practically all hospitals are operated on a nonprofit basis, most of the defects no longer exist. There is no doubt in my mind that similar evolutionary changes will and must take place in the nursing home field. Removal of the profit motive, at least in the care of the indigent patient, whose care is paid for by public assistance funds, would go far toward resolving the shortcomings and abuses in our present system. Institutions of this sort should be sponsored by charitable, church, educational, and endowed organizations, or by local or State governments, with Federal support, in the same way that nonprofit hospitals now operate.

The elaborate complex of medical care cannot in my opinion operate properly in a setting where the institution can make a profit by cutting down on the standards of care of the patient. In Oregon, at present, almost 30 percent of the hundred million dollar biennial budget is allotted to medical care services, and well over half that sum goes into the nursing home care. Medical and institutional care of all sorts has become more costly each year, but, even so, the standards cannot and must not be lowered. As a result, the drain on the public purse has become so great that the taxpayer is going to have to purchase this care on a nonprofit pure cost basis.

This brings me to my final point, the need for long-range planning for the chronically ill patient who may need some type of care and supervision for the rest of his life. When an older person leaves the hospital after an acute illness and if he is unable to return to his own home or former living arrangements, he usually enters a nursing home. Here in a strange and new environment, he is lonely and frightened and is removed from familiar faces and personal posses-

sions. He tends often to withdraw into himself, feeling that he has been shelved by society, and he becomes in a short time a psychological, as well as a physical invalid. It is at this point or before it that comprehensive planning for his future care should be focused. It is here that the services of skilled social service workers are needed, who in cooperation with medical advisers can select the best care modality that is available in the community and who can supervise progressive care planning as the patient's status changes. Increasing emphasis should be placed on rehabilitation and physical therapy especially for stroke patients. Occupational therapy in sheltered workshops, attention to recreational, social, and spiritual needs of these people, will be a part of a broad and comprehensive care plan.

A central agency or director for integrating this whole program is essential, and probably should be centered about the hospital itself. Such a plan has proved successful in a number of areas in this country where such plans are in operation. One of the major objectives of such a comprehensive, progressive care program will be the physical and social rehabilitation of these patients and returning them, wherever possible, to some sort of an active participation in community living.

Many new experiments are being undertaken in this country which deserve encouragement and support. We can also look abroad for ideas and challenges. The enlightened and humane approaches to the care of the aged in Scandinavia, where I recently visited, merit a careful study and have many lessons for those who wish to improve the medical and personal care standards of our elderly Americans. In Sweden and Denmark particularly, the magnificent and wonderful new institutions, the homes for the aged, the nursing homes, and homes for the chronically ill, the hospitals, and apartment houses, all participate in a superb quality of medical and personal care, all financed by their social security programs. These institutions and their enlightened administration are pointed to with pride to all visitors to see and admire.

These new programs will be costly, very costly, at the start, but, once implemented, they will mean not only more effective use of our tax expenditures with savings in that regard, but, far more important, they will help to salvage and to preserve the human resources of our older men and women. Thank you.

Senator MORSE. Thank you. I appreciate very much this excellent statement. It will be very helpful to us.

Our next witness will be Mrs. Bertha Roth, administrator of Clatsop County Welfare Department. Mrs. Roth, we will be glad to hear you. You may proceed in your own way.

STATEMENT OF MRS. BERTHA ROTH, ADMINISTRATOR, CLATSOP COUNTY WELFARE DEPARTMENT

Mrs. ROTH. Thank you. Senator Morse and members of your committee, it is a particular pleasure for the level of government, which I represent, to talk to a Senate committee. It is a very wonderful experience, and I appreciate being here.

Working in this program at the grassroots, I have recognized the need for methods of utilizing, and this morning we have had frequent references to a need for understanding on the part of the staff, and a need for a training staff. I would like to suggest that one way of doing this, which we have tried, is through the Extension Division with the cooperation of one of our institutional members, of course, who have required their nurses aids to take the extension division course for nurses aids. We have worked out a program, which included not only the physical, but also the emotional needs which might go into making for a better nurses aid.

I know in working with these nurses aids that they have been very concerned. There is a great loss financially to turnover in a nursing home because of the fact, not necessarily because of the low-pay feature of their profession, but because they don't know what to expect, nor how to cope with the problems that they meet in nursing homes. If they can be aided to a better understanding of these problems, they are going to do a more adequate job and do it with much more grace and happiness.

We have, therefore, worked on this extension program and have included vocational rehabilitation. We have the division of crippled children, where a physical therapist has come in and shown this resource, and we feel that it has increased the knowledge of the nurses aids, and so it has improved the service to the extent that it is a value to consider it on a State basis.

I would also like to make available the cost study which was prepared by St. Mary's Hospital Nursing Home Annex for our last legislative session. It is similar to the one you have already heard about, so I will not give the breakdown. However, they do show that the total expenses provided on a per diem basis is $6.79 per day. I think that this is slightly different from the figure presented this morning, and I think it may be in the area that they have included an item for depreciation. Otherwise, it seems that from the statistical findings of these two institutions that it is very similar. This is based on a 75-bed patient nursing home.

Senator MORSE. That statement you referred to, Mrs. Roth, will be incorporated in the record at this point.

(The cost study referred to previously follows:)

ST. MARY'S HOSPITAL,
Astoria, Oreg., December 21, 1961.

Senator WAYNE MORSE,
Chairman, U.S. Senate Special Commitee on Aging,
Washington, D.C.

DEAR SENATOR MORSE: We have asked that the enclosed geriatric cost finding information be shared with you through Mrs. Bertha Roth. These statistics were compiled in accordance with the American Hospital Association's recommended cost finding program. We are able to verify these.

We would like to comment on our cost finding statistics. We are using the depreciation figures on the equipment they are actually using in our geriatric unit. Our administrative expenses are distributed on a dollar basis and are possibly too low. Our administrator and the director of nursing service spend the majority of their time working with the geriatrics and certainly the administrative expenses under which they are accounted for should be passed on to the beneficiaries. We certainly would not consider the alternative of giving less than the proper attention and treatment to the patients in these wards.

We would like to qualify the high cost for the laundry and linen. We weigh our laundry as it is processed, so the geriatric department is charged for only the laundry processed for their department. Our incontinent patients use a large amount of bed linen, but the cost of laundering the ambulatory patient's clothing is just as costly as they wear street clothing and this involves hand ironing.

We would like to point out that this is an average cost per diem and that in varying degrees, it costs us considerably more to care for the incontinent geriatrics than it does the ambulatory geriatrics.

For your specific information about our hospital, I enclose the amount we spent over and above our receipts during the past 3 years in caring for our geriatric patients.

1958	$31,368
1959	35,301
1960	40,360

Our entire records and books are available to any interested parties. We hope the enclosed information will help you in further understanding the high cost of caring for a geriatric patient. We will be happy to answer any further questions you may have concerning our costs or cost accounting. Our administrator, Sister Rose Imelda, has approved the release of the above information.

Yours very truly,

Mrs. M. Adams, *Accountant.*

Geriatric cost finding statistics for 1960

Salaries	$57,568
Direct expenses	1,107
Depreciation	4,947
Employee Health and Welfare, Workman's Compensation and social security	2,388
Operation of plant (heat, lights, water, etc.)	5,758
Maintenance of plant	4,875
Laundry and linen service, 122,103 pounds, at $0.102	12,498
Housekeeping, 4,479 hours, at $1.99	8,913
Dietary raw food, 79,101 meals, at $0.2597	20,539
Dietary other expenses, 79,101 meals, at $0.3156	24,965
Medical supplies (items included in room charge)	751
Pharmacy (drugs included in room charge)	148
Medical records, 26,367 hours spent on records, at $1.699 per hour	4,479
Administration and general	30,202
Total expenses distributed to geriatric department	179,138

Note.—Total expenses ($179,138) divided by 26,367 patient days=$6.79 per diem for geriatric day.

An additional insert which we are making available, if it may be found useful, is a survey of the composition of the persons receiving nursing home services, who were known to public welfare. This survey was done on the previously mentioned nursing home caseload.

Age	20 to 30	30 to 40	40 to 50	50 to 60	60 to 70	70 to 80	80 to 90	90 to 100	100 to 110
Sex	1	0	7	4	8	30	36	9	1
Male	1		3	3	4	16	13	2	
Female			4	1	4	14	23	7	1
Type of care:									
Senile and ambulatory				1	1	3	9		
Ambulatory			1	3	4	15	15	1	
Bed care	1		5		2	9	10	6	
Nationality:									
Austrian				1		2			
Italian-French						2			
English			2	2	2	13	24	7	
Finnish			2	1	1	3	7	1	1
Norwegian						5	1	1	
Swedish					2	1	1	1	
Chinese					2				
Filipino									
American	1		1		1				
German			1				1		
Swiss							1		
Education:									
2d grade			1			9	11	3	
Under 5th grade			1	2	2	15	11	6	1
Under 8th grade			3	2	4	3	6	1	
Over 12th grade	1					2	2		
College			3			1	1		
Years of care:									
Under 1	1			1	3	4	6	1	
Under 2			1	1	1	8	5	1	1
Under 3			3	1	2	5	5	1	
Under 4						1	2		
Under 5					1	2	1		
Under 10				1		4	6		
Under 15			1	1		1	6	1	
Under 20			2			3	8	7	
Chronic illness:									
Cardiac						2	7	2	
Parkinson			1			3			
Hypertension									
Diabetes						1	2	2	
Blindness							1		
Epilepsy									
Arthritis			1		1	1	4		
Alcoholism									
Cancer				1					
Mental					1				
Senility						4	11	6	
CVA			1	2	2	2	1		
Polio									
Paraplegic			1						
Aged alcoholic						1	1		
Broken bone							1		1
Asthma					1	1	1		
Work history:									
Logger			1				7		
Fisherman				2		13	7	7	
Housewife				2					
Bookkeeper						1	1		1
Longshoreman									
Businessman						1			
Farmer						1	2		
Teacher			1						
Cook									
Carpenter						1	2		
Laborer				1	1	1	4		
Electrician				1	1			1	
Waitress			1						
None			1						
Auto mechanic					1				
Railroad employee							1		
Artist			1						
Pile driver						1			

Source: Compilation of the Clatsop County Nursing Home caseload.

Mrs. ROTH. There is only one other thing I would like to emphasize, and that is the great need for coordination of our services. We are attempting to develop that in all of our health and welfare services, but it is one of the things that I want most to stress, that the waste which goes into the public at this point is largely, it seems to me, from a lack of coordinated services available, not that the services aren't here.

I would certainly endorse and support any projects which would increase the utilization of these services. Thank you.

Senator MORSE. Thank you very much, Mrs. Roth.

Our next witness will be Mr. H. J. Erickson, representing the Department of Oregon Veterans of World War I. Mr. Erickson, we are very glad to have you before this committee.

STATEMENT OF H. J. ERICKSON, DEPARTMENT OF OREGON VETERANS OF WORLD WAR I

Mr. ERICKSON. Senator Morse and staff, ladies and gentlemen, I am H. J. Erickson, retired postal employee, now serving my fourth year as adjutant of the Department of Oregon Veterans of World War I, in which capacity I learn about the problems of a large group of aging citizens of this Nation. We are a special group of aging people, averaging between 67 and 68 years, therefore unemployable under today's personnel management practices, even if no physical disability exists.

Many of us are not covered by social security because at its founding we were already past the age considered desirable for employment by most personnel managers. We are also the forgotten men among the veterans of this Nation. We returned from our war service in 1917, 1918, and 1919, to different conditions than did later veterans. We received $60 severance pay, not $300; no guarantee of job restoration; no 52–20, or $20 per week for 52 weeks as unemployment compensation; no educational aid; no paid on-the-job training; and no veterans hospitals or Veterans' Administration system at that time.

Under existing laws, we can now draw some compensation for service-incurred disability, or a small pension if we are over 65 and more than 40 percent disabled, scaled at $90 per month maximum, if we have less than $1,000 per year income; $45 per month if our income is less than $3,000 a year. We have no recourse to the veterans hospitals unless we have service-connected illnesses and disabilities, or we take a pauper's oath. Our problems are the same as all senior citizens face, food, shelter, clothing, and medical care.

The constant rise in costs of all commodities and the equally constant decrease in the buying power of the dollar is forcing upon us a constant decrease in our standard of living. A fixed income, such as a pension or disability compensation or social security, no longer permits the maintaining of a decent and respectable American standard of living. We proudly maintain that the services of the senior American citizen to his country in times of war and of peace are such that his country cannot fail to provide proper care for him in his declining years.

We thank the Congress for recognizing this obligation by establishing this committee to study this problem and its solutions. We also want to stress that the problem of medical care is probably the most important one to us, having, as we have, a very limited access to the Veterans' Administration facilities, and having only a recourse to public welfare rolls, and feeling a vast disinclination towards applying for public welfare, and feeling as we do, that it is a national obligation that our country owes its ex-service men and women, to see that they do not become pauperized in their old age. We try to avoid as much as possible participating in the welfare program.

The basic concept behind the establishment of the Veterans' Administration was to prevent the veterans of the Armed Forces of this country from ever becoming public charges, and in as far as we become public charges, the drain upon the public welfare system of this country is larger than it should be because our share of that drainage should be borne by the Veterans' Administration.

I would be remiss in my duty to the Oregon Veterans of World War I if I failed to express to Senator Morse our recognition of and earnest thanks for his efforts in behalf of our veterans legislation in the Congress. Thank you, Senator Morse.

Senator MORSE. Mr. Erickson, I want to thank you very much for your statement. I am so glad that this record includes and shows this very clear statement about the discriminatory treatment that World War I veterans have received in comparison with other veterans of our country. As you know, I support enthusiastically all the programs that have benefited the other veteran groups. I appreciate your comment about my interest in your problems and, I feel I owe you an apology that I haven't been more sucessful in getting some results to date, however, I don't know what the word "quit" means, and I want you to know that I shall continue to do what I can to see to it that the social justice—which I believe is being denied the World War I veterans—is given to them in the very near future. I don't intend to stop that drive.

There is one thing that you didn't mention. You talked just about the veterans, but all the lack of services that you referred to, as far as the World War I veterans is concerned, also applies to his dependents. The veteran may have a wife who has suffered a stroke or is incapacitated, has a broken hip, or in some other way is in great need of assistance and doesn't come under social security either.

I am often criticized for experiencing views such as this; but I am used to it, because on this job one has to have a sense of humor, the hide of a rhinoceros, and the ability to roll with the punches. Regardless of the criticism of those who fail to understand these great problems, I have taken the position that the elderly, who are not eligible for social security, nevertheless should be made eligible for the medical care treatment that is proposed in many of our bills, such as the Morse bill and I intend to continue to do what I can to get favorable consideration of that amendment. I shall also work for the passage of any other bill that may ultimately be given precedence over my legislation, to get these principles into the bill. I don't care whose name the bill carries.

I am glad to have the views you expressed because I think you made a very clear statement. Many people do not realize the special plight of the World War I veteran, who today is fast coming into the age

group, to which you refer. His average now is between 67 and 68 and he certainly deserves consideration. Thank you very much.

Our next witness will be Mr. W. R. Stevens, director of Maplewood Home for Aged, Grand Ronde, Oreg. Is Mr. Stevens here?

(No response.)

Senator MORSE. Will someone watch for Mr. Stevens? I will put him on later if he comes in.

Our next witness then will be Mrs. Helen Zollinger, who is a member of the legislative council on aging, founder of the "Senior Craftsmen" of Oregon, and moderator of "The Challenging Years," a radio series, now in its third year. Mrs. Zollinger was formerly a member of the Governor's committee on aging; the State council on aging; first chairman of the Committee on Aging of Portland; and a delegate to the White House Conference on Aging. She has presented the "Senior Craftsmen" story on the Voice of America and numerous other radio and TV programs, and has been on the Richfield Success Story. She was formerly on the board of directors of the Patton Home for the Aged.

Earlier this year, at the annual dinner sponsored by the Portland area labor unions, Mrs. Zollinger was presented an award for her deep concern for the problems of the aging and her distinguished service in finding solutions for these problems.

Needless to say, we are delighted to welcome you to this committee. I only want to add, in addition to what I have already read of your qualifications, that I can be a witness to your effectiveness in connection with the conferences in Washington. You may proceed in your own way.

STATEMENT OF MRS. HELEN ZOLLINGER, MEMBER, LEGISLATIVE COUNCIL ON AGING, AND MODERATOR OF THE WELL-KNOWN RADIO SERIES, "THE CHALLENGING YEARS"

Mrs. ZOLLINGER. Thank you very much. You can tell from that biography that I have lived a long time.

Senator MORSE. I kept that a secret.

Mrs. ZOLLINGER. I am very happy to report, Senator, that in the 10 years I have been in this area, we have enjoyed very great progress in the raising of the physical standards of the nursing homes and the physical care of the patients. I see some of you here today with whom I have worked during that entire 10 years.

I am very sorry to say that we have not kept pace in improvements in the activity programs and such as we have in the physical care. I am hoping that, as a result of the conference here today, perhaps steps will be taken to improve activity programs, so that every day of life, even in a nursing home, will be of value to the patient.

There has been an increasing number of volunteer agencies working in this field, and they have made considerable progress. It was 10 years ago, for instance, that the community council called a meeting of the committee to help nursing homes strengthen their organization. Public health, the division of higher education, and other agencies helped in that field. Then, more recently, since the National Committee on Aging had its regional conference here, there has been stepped up activity in the field of friendly visiting and also

in recreational crafts. The agencies that have been working mostly in that field have been the Red Cross, the Oregon Visitation, the Council of Churches, and the Salvation Army. It has been my responsibility to help with the leadership training for those projects. As a volunteer and as a member of the leadership training group, I wish to say that, more than anything else, I think we need a professional person who has the background and training and experience in the field of activity programs in nursing homes, to give training and supervision to the volunteers. The efficiency of the volunteers would be tremendously increased, and, as we have many volunteers giving hundreds of hours, the effectiveness of the nursing homes themselves could be very greatly increased if this leadership were given.

Then there is one other field, in which I feel there is a very great need, and that is the need for an information service, so that families will be able to secure adequate information regarding various nursing homes, so that the older person in the family can be placed in the home where his needs will be most effectively met. I think that you can see that actually I am just asking for an implementation of the recommendations made by Mrs. Allison regarding accreditation and Mrs. Pragoff and Mr. Stabler and also Dr. Morton Goodman, and others in regard to the activities in the nursing homes. Thank you.

Senator MORSE. We are glad to have your oral testimony. I would like to make a request, if I may. I feel that, from the positions that you have held and hold, and because of your position on the State council on aging, and the Governor's Committee on Aging—we will hear Rev. Mr. Nicholson, the chairman of that commission—but, nevertheless, I would like to have you give consideration to preparing a memorandum for us, based upon the work of that commission, as well as your other work. It would be most helpful if you would make special reference to the problems here in Oregon that you believe would be helpful to this committee. I would like to have you file it within the next 30 days.

Mrs. ZOLLINGER. I would say, however, that I went off the State council 2 weeks ago, so that I cannot speak officially for it.

Senator MORSE. I am not interested in your speaking officially. I am interested in picking your brain, may I say, to get the information that you can supply the committee. So, as Mrs. Private Citizen, I am going to ask you for that memorandum, if you will oblige me.

Mrs. ZOLLINGER. All right, Senator.

(The letter and memorandum follow:)

PORTLAND, OREG., *December 2, 1961.*

Hon. WAYNE MORSE,
U.S. Senate.

MY DEAR SENATOR MORSE: May I congratulate you on the very excellent hearing you conducted in Portland last month? I would have enjoyed attending sessions in other parts of the State, but have been out of Oregon since the day after that hearing.

There would be no value in my repeating facts and recommendations made by others. I shall therefore confine my comments to my special fields of experience and to a few controversial points.

On my return to Portland yesterday, I found some excellent material from the special staff on aging, of the Department of Health, Education, and Welfare, some 14 case studies of outstanding projects entitled "Patterns for Progress in Aging." I feel very definitely that a large percentage of the problems of older citizens could be solved rather easily by educating the communities and the old

people themselves on possibilities for action and ways of proceeding. That is exactly what these studies do.

If I had to choose only one recommendation for action in the field of aging, I would recommend that the special staff on aging be given the responsibility, authority, and funds to provide materials, develop pilot projects in local areas, and to provide consultant services to State and local agencies, both public and private. Much of the success of our Oregon efforts in the field of aging is due to the assistance of Dr. Clarke Tibbitts, special staff on aging, and to the National Committee on Aging (now the National Council on Aging). Dr. Tibbitts came to Oregon for our first effort, a conference, in 1951, and has returned at various times since then. His assistance has been of great value.

If there is additional material you would like from me, I shall be glad to cooperate.

Sincerely yours,

HELEN ZOLLINGER.

TRAINING AND USE OF VOLUNTEERS IN HOMES FOR THE AGED AND NURSING HOMES

The volunteer is an amazing person. At a time when everyone else is clamoring for more and more money, more and more benefits, the volunteer is giving his time, paying his own expenses, with no paid vacations, no fringe benefits of any kind. Volunteers offer a wide variety of skills and abilities such as homes could never hope to employ. You have only to visit a home where volunteers are used effectively to see how they enrich the lives of the patients. However, they are skilled in their special fields. They are not skilled in working with older patients in nursing homes. They need and deserve training. With it their contribution could be tremendous, hundreds of hours, many skills, at no cost to the patient or the nursing home.

Recommendation for Federal action

(1) The development of materials to train volunteers to work in nursing homes and homes for the aged.

This should include fundamentals in understanding the older patient; orientation to the home and staff, with relationships of staff and volunteer clearly defined (this is too frequently completely absent); techniques of working with older patients; detailed instruction of general and craft programs, with specific attention to patients with special handicaps, such as little or no vision, the use of only one hand.

It should also include special training for volunteers in group leadership and supervisory capacities.

(2) The employment of staff to counsel with State and local agencies in the development of programs.

(3) The development of pilot programs in local areas. It must be understood that there are few persons in Oregon who understand the possibilities of activities in nursing homes and homes for the aged, or who have a background of experience or training in this field. This is probably true in the majority of States. Federal staff could do a job in this field somewhat comparable to that done in the field of housing.

NEED FOR AN INFORMATION SERVICE REGARDING NURSING HOMES AND HOMES FOR THE AGED AND SCREENING CENTERS FOR MENTAL HOSPITALS

There is a great need for services which will enable families to find the place best suited to the needs of the older patient. Should he be in a mental hospital? In a nursing home? If so, which one? Accreditation will be of practical value if it includes information regarding services offered in physical and occupational therapy, diversional crafts, and social programs. Screening centers would result in substantial savings, and also greater happiness.

Recommendation for Federal action

(1) Grants for screening centers to such agencies as Dammasch.

(2) Cooperation with nursing home associations in the development of standards and accreditation procedures.

CARE OF THE CONFUSED ELDERLY

Probably the most difficult problem facing families today is the care of the confused elderly whose confusion impels him to wander. The life of an entire family may be disrupted in an effort to care for one such person.

Our State hospitals are now placing their entire emphasis on rehabilitation, and are attempting to restrict their admissions to those who can be rehabilitated. Where, then, can cases such as the following be cared for?

Case No. 1. A confused man, 75, has just entered a nursing home which is charging $250 a month for his care. His wife, 73, has been for weeks in a hospital with a bad heart attack, resulting from years of caring for her confused husband. In spite of all her devoted care, he was determined to wander.

A daughter called, asking for help. She had been caring for her father during her mother's stay in the hospital. His repeated wandering, especially at night, had so impaired her husband's health that he was temporarily out of work, since his job required a peak of physical fitness. She said that even with her husband working, they did not have money to pay for the expensive hospital and nursing home care.

I know of only two homes in the Portland area adequately equipped to care for such a case. Since those homes had no vacancy, he was placed in a general nursing home. Although he was physically fit, able to walk easily, he was tied in a wheelchair to protect him from wandering into a busy street.

Case No. 2. In another family with a confused elderly father, a younger sister gave up her much needed job to care for him, a daughter gave up her entire time outside of working hours, and a married son and his wife were on call at all hours. Yet the father himself was increasingly frustrated, resentful, and hostile because he wanted only to go to his home of 50 years ago, 2,000 miles away. The confused person himself, the family, and the community would have been greatly benefited if there had been some facility able to give him adequate care.

Recommendation for Federal action

(1) Cooperation with the States in developing facilities for caring for the confused elderly. I see no possibility in the foreseeable future of private homes being able to provide adequate care for such patients.

(2) A reevaluation of the Federal policy of not assisting with the support of patients in State institutions.

SUBSIDIZATION OF OAA RECIPIENTS BY PRIVATE PATIENTS

Private patients should not be charged higher rates to make up for deficiencies in payments of OAA patients. Too frequently, private patients least able to pay are in actuality subsidizing OAA patients. Case No. 1 and the following case No. 3 are typical.

Case No. 3. A woman, 83, broke her hip. Her assets, except for her share in the family home, were completely exhausted by hospital and doctor bills. She applied and received OAA and was cared for in a nursing home for $169 per month. Her home was sold and she received $2,000. She then had to pay $225 per month, since she was no longer a welfare recipient and no longer entitled to welfare rates.

In case No. 3, it might be argued that it makes little difference, since the higher charge means only that she will become a welfare recipient somewhat earlier. Where the family continues to pay, however, as in case No. 3, the higher rate may seriously affect the education of children, and the well-being of the family.

Recommendation for Federal action

(1) Adequate public funds should be provided to meet the entire cost of care of patients in nursing homes and for residents in homes for the aged.

HOUSING FOR THE ELDERLY

Recommendation for Federal action

(1) A reevaluation of standards of design and construction of retirement homes necessary to qualify for Federal aid to modernize them to fit modern materials and methods of construction.

TAX LIABILITY OF RETIREMENT HOMES

It is my belief that it is only right for retirement homes to pay property taxes. I question decidedly, however, the taxing of founders' fees as income. My experience has been that a large percentage of those in retirement homes in Oregon are persons such as schoolteachers who have given a lifetime of service at a modest rate of pay. Since the homes are nonprofit, any income tax would have to be paid by the residents. It would, in many cases, be ruinous.

Recommendation for Federal action

(1) A clarification of the liability of retirement homes for various types of taxation, especially the Federal income tax on founders' fees.

EMPLOYMENT OF THE ELDERLY

Recommendation for Federal action

(1) A continuation of the forums on employment in local areas as developed by Alice Leopold of the U.S. Department of Labor.

Senator MORSE. Thank you very much. I would like to have the staff see to it that Mr. Stevens, who couldn't get here, is notified that we will keep our record open to receive his printed statement for the record, if Mr. Stevens by any chance hasn't come in.

(The statement of Mr. Stevens follows:)

STATEMENT OF W. R. STEVENS, DIRECTOR, MAPLEWOOD HOME FOR THE AGED, GRANDE RONDE, OREG.

The State board of health has consistory powers over the home operators. In our case, it was a case where it was impossible to find an administrator for our home when it was running as a nursing home. We were trying hard to find an administrator but those people are awful scarce and they took away our nursing license. Our only salvation was to turn it over to a home for the aged, which left us with five people. We had 10 at the time this happened—we were set up for 24. We had just enough people to keep dragging along to stay out of bankruptcy. I feel that there should be some control over that kind of situation where we are doing our best to take care of the people, running a good home, to have our end covered. We were just unable during that time this happened to find a good administrator. We are not the only ones—there are more in Oregon that this happened to. I feel some controls are in order over this type of occurrence.

Senator MORSE. Ladies and gentlemen, we now come to that part of our hearing which we call the town meeting of senior citizens. This provides an opportunity for Congress to learn from the older people themselves and those with personal knowledge of the problems which aging brings, which of those problems they believe to be important, and from them, too, we hope to get suggestions or proposals as to how we can best attempt to solve these problems.

Our committee is going to be hearing from senior citizens in every part of the United States. For instance, I have been told that right now in St. Petersburg, Fla., more than a thousand people are gathered to tell another one of our subcommittees what they think should be done. This is Oregon's opportunity. This is the time when I hope that every one of our older people who believes he has a suggestion to make will make it so that, when the Congress reconvenes and studies these hearings, the views of the people of our fine State will be given equal weight with those of other people elsewhere. Possibly we cannot get to hear all of the people who may desire to talk and tes-

tify in public hearings. I want to make very clear that, when I offer the opportunity to file a statement for the written record with this committee, that it doesn't mean the written statement will be disregarded. I give you my word that every statement that is filed in this record will be thoroughly read by your chairman. There is something else I do in cases of this type. Some of my staff colleagues here know that, with my professorial background, I conduct a seminar back there in Washington. These are my graduate students and they are going to have to file with the committee a synopsis of what this committee hearing will show, so that even members of the committee who are not here will have the benefit of the written statements that are filed with the committee. And I want to urge you to remember that, even though you do not testify orally, your written statements are just as important and usually they are enlarged upon and contain a good many bits of evidence that a speaker at the time may forget to state when he or she is testifying orally. So, please remember my invitation to file statements. This record will be kept open for some 30 days to receive them.

We will begin by hearing from representatives of an organization of older citizens. There are three individuals who have written us indicating they would be here and would like to be heard. After that we will hear, subject to our time limitation, from anyone in the audience who chooses to speak.

Our procedure will be as follows: We will ask those who want to address the subcommittee to come up to the microphones that you see down on the floor before us, one over here to my left and one over here to my right. We will, of course, ask each individual to begin by giving his or her name and address to the reporter here so that he can get it down for our official printed record of the hearing. In fairness to all those who may want to participate, we will ask each individual not to talk for more than 4 or 5 minutes and then file a written statement in addition to any oral statement that you make, if you care to file such a statement.

In case there should be more people wanting to be heard than time permits, or in case there are some people here who would like us to have their views, but who for one reason or another do not care to speak out in public, you will find at the side of the room, as you leave, letterheads addressed to me saying, "If I had had an opportunity to speak, this is what I would have said." Please take one and fill it out. You are not limited to that page. Supplement it by writing as many pages as you care to. You will also find franked envelopes which do not require any stamp. Take an envelope and a sheet of paper and let us have the benefit of your thinking.

We will now begin by calling upon the representative of the Social Security Clubs of America. I understand that Mr. Merl E. Jones, vice president of the Social Security Clubs of America, is here to speak because Mr. Dover, the national president, was unable to be with us today.

Mr. Jones, if you will go to the microphone, you may proceed in your own way.

STATEMENT OF MERL E. JONES, VICE PRESIDENT, SOCIAL SECURITY CLUBS OF AMERICA, AND VICE PRESIDENT, INSTITUTE OF SOCIAL WELFARE

Mr. JONES. Thank you, Senator Morse and members of the committee. I am greatly indebted for the opportunity to give you a short statement as to the needs of the aged that I have come across so often here recently regarding the appeals made to Social Security on cases where disability is claimed, and the inability to get any action taken for those people. Some of the people are so bad that they can hardly move around. They have to take pills for their heart and are in such awful shape.

Our organization frequently takes an appeal before the referee, and his decision is adverse; he simply will not see it our way, but then we are allowed to go before the board of appeals, and then that is also turned down, and then we only have one recourse—to go to court, and there is very little money in the hands of the people to do that.

So we ask, if it is possible, it would be a very good thing, instead of having a one-man decision, that there should be a three-man board, a doctor to look over the other doctors' reports, and a layman, and a lawyer. Therefore, with that board, the people that are in terrible shape and do not have a chance to appeal and get their decision at least workable, they would have their chance because they would have to have a decision of three, or at least two, and we ask that you consider that if there is any way possible that that can be put over.

Our cases come before us. We have from 8 to 15 cases a day that come into our office, and some of them are pretty serious. There are things that are very bad, and we are not able to do much about them, and with this three-man board we would have a chance to get adequate results, and that is practically all I have to say on that. Thank you.

Senator MORSE. Thank you, Mr. Jones. I would say that we have had similar proposals made, and I think the record should show, and I think this is true with most Senators, that during the year I receive more mail on social security problems than any other subject matter that I receive mail on, which is some indicator of how serious the general problem for the aged people on social security is. The quantity of mail that comes through my office is simply voluminous.

I am very glad to have this statement from you this afternoon, and it certainly will be given very careful consideration by the committee.

The next speaker will be Mrs. Evon Crawford of Portland. Mrs. Crawford, we are happy to have you.

STATEMENT OF MRS. EVON CRAWFORD, PORTLAND, OREG.

Mrs. CRAWFORD. Senator Morse, I am speaking for the elder citizens, and things that they think about and what they are talking about. Of course, there are three subjects with them. The first of them is about taxes. Something should be done about the taxes on property owned by elderly citizens over 65 who are on social security or welfare.

Most of them cannot pay their taxes without great sacrifice on their part. Some are not paying them at all. Therefore, they will lose their homes. They cannot receive enough money to live properly and pay their taxes at the same time. I think these taxes should be exempted entirely for these people.

The next subject is medical care. As I understand it, a person applying for medical aid must pay the first $50, or whatever it is, of the amount of money granted that they received. The greatest part of these people cannot pay that much at all, outside of a small fee to register, and we think the medical care should be free for any person, and many persons cannot register at all because they cannot pay that amount. I think this bill should be amended.

The third subject, and we have asked about this several times and, in fact, I worked on the bill and got around 400 signers and this was sent in but was tabled, and we still are thinking a great deal about it, and many of us feel that the law should be amended so that people on welfare or old-age assistance can earn $50 a month over what the welfare is and the welfare cannot be deducted from their paychecks. Now, no money is given for clothes or medical care, and it makes it very difficult for the people. We want the people to feel free from worry about how they are going to meet their urgent expenses. We feel that America's elderly people should spend their last days free from worry about constantly trying to live. As we see it, the welfare does not equal the gradually rising costs of living. Therefore, it makes it very difficult for them to meet their expenses, and I think these three subjects are serious problems for the aged, and we would like to have them considered. Thank you.

Senator MORSE. Thank you very much, Mrs. Crawford. Counsel advises me that he thinks the rule in this State is that the recipient has to pay the first $70, not the first $50.

Dr. STEWART. Senator, I think there is a requirement that the recipient assume responsibility for the first $50 of cost for the physician's services. This does not necessarily require that this is paid, but they assume this as a responsibility.

Senator MORSE. Then there is no requirement for $70?

Dr. STEWART. There is a similar sort of requirement with respect to hospitalization, where again he is expected to assume responsibility of $7.50 a day during the first 10 days of hospitalization.

Senator MORSE. Thank you. Representative Peck has just handed me the "Medical Assistance For the Aged of Oregon" information leaflet, and I am going to ask that it be incorporated in the record of our hearing today, Mr. Reporter.

Representative PECK. There is another one I have in my brief case that I can hand you too, that goes into it a little more thoroughly than that leaflet, if you would like to include it.

Senator MORSE. Certainly, and thank you very much. We will put them in the record.

(The material mentioned above will be found on p. 104.)

Senator MORSE. Our next witness will be Mr. A. R. Kirk, of Portland.

STATEMENT OF A. R. KIRK, FORMERLY MEMBER OF OREGON COUNCIL ON AGING, PORTLAND, OREG.

Mr. KIRK. My name is A. R. Kirk, and I was formerly on this council of aging in Oregon here for 3 years, and I can verify what Mr. Erickson said on the World War I deal, as far as the pensions and the hospitalization. I have a short statement here I would like to read.

I believe that most of this has been on the nursing homes so far, and I think that, if we can do the right thing for these people, it might delay the time when they have to go into the nursing homes. As to the senior citizens' problems and how they may be benefited, when we leave our jobs for the last time, we come to the point were we give up certain connections and friends. Communication between older persons out of circulation is a very difficult thing, and as to where to obtain wanted information, most of us do not know where to turn. What they need is a better means of communication.

The Legislature of the State of Oregon has discrimination laws for older workers, those who are 45 to 64, that completely ignores the 65 age. Too many of these are of low income who are not permitted to obtain unemployment benefits under social security. We need a State and National bureau of communications for information concerning ideas, employment, travel, relocation, and general counseling, of whatever nature the need might be. Because too many of those who are able and wanting to continue living a normal life may never again be able to find employment under today's working conditions, they are classed as expendable by our industrial society. Their retirement income is not sufficient for a decent living. They cannot maintain their usual way of life. Their mental and physical health could be better if an active interest in life is maintained. This could delay or eliminate a later institutional stay.

Since there are few employers of today's caliber that will even consider them, that is no valid reason why their talents are not a value to the world. For individuals to enter self-employment at this advanced age is a great difficulty, greater than through a cooperative effort through a business group that has a sound business program. It is entirely possible for an active group to form the nucleus of a growing organization to put their talents to use in a cooperative nature on behalf of their own good. A considerable part of the Nation's challenge today are servicing our needs.

The charges for these minor services are entirely out of line with the income most retired persons now receive. Therefore, repairs are neglected and appliances left to deteriorate further. I maintain the low-cost housing needs could begin in the forest and sawmill and be carried through to the trade to the betterment of all. Just why do business interests welcome new industrial enterprises to a community or State and still oppose an enterprise that would be of a great benefit to the major proportion of the people, to say nothing of the ultimate saving to the Nation.

Health and happiness is a greater asset than the monetary value that might be laid away. However, there should be a properly set up organization to preserve the economic value of their substandard income, by defined operations. The building of their own homes, the maintaining and supervising of operations, establishing training for trades, and promoting ideas and products that could be utilized by themselves, in buying as well as selling, and this would benefit outside business interests to move more merchandise, and also there is the competition that is quite possible in foreign headquarters for a market. One of our larger corporations has said that they would be glad to contract work for them to do.

We speak of farm surpluses. Have we ever experienced famine in this country? A surplus is much more to be desired. As the Government operates, a large part goes to administration and policing in this field. The cost of packaging and distribution takes a large slice that is paid for service of the average needs, and taxes which are included in the processing could all be lessened by a self-help operation. When there is a raise or an increase in pay, it is to those of the top group that get the lion's share. Still, the cost to the low income man is the same, no matter what his income, except he knows that most others are in a better position to bargain for what they buy. No matter what the supply or what the cost is, it takes money to obtain it. The usual way to obtain it is through selling your goods or services. There will be opposition by selfish interests who want their take from whatever the small pension might be. The productive capacity of a people, no matter how small, is bound to benefit many others.

I was once told, "Do good for the good that it does and you will not suffer from the price." Problems, yes, the least of which should be financing for the present laws of the land should be sufficient. The hours of work should be adjusted to the strength and ability of the aged. Communication among these people is at present not favorable for they are somewhat isolated. Not enough is being done to make them a part of us.

Senator MORSE. Thank you very much, Mr. Kirk. I want to point out that these spokesmen, testifying now in behalf of the full committee, have left the nursing home subject; although you can still comment on the nursing home subject, we are now really sitting as a subcommittee of the full Committee on Aging. You have given testimony on the problems of the aging, and you are not limited in any way to a discusison of the nursing home problem.

The next spokesman will be Mr. H. A. O'Neal of Portland.

STATEMENT OF H. A. O'NEAL, PORTLAND, OREG.

Mr. O'NEAL. Senator Morse, members of the committee, ladies and gentlemen, this statement concerns certain aspects of the aging people. In the matter of health benefits for the aged, benefits that will assure the recipient of relief by right, instead of relief by dole after taking the pauper's oath; legislation to provide and finance this program under social security will be necessary.

Before I continue concerning such legislation, I would like to relate an experience on insurance that one of the members of my family had with one of the large companies. In 1948, an agent sold Mrs. O'Neal an accident and sickness policy, which also covered then a

year-old granddaughter, who lived with us. At the end of the policy year on March 31 of 1961, the company gave us an option of (1) accepting a rider provision canceling all benefits for Mrs. O'Neal that could in any way be attributed or connected to her heart, and/or circulatory system, or (2) canceling the policy. It is significant that in dollars and cents the premiums paid to the company amounted to $99.30 more than the amount of benefits received by Mrs. O'Neal.

Now, to get back to the original subject, which in the final analysis is a determination of whether or not the potential recipient gets adequate rights, adequate benefits by legal right. A good example of such requirement can be found by examining the Railroad Retirement Act, the U.S. Civil Service Retirement Act, as well as the Social Security Act. Out of these, it is a legal requirement that both the employee and the employer must contribute to the fund, from which benefits are legally required to be paid. None of these acts permit the whim of any employer, or the unsympathetic attitude of a State legislature, to determine whether or not and to what extent benefits will be paid. The above legal requirement has been brought to light over and over and over in connection with so-called company pensions, which are of benefit to the retiree in an amount and only so long as the particular company sees fit to pay them. The retiree has no right himself whatever in the matter.

It is interesting that currently, right here in Portland, that the above is of particular concern to many retirees of the Rose City Transit Co. One of them happens to be my next-door neighbor. These retirees have never contributed to any fund because there is none, and now due to financial difficulties of the company, it appears these pensons may be discontinued. Thus, these men who performed long years of service are now faced with the danger of losing their $60 a month. Picture, if you will, the contrast between these retirees and the retirees of railroads, whose pensions are guaranteed by law.

It would be well to pause here to remember that at the time Congress was considering enactment of the social security law, it was bitterly opposed by the American Medical Association. It, like the other above-mentioned acts, proved to be sound, workable, and highly humanitarian. Today, Congress is considering a health benefit law to be administered under the same social security law. This proposal, for the benefit of the aged people, would receive an overwhelming affirmative vote if we were referred to the people. However, it is said that such legislation would lead to socialized medicine, and the American Medical Association and a few allied organizations are spending millions in an attempt to defeat it. If these opponents with their scare tactics ever elaborate on just what socialized medicine is, I would like to hear it.

One more thing in connection with pensions and health benefit payments in general. It is recognized that the bargaining activities of labor unions are in some measure able to secure wage increases to offset increases in the cost of living. But what of the retiree? He has no employer to bargain with. Consequently, society should acquiesce, and our lawmakers should see to it that retirement and health benefits are periodically increased to keep pace with the increases in the cost of living.

We know that our Senators from Oregon will support such legislation, but, for them to be successful, we, the aging people, must present a front that will refute any argument the American Medical Association and their allies may advance.

I appreciate being allowed to testify at this hearing, Senator Morse. Thank you.

Senator MORSE. Thank you very much. I appreciate very much, Mr. O'Neal, this statement going into the record. This is a statement similar in philosophy to the statements we are receiving across this country. I simply take the position that we have to take an objective attitude toward this. The case has to be built up, all sides be given full opportunity to present their case, and then the elected officials of free people have to stand up in common on the basis of what a fair forward movement may be in regard to this matter. This is one of the purposes of this hearing, and I think you have helped it in that cause.

Our next witness will be Mrs. Paul Conrey, administrator of Colonial Manor Sanitarium, Portland.

STATEMENT OF MRS. PAUL CONREY, ADMINISTRATOR, COLONIAL MANOR SANITARIUM, PORTLAND, OREG.

Mrs. CONREY. Thank you, Senator Morse. I think this came about this morning due to the fact that Miss McCamman and Mrs. Zollinger were talking with Mrs. Allison and myself about our occupational therapy. We are doing something in Oregon aside from the physical aspects for the aging.

It has always been a problem of mine to try and find something for people to do when they have nothing. Dr. Gutman expressed the situation very well in most nursing homes. The people feel quite rejected, unnecessary, unloved, useless, unwanted. However, we started first by a trial and error method. We started music therapy, and it is therapy, not recreation. It worked out beautifully, and one of the assistant professors at Portland State wrote a paper on it. Then later on, we decided we would give these older people an opportunity that they weren't used to, being given an opportunity to do something to give to somebody else. So we started a toy- and joy-making group last year. We picked up old discarded toys that could be repaired. Our patients paint them, they renovate them, they make doll clothes, and every year, right after Thanksgiving, we have a big party and donate the toys to people's children in our district. This year, we have added another district to it.

Last summer, Mrs. Zollinger called in regard to a little family which had five little children, the oldest 7 and the youngest not quite 2. It was a hardship case. The youngsters really had nothing for Christmas, the way the lady told me. So we thought it would not only help our patients, but the children would help them and the patients would help the children, and they would have lots of grandparents. It has worked out very beautifully, and we have had many parties. The local newspapers have been out to take pictures of our parties a number of times.

So Oregon is striving. There has been no precedent set, but we are trying to set one. It isn't a fact that old people are all confused people. Remember this. You can go in there with them and get their cooperation, and that is another reason that I think, if we can do it, anyone can do it, because you have a little more to work with as our people are happy. They are no longer unwanted. They don't feel useless, and it has been quite a challenge to come this far, and I am sure that in the future we are going to have wonderful cooperation here in Oregon. Thank you.

Senator MORSE. Thank you. I am glad to have your statement, and I hope you will see to it that we get the article on music therapy, to which you have referred. I would like to have it for the staff to study and read myself.

Mrs. CONREY. I will certainly try, Senator.

Senator MORSE. I was interested in your account of what you seek to do in an attempt to get many of these people rehabilitated. For many years now I have worked very closely with the National Orthopedic and Rehabilitation Hospital in Arlington, Va., which is a hospital under Federal law that is sort of a pilot hospital for Federal employees who suffer from some accident on the job or in coming to work, where they may lose a leg or two, or break a back, and they are put in this hospital for months and months in many instances. It is a hospital that seeks to do some of the things that you have referred to in your tesimony, rehabilitate them, bring them back.

All one has to do, as I have said so many times on the floor of the Senate, when I have sought to get funds for this hospital in connection with its Federal responsibility, is to just go out and see. If you could just get people to look, that's about all that is necessary in most of these instances, and sometimes I get a Senator or two to go out from the Appropriations Committee to get a look, and it is always beneficial to my cause.

I want to thank you for your testimony because it is along the very line of the program that I have been working on in connection with that hospital.

The staff advises me that there is a request from Mr. William Miller, of Portland, to make a brief statement. Is Mr. Miller here?

(No response.)

Senator MORSE. Mr. Miller isn't here. I want to say now that the floor is open, and I will welcome any testimony, and I will recognize you in the order that I see you rise. I see a gentleman in front of the microphone, and he will be first. Did you want to testify, sir?

STATEMENT OF CHARLES E. WOODWARD, PORTLAND, OREG.

Mr. WOODWARD. My name is Charles E. Woodward, 503 Southeast 34th Avenue. The problem that I have probably does not concern this committee directly, but it probably will later on. My problem is the problem that confronts many of our older citizens, and that is the question of taxation.

We have a system of taxation which has been confiscatory for some time, and it, therefore, deprives many of our old and retired citizens of their homes, and, of course, that naturally adds to the welfare roles. Now, this last year, my taxes were increased about 75 percent on my home. In other words, my taxes were increased $94.20 over last year. Now, I find, by inquiring around, that this is typical throughout the county. I know of other cases where their taxes have been increased in proportion.

Now, another gripe that I have is this question of medical care and hospital care. At the present time, the cost of medical care and hospital care is absolutely prohibitive to people in my category. I am drawing social security at $64 a month. My wife gets half of what I get, and she uses the entire amount that she draws for her own benefit. She is under a doctor's care, and it takes all the $32 that she receives to take care of her medical care. So, it leaves nothing for me. So, that leaves $64 a month for me to pay my taxes and provide the provisions that we need to live on.

Then I have another gripe, and that is that we have a subdivision of the State of Oregon known as the department of motor vehicles. Now, they have adopted a system of depriving the older people of their driver's license and privileges upon the least provocation. I don't know what their object is, but it certainly works a hardship on people who are dependent upon their automobilies for transportation and have been for the last 40 or 50 years. Now, they are deprived of their transportation, and it prevents them from carrying on their business opportunities and their social opportunities.

Now, of course, that is something that probably doesn't concern this committee, but it is something that concerns the elderly people in this State. Thank you very much for the time you have allotted me.

Senator MORSE. Thank you very much for making your statement. While there is no provision for a Senator invading a jurisdiction beyond the Federal jurisdiction, I say you are welcome to point out in this hearing whatever aging problem concerns you. Of course, my jurisdiction necessarily is limited to Federal jurisdiction, and I can only be of help as a Senator in connection with Federal matters, but I can be of help as a private citizen, which I am, in connection with any other matters about which anybody wishes to talk.

Our next witness, please.

STATEMENT OF EDWARD DAY, MEMBER, LEGISLATIVE COMMITTEE OF VETERANS OF FOREIGN WARS

Mr. DAY. Senator Morse, my name is Edward Day, a member of the legislative committee of the Veterans of Foreign Wars. I am here at the request of one of our widows, who is 74 years of age. I want to present her case. I don't believe it has come up here all day. There has been a lot of welfare, a lot of this and that, but in this State we have a number of proud people, people that are good citizens, and they think that they would starve to death before they would sign a pauper's oath. We have lots of them. In this case right here, here was a World War I veteran, a man that had every right to go to the veterans hospital. He refused because he still had a few dimes left. This man was a good friend of mine and a comrade for about 12

years. I was very close to him. He happened to be in a precinct from one party, in my precinct, and I was precinct chairman for the other party, and we had lots of good times together. We were good friends and talked together.

This man, on the 3d day of September, who had had quite a bit of medical care before that, was slowly failing, and on the 3d day of September 1961, he had a heart attack. He was rushed to the hospital. He died on the 12th of October. He passed away, leaving bills for his widow, who is 74 years of age, of $2,436.40 for his last 39 days on this earth, a good citizen of this country. Now, I believe, Senator Morse, that that is wrong in this country, and I feel that we must do something so that cases like this cannot be happening in this country. We're too rich to have things like that happen. I thank you.

Senator MORSE. Thank you very much. The next witness may proceed.

STATEMENT OF MARTIN C. DAY, PORTLAND, OREG.

Mr. DAY. Thank you, Senator Morse. I am Martin C. Day, of Portland, Oreg. I am a past State commander of World War I boys, and I have spent 30 years in veterans assistance in Multnomah County. I consider all of them my friends and I am always ready to help them.

I am going to say two or three things. One of them is outside of your jurisdiction, as you state, and another one comes under your jurisdiction. The one that comes under your jurisdiction, as I understand, is this medical plan that they put into effect for the old people, that they have to sign a release on their property to the State, and it gave in the newspapers the number of people who refused to take that medical assistance although they needed it because they wouldn't sign such a statement. I think that should be amended and taken out of there, out of the Federal program.

The other matter that I want to speak on is the fact of the lack of coordination between groups in our own State and our own county. Grace has heard me harp on this off and on for quite a number of years, but we have on the statutes of the State of Oregon a law which provides five-tenths of a mill for the benefit of the veterans, their wives, and their families. That's a State law. That gives Multnomah County upward of $400,000 a year. It isn't being used. Why? They go down and make an application, and they send him over to the welfare, and the State picks it up from there, and once again they have to sign a lien against their property.

I am going to submit to your board a copy of the State law that covers this. Thank you very much.

Senator MORSE. Thank you for your statement, and I will allow that material to be inserted in the record. You can supplement it with a further statement.

Mr. DAY. I would be very happy to do it. Would you like that mailed to you in Washington?

Senator MORSE. Yes; you can mail it to my office.

(The material referred to above follows:)

MISCELLANEOUS VETERAN'S AND SERVICEMEN'S BENEFITS

BENEFITS TO INDIGENT VETERANS

408.710 Indigent war veteran defined; effect of property ownership. (1) As used in ORS 408.710 to 408.750, "indigent war veteran" means any war veteran who is without means of procuring the necessities of life.

(2) No person shall be deprived of the benefits provided for in ORS 408.720 to 408.750 by reason of the fact that he owns property which is not of such a character that it may be used to give him assistance, or owns a home which is not disproportionate to the needs of such veteran and his family. No person shall be deprived of such benefits until he has ceased to be domiciled in the county for a period of 1 year.

408.720 Indigents entitled to relief; method of financing program. (1) The county court or the board of county commissioners is authorized to levy, in addition to the taxes now authorized to be levied by law, a tax not exceeding five-tenths of 1 mill upon taxable property in their respective counties, to be levied and assessed as now provided by law for the assessment and collection of taxes, to create a fund to defray the funeral and last sickness expenses of persons described in paragraphs (a) and (b) of this subsection and of the indigent wives, widows, and minor children of such persons, and for the relief of the following:

(a) Indigent war veterans who have resided in Oregon for 3 years and in the county for 1 year.

(b) Indigent soldiers and volunteers who served not less than 10 days in any of the Indian wars, or who received a permanent disability while in such service, and who have resided in Oregon 1 year and in the county for 3 months.

(c) Indigent widows and minor children of such war veterans, soldiers, and volunteers.

(2) If no levy is made by the court or board for any year for the objects specified in subsection (1) of this section, all expenses incurred under ORS 408.720 to 408.750 shall be paid from the general funds in the treasury of the county the same as though such levy had been duly made.

Senator MORSE. The next witness, please.

STATEMENT OF IRENE WALDO, STATE MEMBER OF THE BOARD OF THE TOWNSEND NATIONAL PENSION PLAN

Miss WALDO. Senator Morse, I am Irene Waldo, State member of the Townsend national pension plan. I am wondering why the Townsend national pension plan is so poor and all others work, and it seems to me that the main thing that is the matter with us old people is just plain starvation. I get $35.90 a month on social security. I was turned down recently as a matron possibility in a home because I was 68 years of age. I just couldn't possibly physically fill the bill. Now, all the bills in the world seeing that needy people get a chance at employment isn't going to make any employer happy. We just can't get employment at our age. I should have lied about my age, but somehow I didn't. So, that was the result.

We are getting the Townsend pension plan in our social security law, inch by inch, as we cut off the dog's tail, but we're not inhumane. It isn't possible that people with—what will I say—brains can dodge the point brought out in the Townsend pension plan that the social security is incorporating; everything that has been done to improve social security since its inauguration has been a part of our Townsend pension plan. The Townsend pension plan has a setup that would give increased or decreased pension payments, according to the prices that old people have to pay for their goods. The Townsend pension plan payment would come from a cheaper source, the gross

income tax, than any other method that could possibly be or has been set up for taking care of old people. The gross income tax in the State of Indiana in the past more than 20 years has put the State of Indiana as the only State in the Nation out of debt, in the blue, out of the red, running on a completely cash basis, and even their chamber of commerce advertises that their gross income tax is feasible for business to come to Indiana, which certainly recommends the gross income tax.

The State of Hawaii, long before they were a State, carried on that same gross income tax, and yet you people in general don't know what the gross income taxes have already done.

Now, just to get down to personal items, I started my social security at 63 because I was a little impatient over starvation. I was a chiropodist, but I gave that up to take care of my own mother until the time she was gone, and I saw no need of going back and restarting my work there because people didn't care about their own feet. If you don't believe me, just look at their shoes today, and you will know that they don't, and it was just a losing game to try to trim off corns and calluses if that's the way they put them on.

I have been spending the last 15 years minding everybody's business but my own and having a big time of it. My last automobile cost me $40, and I take the old people with me to get commodities, and I take them to the hospitals and to clinics. I go to the Welfare and fight for pensions for them. I do anything that nobody else will do, and I certainly would like to have my taxes reduced. I am going to pay or going to try to pay $119 on a house that is so depleted that it's almost deleted, and I think it will be some day. I put up boards where the windows are broken, and I'm not joking. I think that the $35.90 social security that I get now is a disgrace to humanity.

Senator MORSE. Thank you very much.

STATEMENT OF MAY CONNER, SANDY, OREG.

Miss CONNER. Senator Morse, I am May Conner, an associate of Dr. Noren at Sandy, Oreg. I took your picture in your hunting clothes out there, and you will remember that.

Senator MORSE. I remember it very well.

Miss CONNER. I am 82 years old, and they have been talking about me and I have been sitting here, taking it. It's pretty hard to do, you know, but I am not in such circumstances as they are. I've been a logger for a long time and I've worked around men. I haven't worked around women but very little, and, believe me, I can work just the same as the men can, and I do think that all of these people that want to work for wages should have them.

I am not an educated person, but I am hard working, and everything they have said is good. I thank you.

Senator MORSE. I want this record to show the appreciation of the chairman for the wonderful work that you are doing in your community, cooperating with the doctor and helping sponsor that clinic that you maintain in the Sandy community. I want to say, as I said at the time we dedicated it, that I happen to think that, if I were to be giving an award for dedicated public service, you would be one of the recipients of that award. It's a wonderful service you render.

I wonder if the doctor is here.

Miss CONNER. I would like to introduce Dr. Noren, sir.

Senator MORSE. I wonder if the doctor would make a statement at this time.

STATEMENT OF DR. NOREN, SANDY, OREG.

Dr. NOREN. Thank you. I have a statement, but, before I start it, I would like to make one or two comments, in concurring with Dr. Goodman, whose point of view is quite different than mine. I would point out though that he is a big city specialist, and I am a country doctor, family doctor. When he talked to the civic club, he pointed out that he was not a specialist in sociology. I would like to claim that I am and so I have been giving my statement some careful study.

Now, my proposals for health care of the aged will be published in the American Journal of Medicine in an early issue, and they have been approved by the Oregon State Medical Society, and they will be considered by the American Medical Association in Denver, Colo., later this month, but, in talking here, I talk as an individual, and not as a physician representing an association.

I would like to make three points. The first of these might be considered sentimental, but I think they are all important, and one is for practical consideration. The first point concerns the spiritual interest of the elder citizen. This is a personal thing that has to do with individual freedom. In this day and age, they tend to institutionalize and federalize and governmentalize, to arrange matters by taxation and regulation, and administrative action. The dictionary definition of this can best be described under the terms of socialization, and this is what Russia does under the misnomer of socialism, scientific socialism. They may have such socialism all right, but later on it will be proven unscientific and unnatural. We hope to prove it by producing crucial data in this respect in Oregon. That is what we are trying to do out in Sandy today.

Now, with all due respect to the nursing homes, of which we have real need, and which in my many years of experience are of very fine quality in Oregon, we certainly should congratulate our nursing home operators. However, the committing of elder citizens to nursing homes on more or less of a permanent basis seems to be somewhat an unnatural thing to do. It differs from the natural custom whereby the elders stay in their own home or the homes of their children. To place the elder citizen in a nursing home is not always bad; no, sometimes, indeed for the better, but in my experience it is usually detrimental.

My friend here, who is 82—she said so herself—has taken care of an elderly man who has been in the hospital and not very well, and who, by all contemporary standards, belongs in a nursing home, but she takes care of him up in the woods where he lives in a shack, where he can, as she says, watch the deer and he can feast with himself, and it doesn't cost the State anything.

The second point concerns the family relationship of the elderly citizen. In natural circumstances, the older person lives with his

children and that makes for a great mutual value. You can recall the Thanksgiving song, "Over the river and through the woods, to grandfather's house we go." So, you must recall the elder citizen's greatest pride is in his children and in his grandchildren and his great grandchildren. Again, in the Communist movement in Russia and China, we find that the families are separated. We are now doing the same thing to some extent, and I think it is wrong. Our old friends are very wise and have much to offer our children, and perhaps even some of the children's evil can be traced to this separation.

I think the best assertion of the fine relationship between the old and young are the wonderful skits by Mr. Red Skelton of the old man and the young boy. Again, my young friend here is frequently in a home where there are five or six children, and the only surviving grandparent is at a distance. I can see clearly the pleasure of teaching these children.

The third point concerns economics, and this, I believe, is of major importance. We have heard much talk today about the high cost of medical care. This is a confusion in dealing with a social science. Consider the true cost of medical care, including the cost of preventive care. They are relatively low, and they will continue so, but we must have a better understanding. In medicine, we must have a much improved method of cost accounting, and this is what the Senator has been asking for here all day. We don't have enough of it, but we are also trying to produce some of that. This cost accounting must be accurate and has to be logical. Perhaps the cost of all social activity could include medical care costs. The biological and mental health of patients, various categories of social activities, all must be cost accounted, simply, however, and then related and integrated into understanding. In our nursing home costs, there are being considered medical care costs, but most of them are not medical care costs, but are in the category of housing.

In my own practice, the only patients I have in a nursing home are those that have no home of their own and no responsible families to live with. The majority of my elderly patients stay home. Occasionally, this may even be of some disadvantage to their physical health, but the integration of their mind and body and the reaction therein shows they would be better off in their own home.

I will conclude by reading portions from a letter from a very fine woman, whom I have known for many years. She lost her husband, a newspaperman, several years ago. This particular home where she is meets all the standards of excellency and they couldn't be improved on. She writes this:

> My health is fine now, and I can outwalk most of them here. Once again, I want an apartment of my own where I can work like I used to. I don't like these homes because they are not really homes. Always something goes wrong with them. One needs to be a millionaire to live in one, and someone always seems to be passing away during the day, which doesn't help matters much.

Senator MORSE. Thank you very much, Doctor.

STATEMENT OF CLAUDE ARROWSMITH, PRESIDENT, COLUMBIA RIVER PENSIONERS ASSOCIATION, INTERNATIONAL LONGSHOREMEN'S AND WAREHOUSEMEN'S UNION, PORTLAND, OREG.

Mr. ARROWSMITH. Senator Morse, committee, and distinguished people here, I am Claude Arrowsmith, president of the Columbia River Pensioners Association of the International Longshoremen's and Warehouseman's Union, here in Portland, Oreg.

So far, we have not heard anything, I don't believe, on the high cost of drugs. Now, we all know you can go down here to the drugstore and you can get aspirin or Anacin, or something else, Bufferin, very reasonably, but you cannot get the drugs very cheap for your heart, high blood pressure, and so on.

We are affiliated with the Kaiser Hospital over here, and we have coverage there for a number of days, but it's the people I am thinking of, when the husband passes away, the widow, who is left behind, and they are the people who strive to make our organization and all organizations here and all over the United States what we are today, just by the women's help, just as that lady over there spoke just a few minutes ago. We have had quite a little correspondence with Senator Kefauver, who is the chairman, I guess, Senator Morse, on the high cost of drugs, and that is what our concern is today.

Now, we have had some of our people spend as much as $40 per month for drugs, trying to alleviate the pain, you know, that they have in their heart, also for the high blood pressure, and so on, whatever it is, whatever it might be, and those are things that we are concerned about, the pensioners of the longshoremen here in Portland, also along the Columbia River here. It is a thing that has been bothering us people as we are getting older. We have some people 85; we have one man 90, who is enjoying good health; and then we have many others who are at the home with strokes, and their wives are taking care of them. Now, where would they be if they had to put out $180 a month? We do have some that are in homes, nursing homes, rest homes, at $180 and up. Out here on the other side of Parkrose we had some men in there at $110 a month. We have right at the present time two men up in Salem in the State Hospital, not on account that they are mentally disturbed, but they are there for other reasons. They do not have enough and they were not capable of even getting money, getting enough from social security, and so on. Anyway, they pay $94 there a month, and they even receive wonderful care. We go up—many of us go up there to see these people.

What we are concerned about is the high cost of drugs for everybody in these United States. That's what we want to get down, is the high cost of drugs. I have one man sitting here who is 85 years old, a man with whom I have worked for years on the waterfront here in Portland. He is enjoying good health, but we have plenty others that are not, and they call me. I have been president for the last 3 years of the retired longshoremen, and I know what it is. They contact me and want me to help them.

By the way, Senator Morse, I am a recipient of your paper and I get it every year. When my wife and I were back in Washington in 1950, we were in your room.

Senator MORSE. I remember you.

Mr. ARROWSMITH. You do? Well, I want to congratulate you then on your memory because I didn't think you would know this old homely face of mine. I wonder if I have gone over my 4 minutes. Maybe I have.

Senator MORSE. We will give you another minute.

Mr. ARROWSMITH. You will give me another minute, all right, but I don't think I have anything more to say and so I'll sit down. Thank you very much.

Senator MORSE. Thank you very much. All I want to say for the record, of course, is that the whole program that we are dealing with necessarily has to go to the question of the totality of medical costs, which includes the cost of drugs, and I am privileged to tell you that Senator Kefauver's subcommittee works very closely with this committee in regard to the particular problem that you raise.

Mr. ARROWSMITH. Thank you very much, Senator Morse, for your statement.

FURTHER STATEMENT OF MERL E. JONES, VICE PRESIDENT, INSTITUTE OF SOCIAL WELFARE

Mr. JONES. My primary purpose in coming before you today was with regard to the Institute of Social Welfare. However, I represented Mr. Dover of the social security clubs.

I have just a few words that I would like to say that are important. In regard to the Oregon Institute of Social Welfare, which is an organization of a number of people around Multnomah County, and so forth, I come before you today to represent a number of people that are in nursing homes. Hearing all of this talk that was given this morning, I do not wish to criticize in any way the wonderful work and the progress that is being made in nursing homes, but I do wish to bring to your attention the fact that one of the most outstanding problems that I have been able to see, among a number of others, is the fact that these nursing homes lack communication. One of those that was talked about today, the manager's wife talked to me personally and she said, "We would like to do better, but we don't hear of everything that goes on. We don't see all of our help, and we don't know all that goes on sometimes, but we try our best."

Now, the point is that, through talking with nurses' aids, which, incidentally, I have a daughter who has worked in a number of these nursing homes in Portland, and others that I have talked to, they said they believed the nursing homes were sufficient and doing the best they could, but their principal trouble was that they did not have enough help, and that is the complaint that the patients in these nursing homes are making. One old lady grabbed me by the arm going out and she said, "Please, for God's sake, can't you get somebody to do something for us?" and I wanted to know what was the trouble. She said, "Well, I can't get any care." Well, I inquired of one of the nurses' aids there and asked her why they couldn't give better care, why they couldn't be waited on, and she said, "Well, I can't do everything."

Now, the point is that I have heard from three different nursing homes in this town that 1 girl had to take care of from 28 to 40 persons alone. That is too many, and then in another nursing home out there, there was eight lights on with one girl trying to get around to them.

Now, the point that I am bringing to you today is this: Could there be possibly that a maximum number of patients would be assigned to any one girl? I realize that the money factor or the cost is a very important matter, but it's also an important matter that the people get some care at times, and there are lots of them that don't. I know what I'm speaking of, and if there is anyone that wishes any further information of what I'm speaking of, I will gladly supply all the details, and there are some most alarming things. Thank you.

Senator MORSE. Thank you, Mr. Jones.

STATEMENT OF FRANK HILLMAN, GLADSTONE, OREG.

Mr. HILLMAN. Senator Morse, I am Frank Hillman of Gladstone, Oreg. This subject that the gentleman has just brought up about labor or help in nursing homes, I am pretty well acquainted with. We just conducted a cost survey in some nursing homes this last year. Now, they were put out by the State welfare commission, and there is a statement as to how they arrive at the payment made to nursing homes, so much for supplies, so much for housing, so much for utilities, so much for food, and so much for labor, and they arrived at this figure, on the average basis of a patient at $169, there is a labor cost of about $65 per month.

In the nursing homes which I surveyed, which was about 60, the labor question was one that I seized on because it's one there that we can prove, because the payroll wages are a matter of State record for taxes, and the wages are reported quarterly to the State. Therefore, on that basis alone, I searched for a cost in nursing homes because I knew that the welfare rate was not fully paying the cost of welfare payments like they should. We found that the labor cost, as reported to the State, was averaging about $90 per patient. Some ran higher than that. My own ran more than a hundred dollars a month. Yet the welfare is allowing approximately $64 a month for labor.

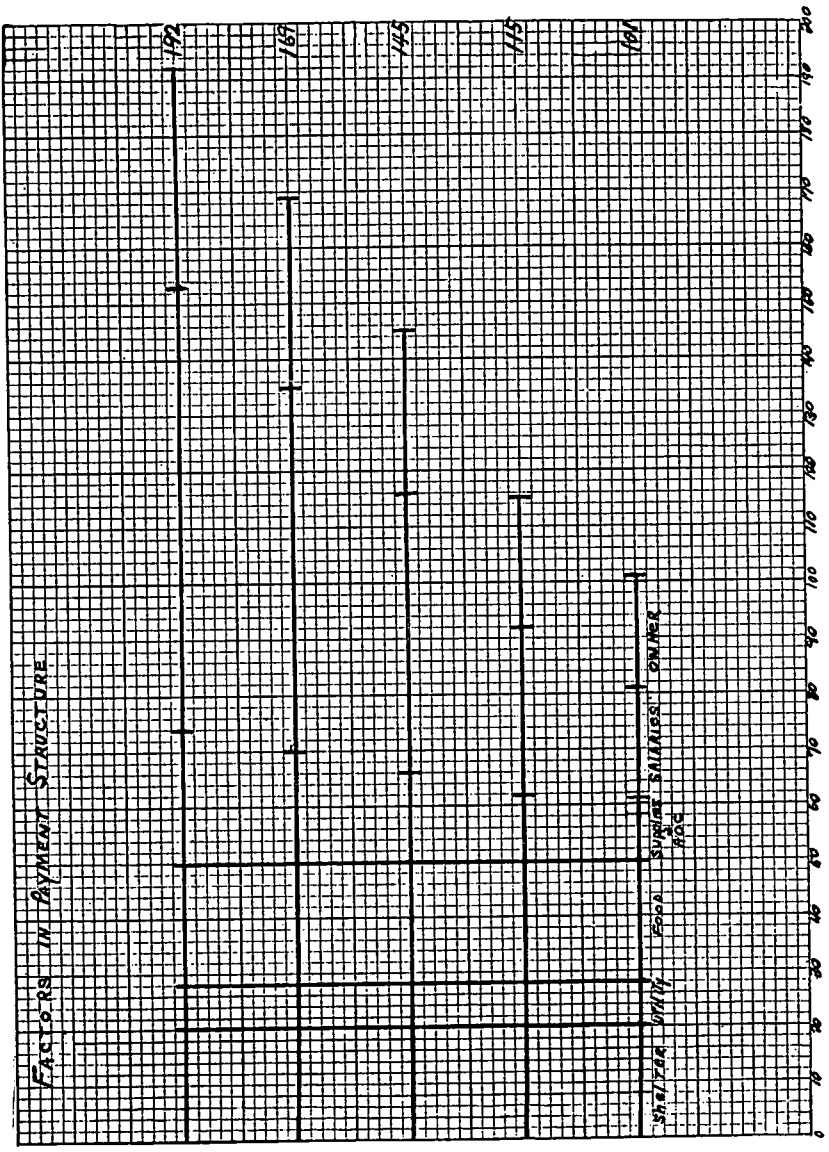
Now, you can see why there is not enough help in your nursing homes. There just isn't enough money there. I think they do the best they can with what they've got. If they happen to give more help, then perhaps they cut down on the facilities costs, maybe on food, maybe in some other department. Each nursing home tries to work out its own problems, but that is one of the problems in nursing homes, the fact that there is not enough in the welfare rate to permit employment of adequate labor. Thank you.

Senator MORSE. Thank you very much, The next witness?

STATEMENT OF ORAL LOVE, LOVE CONVALESCENT HOSPITAL, PORTLAND, OREG.

Mr. LOVE. Senator Morse and committee, my name is Oral Love. I operate the Love Convalescent Hospital at 2363 Northwest Flanders. I have a breakdown here from the department as to how they arrive at their figures of paying, and you are very welcome to have this if you don't already have it.

Senator MORSE. I would like to have it, and I will make it a part of the record at this point. You may keep it now for your discussion.


FACTORS IN PAYMENT STRUCTURE
1942
1941
1940
1939
1938
1937
SHELTER
CLOTHING
FOOD
SUNDRIES
SALARIES
OWNER
AGE

Mr. LOVE. Taking $145 a month per patient care, which includes food, lights, water, heat facilities, employees taxes, insurance, that gives us $3.85 a day to do all that for one patient. That is cutting it pretty close, and most of us can't take care of the drycleaning on that. If you will look at those figures over there, that I have given you, Senator Morse, you will find out that we are working on a very, very close margin, and we are trying to do the job that very few States can equal with what we have to do with. I know a lot of the senior citizens feel that the nursing homes are somewhat taking them for more than what they should, but if they will stop and analyze this welfare program we have, which is by the point system, at the present time, a patient comes into the nursing home first at $145 a month, and then they are evaluated afterward, maybe in 2 or 3 weeks or a month, or even longer before the evaluator comes around and checks it. By that time, we might have the patient in much better shape than when they actually came in. So, consequently, we don't get more than $145. Thank you.

Senator MORSE. Thank you very much. Any more witnesses? Representative Peck?

FURTHER STATEMENT OF HON. GRACE O. PECK, MEMBER OF THE OREGON HOUSE OF REPRESENTATIVES

Representative PECK. Senator Morse and your staff, I would like to correct a couple little things here to clarify the air and come to the defense of our State hospital. A gentleman referred to someone being down there for $94 a month, who apparently wasn't ill, just sick or something. Now, this is one of the things we're seeking to avoid, some people who have money and who don't have to go to welfare. They've been declared incompetent or something by someone, and they will try to put them in the State hospital because it's cheaper than it is in a nursing home.

Today, the only way you can go into the State hospital, you can go in on a voluntary commitment for 30 days, and at the end of 30 days you can renew this commitment, voluntary commitment for 90 days. You are privileged to leave the hospital at any time if you want to after that unless the doctor at the hospital decides that you should stay in the hospital. They can take some steps and have you committed. Otherwise, you have to be committed by two people signing a petition. I know because that was one of the things that I helped do in my first session in 1949.

Now, this $94 means that this person, whoever it is in the hospital, had the ability to pay $94, the per capita cost since the first of October in our State hospitals, and this does not include the building or capital outlay, just the care of the patient. If you want to figure it, they can do it on a big buy sort of a thing. They can buy in large amounts and they get surplus foods, and all, but nevertheless, the per capita tax right now has gone to either $134 or $137. I think there is a little difference perhaps between Wilsonville and the State hospital, but the board of control told me last week—and we keep in pretty close touch—that it is either $134 or $137, and there are many persons who don't pay anything. You pay whatever your ability is to pay. If this man is paying $94, it's because he has the means to pay $94. If he isn't ill

or isn't mentally ill, he doesn't belong in the State hospital. He belongs in a private institution someplace else and he shouldn't be forced to live in a State hospital, and we shouldn't be taking care of him in a State hospital, with all due respects to the longshoremen. My dad was a steamboat man and I like the longshoremen and everything that has to do with the river.

Now, at the State's TB hospital, we unwittingly in the 1959 session took the lid off, so to speak, of the cost there in passing some other legislation, and the cost there is over $500 a month, which it costs the State now to take care of a TB patient. Fortunately, in the last session, we were able to put a new lid on. It used to be $65, and now it's $112, and that is the maximum that the family or the person can be required to pay in the TB hospital, and maybe they have an insurance policy that would pay three or four hundred dollars, or whatever it is. But the thing is that the people paying into the institutions are doing so according to their ability to pay. If they can't pay, they don't have to pay, but the State hospitals are not intended to take care of people who are not mentally ill.

Another thing I would like to correct, and I think perhaps you know this as well as I do, a gentleman—and he is a friend of mine—referred to the lien we have for the aged or the recipients here. We don't have a lien. We have a preferred claim which goes into effect at the person's death provided they do not have a surviving spouse or dependent children. Dependent children sounds kind of foolish when speaking of aged people, but sometimes some old fellow—the women are outlawed in this thing, I would say, by circumstances or necessity, as this doesn't happen to old women—but the old men sometimes marry a young woman, and they bring on a new family, and so they could be quite aged and have some dependent children, and this preferred claim would now go into effect.

You don't sign a lien. If you sell the property during the time that you are getting this assistance, you go off the relief rolls for 3 years, and then you come back if you have exhausted your money down to $250. The only other way you can get back on is in an emergency. Sometimes emergencies happen. I made a request yesterday to the State county administrator, to his home because it was Sunday, because of an emergency that came up, where a daughter is very ill in a hospital, and the son-in-law is desperate because his 92-year-old mother-in-law lives with them, and she needs to get into a nursing home. They haven't any money. They spent their money, and it has just been a little over 2 years since they sold their home. I'm sure that she will be in a nursing home today or tomorrow because this is truly an emergency.

I say this out of respect to our State laws and out of respect to the legislators who went along with me and worked hard over a period of years to get these sort of things into effect.

Now, the law that takes care of this mental illness is our old-age assistance law that went into effect in 1949. You may remember when, through the efforts of the Townsend group and Joe Dunn, and all concerned—I think they called it the Joe Dunn bill—they put in a bill for old-age assistance so that everybody got it, there would be no waiting, and it was simply a clear-cut bill with a $50 minimum, and it called for an administrator, a single administrator, which was

against the Federal regulations. So, we worked with the committee for a long, long time, and eventually the bill was passed by an overwhelming majority, and the present old-age assistance law has been amended from time to time a little.

Now, on this medicare program, the enabling legislation that we passed this session so that we could take advantage of this so-called medicare program was amended. This bill was amended, and the part that calls for this preferred claim was left in it, the same as for the old-age assistance, it was left in this bill. I wanted to clear the air with you on that.

I wanted to ask a question of you, which I have written down here. I have been asked by some people here to ask you if you know anything about the association called American Society for the Aged. At the annual convention of the nursing home people in Cleveland a while back, Mary Pickford and Buddy Rogers were there, and they made a pitch for some help. They claimed they had a lot of chiefs, but they needed Indians, and I think financial support, too, for this group. It was to be a national thing and they were going to offer some real services to the people. If they couldn't cook their breakfast, they would call them up and they would send somebody to do it, or if they needed help of any kind. I wonder if in your travels you have come across this association. Some of the nursing homes are interested in knowing just what this society is.

Senator MORSE. That is one of the class assignments I will now make, and I will assign to Mr. Reidy the responsibility of looking into your request and preparing a memorandum letter to you, and we will give you any information we can find out about that particular society. I myself am not familiar with it.

Representative PECK. Do you think Mary Pickford could tell us about it if we called her up?

Senator MORSE. Any further witnesses?

Mr. MARTIN C. DAY. Senator, you are a lawyer. What is the difference between a lien and a preferred claim?

Senator MORSE. Well, if you lose your property, you've lost it. Do we have any further witnesses?

STATEMENT OF MRS. SUTHERLAND

Mrs. SUTHERLAND. Senator Morse, I feel that you are my chief because you represented the Department of Agriculture a good many years, and I started in too at Oregon State College for a dollar a day. You know how long ago that was that I started in, and then I went to Columbia University about 50 years ago. They told me that in that college they didn't want anyone who did not have high school credits.

I want to tell you that, since you were chief in the Department of Agriculture, that I feel more should be done for our children down in the grades, because I was a child development and family life specialist for your Department of Agriculture as an extension specialist, and I had to work with about 75,000 women in helping them to prevent certain conditions from arising. I went around the world about 2 years ago, and when I think of what they told me, whether it was in Jerusalem or London or in Belgium or in Switzerland, they all said, "What is going to happen to America because of what is happening

with your hospitals and with your aged, and so on, and the care that you have?" So, I want to talk to you later. I won't take the time of this group to talk to you now. I feel it is very important for us to begin in this prevention program and cooperate with all organizations all over America, and it's your place, Senator Morse, to make us do that in each State. I have been interested in the adopting of children and helping along that line and when I saw those people hungry and in need in India and Egypt, and the great many fugitives that have lost their homes and all, I said to myself, "I'm going back to America and talk to them about what we need to be doing in prevention," because they told me in Italy and other places, "You should keep yourself at home, you have no real culture in America." I said, "You don't know America." Then when I was entertained by Madame Saroya in Egypt, in Cairo, she told me the same thing.

So, all I can say to you people, who are assembled here today, let's think about this. Ever since I have had this little gray-eyed, laughing lad, I love them all. All mothers' sons are mine. So, today, I cannot say, God keep my child, unless I say, keep all mothers' sons this day. Let's go back to the Chinese. Four thousand years ago, one of the greatest philosophers of the world that ever lived, when asked, "What is the greatest joy of all your life?" he said, "It's watching a little girl go laughing down the road after I had shown her the way."

So, you people here today, let's be quite sure. Let's each one feel our responsibility for the greatest country in the world. How proud I was to see that flag floating in other places, and you who are gathered here today, we can all work together and keep this country the greatest country in the world today. How proud I was as that flag floated overhead as I saw it in these other countries. Thank you.

Senator MORSE. Thank you. Before I close the hearing, I have received a most interesting letter from Mrs. John Shepherd, of Eugene. Mrs. Shepherd has been identified with civic projects for more than a decade and is currently identified with the Lane County stroke rehabilitation project, and she really raises many interesting questions about care facilities for the aged and describes a proposal for planning and directing volunteer assistance programs in nursing homes in Lane County.

Mrs. Shepherd's letter, together with attachments, will be made a part of the record of these hearings at this point.

(The letter, with attachments, follows:)

EUGENE, OREG., *October 16, 1961.*

Senator WAYNE MORSE,
Portland, Oreg.

DEAR SENATOR MORSE: The enclosed materials reflect some of the thinking and effort of a small group of us in Lane County that is interested in problems of the institutionalized aging in this country.

About 2 years ago, we began asking questions that seem very similar to those being asked by both of the subcommittees that will be hearing testimony in Oregon next month. We started from several different isolated points on the local scene with the hope of discovering for ourselves how typical our local facilities and potentials might be, whether or not problems that we recognized here were prevalent elsewhere, and what people in other areas of the country may be doing about them. We have talked and corresponded with many agencies and groups and have been advised, informed, and encouraged. We have not satisfied our curiosity or concluded our efforts by any means, but feel strongly

that we are now raising some basic questions, that, taken together, define our general interests and imply certain ideals that have captivated us (and are summarized in the first enclosure.)

To the extent that legislation can be (as I heard you say so well recently) the practical implementation of an ideal, we think these materials may be of interest to you, generally, inasmuch as they represent a new undertaking in the State of Oregon, and specifically, in connection with your work for the subcommittees of the Senate Special Committee on Aging.

As you will see from the first enclosure, we have a particular interest in the quality of care in all kinds of institutions now existent or contemplated for the elderly, and certain doubts that as a culture with a new problem, that we are entirely right in the directions we have been taking. The necessity for immediate and careful research, especially in the social and psychological sciences that pertain to aging, and specifically as they pertain to institutionalized aging, seems to us to be of utmost importance. It seems to us that planning must follow research and factfinding, or we may, as a people, find that we have solved this increasingly urgent housing problem quite superficially, perhaps tragically.

The second enclosure, a request for funds, is a plan for a limited experiment we hope to undertake in Lane County. It has been directed to the Edwards Charitable Trust Fund Committee of the First National Bank of Oregon, and will be analyzed by that committee this evening. (We plan to seek elsewhere for funds if necessary.) The plan is meant to reduce some of our general questions to the dimensions of a small laboratory demonstration and begin to solicit the interest of the managers of institutions, as well as the public, in the social and psychological aspects of life for the elderly who live in groups. This plan, we hope, will be only a beginning that will qualify these cooperating groups, including the university, for more assistance in research and community experimentation in this field. (Hence our interest in H.R. 4998, the Community Services Act, about which I wrote you in August.) As indicated by the footnotes of this second enclosure, you will see that we have gained the confidence of several groups whose participation in community affairs, and participation together, is long overdue but vital to the success of our plans.

We are a little anxious, frankly, that headlines of the nursing home hearings, especially, may renew some old hesitancies and negative attitudes toward professional cooperation of some of these groups by overemphasizing those conditions, in many institutions, with which we are very familiar, which we hope to effect favorably.

The intent of existing Federal legislation that encourages development of various kinds of housing for the elderly is, by implication, of great interest to our group, also. Are nonprofit units allowed in order that costs to residents can be held to "reasonable levels," and if so, what are the implications that cause the current realities to exist, where residents of certain of the newer nonprofit homes pay nearly double, for equal (minimum) care, the costs to residents of smaller homes where management struggles to make a profit?

We are unsure if any of these materials or questions are appropriate to the hearings that are planned, but would enjoy talking with you personally if your schedule would permit it, sometime before the next session of the Senate.

Sincerely,

RUTH SHEPHERD
Mrs. John Shepherd.

[Enclosure 1]

SOME QUESTIONS ABOUT CARE FACILITIES FOR THE AGED

In all of the institutions that are provided for our senior citizens, or contemplated for them, two top-ranking problems are given priority by residents and management alike: costs of board and room, and medical care. For most owners and managers of facilities ranging from nursing and convalescent homes to apartment-type retirement units, it appears that investment liabilities and cost of care for basic physical needs of residents push chances for profit to minimum levels, while most residents are faced with a future of increasing costs for shelter and care, and no source of replenishment for dwindling reserves, if any.

In a rush to solve the housing problem made increasingly urgent by a rapid swelling of our population in the older age groups, we have real reason to deal with these problems of food, shelter, and health as priority problems. If our planning ends there, however, and excludes considerations of social and psychological aspects of group living for the elderly, we may find that we are solving

superficially, even tragically. It is the responsibility of all of us, and particularly of our Government, to look for new methods and approaches that may be suggested by a careful examination of facts and a massive dose of imagination.

It is clear that many of us will live in groups with others our own age when we are elderly and that people younger than ourselves will be responsible, in most cases, for our shelter and care. Beyond these basic provisions, should we expect that the management might also be responsible for activities that might enrich our leisure hours? Does it take special skills to provide this enrichment? If the management is not to be held responsible, does the community have a part?

Can we hope, for ourselves, should we choose or be persuaded to live in one of these institutions, that we will have found the one that is correct for us? If we tire easily or our initiative wears thin, will it be our responsibility, still, to seek our own leisure pleasures? Or will we cease, at that point, to want more than shelter and physical care? If we give up emotionally, is a rapid physical decline likely? What are the possible effects of institutional life on us, for better or worse?

Research that examines the social and psychological aspects of life for the institutionalized aged who are chronically ill or bedfast, as well as healthy, and research that defines the attitudes and values that surround these people, is urgently needed.

The group of institutionalized elderly is growing, for reasons in addition to the population increase. The proportion of our elderly population who will be living in institutions in the future will be increased by a group of concepts that is fairly new to our culture, that seems to be gaining popularity and deserves close examination by competent workers. Part of our second-generation population, at least, believe that placement of older family members, even healthy ones, in homes, retirement spas, or nursing homes and homes for the aged is preferable to bringing the oldster to live with their own families, and better than arranging, even if possible, for him to stay on, alone, in his own home. Some of this thinking is in evidence, in fact, among that group of older retired couples who voluntarily remove themselves from their own homes and take up some sort of community living together with others their own age. This kind of choice is made possible to some extent by improved retirement benefits attached to many kinds of employment, plus the fact that more families than ever before are financially able to assist an older relative. At least two rationales are used: (1) placement in a home or a group is thought to be a favor to the family unit, which is often presumed to be overburdened by the psychological and physical hardships involved, and/or (2) it is thought to be desirable for the oldster himself, to enjoy life with others his own age. Research that might determine the prevalence of these values would be of assistance to those who will plan new facilities, and information that reveals the kinds of situations that favor good adjustment for various families and older individuals would be of great help to people who direct living groups for the elderly, as well as to the families who seek the best conditions for all concerned.

We need to define the special types of institutions that we do offer, or plan to offer, in order to avoid "misplacement."

It has been observed that many uprootings and placements of older family members are made in the midst of family crisis, with confusion and misconception on the part of the family and oldsters about the functions of nursing homes, homes for the aged, and "retirement homes." Confusion of these terms and functions can be identified at many levels, including people who manage these groups, agencies that are called on, often, to make placements, physicians and the clergy, and in statements of law that attempt to define the differences. We are able to find, therefore, as one result of this confusion, residents who need medical care in retirement homes that have not planned that type of care, and residents of nursing homes who were able, when they were admitted, to care for themselves handily. We do not know, in fact, what percentage of "misplacements" does exist, for there has been very little research that actually defines the characteristics of the elderly people who now live in groups, apart from their families. Neither do we know about attitudes, or change in attitudes that residents of these institutions have about their life there, nor do we know or understand the attitudes of families who have witnessed the experiences of older relatives. Since the concept of "group retirement," especially of healthy couples who freely choose to abandon homes for institutional life—is new; can we say with accuracy that this kind of choice and housing is satisfactory? Do we know what the aging population wants for itself for housing,

or what motivates people who have enjoyed association with a variety of ages throughout their lives on a daily basis—suddenly, in retirement, to seek out and live with a group that excludes others than their own age group?

Our country, in fact, can be described as being too young to have established a cultural response to the problem of caring for grandparents, and is unlike oriental cultures of the past in which older family members were worshipped with ceremony and enshrined alive in the homes of their children; or the eskimo tribes, where functional contribution to the group was emphasized and old members who ceased to contribute were abandoned to the brutal elements. Americans seem to have divided opinions in this matter, so that, given the financial ability to choose, some of us seem to follow something of the oriental pattern of protective care in our own homes, while others seem to think it is a wholesome resolution for all concerned, including the grandparent, when he is placed in a "nice home," away from "home." Still others seem all too pleased to get rid of relative and the responsibility.

Tangent to these attitudes that surround the placement of an older person in a group with others his own age, are many concepts and misconceptions about elderly people in general, and here is a "jungle" for research that becomes truly basic. Is there a point, as many people believe, at which we can expect to lose our memories, our minds, or our good sense? Is there a point, as many people, including some administrators of institutions that house the aged believe, after which it is really no use to offer anything but physical care? Is that point determined by age? By restlessness? Is it inevitable that some of us will shut out reality and become "not of this world"? Is it true that we all become "as children"? What percentage can expect these things to happen? Why does it happen to some? Does our past relate to these conditions? What parts of our past? What aspects of our lives seem to sustain us the longest? Do certain characteristics of the early life of some people seem to be related to their happiness in later years? Does past family pattern seem to matter? Education? Interest? Hard work? Sheltered existence? One does not have to undertake an empirical definition of "happiness" to realize that the adjustment patterns of the elderly who now reside in institutions could be related to certain selected factors that could be defined by careful research. The kind of care that is offered in any institution, from luxuriously appointed "spas" to the barely habitable bed-care centers, is determined most of all by these attitudes. Few researchers have turned their attention to them, however.

Even though these crucial questions will remain unanswered for some time, we know that many elderly people will make the decision, in the years immediately ahead, to live in a group with others his own age. Still more questions, related to this general discussion, confront the management of homes that seek to offer the best quality care, and the family who seeks that care.

The elder member, in fact, who may be suddenly and reluctantly dependent on his younger family for financial support, be suddenly ill or faced with life alone, is seldom the decisionmaker when the choices are made for him. What kinds of places are available? What are the differences? What responsibility for care does the law require? Does the physician have a thorough knowledge of the institutions in the area? Does the management consider needs other than physical ones? Are there initial "shock" factors when first entering an institution? Does, or can the management prevent or absorb these? What is the impact of the institution, as time goes on, on the elderly healthy individual? The one already confused, but healthy? The chronically ill and confused? The chronically ill and alert? Can an otherwise healthy old person regain stability alone, if there are initial adjustment problems that are not recognized? What are the admission practices? Does the management provide any program of activities that might assist initial adjustment? Can it be assumed that the physical decline we so often observe might have been slowed, at least, by an offering of interesting activities suitable to the individual? How influential is the attitude of the family? The management? Can the factors that make for reasonable adjustment be defined? Is it possible that physical decline and resulting increased costs to management, could be postponed with a program of directed leisure time? Rehabilitation?

We have not really examined the impact of the institutional life on the elderly. We need to know the implications for the oldster as he grows older in the institution, and whether or not it would be practical for management to assume responsibility for more than physical care.

In view of the population increases projected for this age group, and the continuing popularity of retirement housing of all kinds, a careful and immediate survey of these problems seems justified. We have not been concerned enough, in administering licenses and writing laws that govern these institutions, about these problems. Placement for many of our older relatives and ourselves is inevitable: "misplacement" can be avoided only if the kind of care that is to be provided is clearly defined by law and some responsibility for the quality of care is assigned to the management. Until broad and careful basic research can be extended to a consideration of these questions, we must continue to wonder if group living, as we see it now, is the answer for such large numbers of us in our last years, and wonder, too, if what we have developed as the "answers" are really not "second-best", or fads.

The answers are not so deeply hidden or obscured that they could not be found, rather quickly, through an extensive crash program of research that would further the beginning efforts seen at certain universities, in particular, across the country at this time. When we have a more workable body of knowledge, we can begin to evaluate and plan with good reason; to dream the finest, and take some pride in the solutions. The sudden appearance of various attractive buildings and plans for many more, with present encouragement from the Government, is a typically American thrust to solve quickly. We may not, however, be solving well, especially for future millions, and we can only make these judgments through further examination of the facts.

[Enclosure 2]

A Proposal for Planning Directed Volunteer Assistance to Nursing Homes in Lane County

It is proposed that: (1) A detailed description of the characteristics of nursing home residents in Lane County be made by competent research worker(s). (See attached sample of preliminary survey being conducted by committee.)

Assumptions: Services that are intended to enrich the lives of the elderly who live in nursing homes and homes for the aged need to be related to the needs of these residents. It is assumed that the best service, paid or volunteer, is offered out of understanding of the aged and their needs and that part of that understanding requires a definition of the characteristics of people who reside in these institutions—their physical abilities and limitations, their backgrounds, hobbies, interests, past family patterns, abilities and training, expressed desires for themselves, vocations, circumstances that cause them to be living there, attitudes toward the institution and the attitude of family or parties who were instrumental in making the placement. It is understood that very little of this type of information is now available. Those few researchers whose attention has been drawn to this area have concluded that much more study is needed.[1]

Possibilities of volunteer assistance program based on research: With new facilities for care of the aging being encouraged, especially by liberal Government loans, and with population trends developing as they are, it can be expected that the percentage of those who live in institutions for the elderly will increase rapidly in the next decade. The needs of the residents should be examined and questions of better quality care considered.

It is assumed that most operators are unable, because of financial limitations, to provide personnel or materials necessary for any leisure-time program. Volunteers are able to provide some of the social and psychological needs at this time by providing assistance for the enrichment of the leisure hours of residents. Such a plan, if undertaken, however, needs community cooperation and understanding, firm grounding in facts, full cooperation of administrators, and specific information about the physical, mental, and social needs of the people we might hope to assist. Careful coordination of these efforts and understandings will well result in a dynamic program in which creative and meaningful experiences are matched to the needs of the institutionalized elderly.

---

[1] Cecil G. Sheps and Eugene H. Taylor, "Needed Research in Health and Medical Care," Chapel Hill: University of North Carolina Press, 1952.
Also: "White House Conference on Aging, 1961," Psychological and Social Science Research, sec. 16.

The first task, therefore, would be to sponsor a research project that could determine at least some of these suggested "personal information factors" about the lives and backgrounds of the residents.

Specifically, it is proposed that responsible administrators of the Universtiy of Oregon be asked to assist in the selection of a qualified person(s) to frame and direct the gathering of reliable information about the elderly residents of institutions in Lane County. To this end, $4,000 is requested as part of the proposed budget, in order to pay for salary and materials of the research.[2]

It is further proposed that: (2) A coordinating committee be established.

The need: Evidence from a simple survey now being completed[3] indicates that administrators of nursing homes are interested in the possibility of using trained volunteers to supplement the basic care now being provided. A majority of the replies show a willingness by most of them to explore this area more deeply. In a recent letter from the president of the Lane County Nursing Home Association, it was stated: "Nursing homes, as a rule, are geared for the sick and chronically ill. It will take a special kind of creative imagination to work satisfactory programs in and around these circumstances, but with interested people * * * I'm sure we can prevail."

If the proposed research is undertaken, and when the results are ready for analysis, there will be need for a work group of those individuals (some already participating at this time) who are interested, and who represent a sound cross-section of the community, capable of stimulating and directing community-wide participation. For the success of this endeavor, the cooperation and participation of the management of these homes in the county is seen as a requisite. The committee, including responsible community leaders and administrators of nursing homes, would first serve as a source of education for its own members, through the proposed research materials, film, and other visual aids, as well as through discussion and exchange of ideas.

Using the information gained from the professional researchers, the planning and direction of a volunteer assistance program could proceed with at least a few guideposts for the kinds of experiences that might be offered.

Work of the committee:

A. To study the research results and define a variety of experiences and general areas where it is thought that trained volunteers might be of most assistance to the residents and staff.

B. To evolve a plan for the recruitment of volunteers, and criteria for their selection and placement.

C. To plan and initiate training courses for volunteers, using resources of the community and materials from the State board of health.

D. To establish Sunset Home as a demonstration center,[4] with varied leisure time activities offered; and to provide at least one activity, continuously, to each of the other cooperating homes.

E. To describe the needs of the project to the community and serve to focus public attention on these problems.

Finally, it is proposed that: (3) A part-time coordinator be employed, sponsored by Lane County Medical Society,[5] to implement the proposal and work closely with State and local boards of health.

The framework of this plan includes the participation of the University of Oregon, Nursing Home Operators Association, Lane County Medical Society, and a multitude of community groups such as the Emerald Empire Council on Aging, Community Volunteer Office, men's and women's service organizations, church and young people's groups, hobby clubs and entertainment troupes, as well as city and county governmental agencies. The Eugene-Springfield area stands as Oregon's second-largest population center. As shown by the attached materials, beginnings have been made, but the scope of co-

---

[2] Conferences with personnel at the University of Oregon, and the Director of the Institute for Community Research indicate that full cooperation and interest can be expected to be vigorous, and it is the hope of the committee that even broader research, to follow this pilot project described here, will be stimulated.

[3] A copy of this preliminary survey is appended. The purpose of the project has been as a "trial balloon," and there is every indication that it has been successful as an "opener" in getting some favorable reactions and various groups started toward further cooperative effort.

[4] Approval for this plan was given, recently, by the board of trustees of Sunset Home, a 180-resident home that houses "retired, healthy" persons, as well as those needing nursing care.

[5] Approval for this plan was also given, recently, by the Lane County Medical Society, through the effort and direction of Dr. Ralph Christenson.

ordinating the project described here requires continuous, responsible leadership. Such coordination could be made possible with the services of a qualified person from the community whose initiative is authorized and sustained by responsible groups such as the medical society, and by reason of employment. Continuity of the project could thus be assured and direct communication between participating groups made with ease.

To this end, the sum of $2,500, as salary for a "half-time" coordinator,[6] for 1 year; and an additional $500 for clerical supplies and training course materials, as well as duplication of educational materials for committee use, is requested.

Half-time coordinator and supplies	$2,500
Research assistant(s) and supplies for research	4,000
Total budget request	7,000

Mrs. John Shepherd (Ruth Alltucker Shepherd) is proposed as the coordinator for this project and was endorsed, as such, by the medical society, pending receipt of funds.

Mrs. Shepherd is a graduate of Stanford University, 1946, has taught in public schools for 5 years and in demonstration schools connected with the University of Montana and Whitman College for a total of 3 years, having established and directed the latter.

Community experience includes membership and office in the State and local levels of the American Association of University Women, volunteer director of YWCA high school groups, and Junior Red Cross activities. She is currently a member of a lay advisory group for the Eugene Public Schools, and is quarter-time secretary for the Lane County stroke rehabilitation project, administered by local medical society and State board of health, through Dr. Robert Heilman, at the State level, and Dr. Ralph Christenson, locally.

Mrs. Shepherd has lived in Eugene for 5 years, with her husband (a university professor), and two children.

Senator MORSE. I also have a letter from the Oregon Nurses Association, in which Mrs. Bertha G. Byrne, executive secretary of the association, advises me that the Oregon Nurses Association agrees with the American Nurses Association that necessary medical care for our senior citizens must be provided through the mechanism of the social security system. I note that Mrs. Byrne and Mrs. Shirley Thompson are present in the audience and will be available to answer questions if necessary. I would like to personally thank them for their attendance and to assure them that their association's letter will also be made a part of this official record at this point.

(The letter mentioned above follows:)

OREGON NURSES ASSOCIATION, INC.,
Portland, Oreg., October 3, 1961.

HON. WAYNE MORSE,
Senate Office Building,
Washington, D.C.

DEAR SENATOR MORSE: We have noted in the papers your plan to conduct a series of hearings on problems of the aging and nursing homes during November. The Oregon Nurses Association is deely concerned with these problems. We realize that, with the constantly expanding population of older citizens, there will be more and more need for facilities to provide long-term care and that this need may eventually change the whole pattern of nursing care.

The Oregon Nurses Association, as you know, has endorsed the position of the American Nurses Association that the necessary medical care for our senior citizens can best be provided through the mechanism of the social security system. We plan, therefore, to have representatives at least in the meeting in Portland on November 6 and possibly at the hearing in Eugene on November 8. In the very near future we will notify you of the names of our official representatives and whether or not we will wish to be scheduled to present testimony.

[6] See qualifications, attached, of Mrs. John Shepherd.

Again, we thank you for the leadership you have shown in attempting to develop plans to take care of the health needs of the people of our State and Nation.

Sincerely yours,

BERTHA G. BYRNE, R.N.,
Executive Secretary.

Senator MORSE. Is there anyone else who wishes to make a statement?

(No response.)

Senator MORSE. I close by saying, ladies and gentlemen, that you would have to be in my position to fully appreciate the cooperation which you have extended to me and to this committee. I think we made a splendid record here today. I am proud of it. I shall point to it with great pride when the committee meets back in Washington. I think we have already collected through these hearings very valuable information for the committee legislativewise, and I am sure that many of you will accept the invitation I extended to you earlier to supplement these hearings with written reports. I want to say that you can be of just as much assistance to me by giving me written reports and supplements to add to this record of splendid testimony that has been offered today.

We will recess now, and we will meet again on Wednesday in Eugene. Thank you very much, and good night.

(Whereupon, at 4:10 p.m., the subcommittee adjourned, to reconvene on November 8, 1961, at Eugene, Oreg.)

APPENDIX

State Licensing Requirements for Nursing Home Administrators

(Prepared as part of the gerontological studies sponsored by Mount Angel College, supported by grant HF-RG W-197 from the Hospital Facilities Division, HEW, Carrol M. Mickey, Ph. D., Institute of Gerontology, Mount Angel College, and Kathryn Ann Beatty, M.S., Institute of Gerontology, Mount Angel College)

An increasingly large number of older people are spending part of their later years in nursing homes. In the past decade, the concept of the nursing home appears to have captured the attention of many who earnestly seek to provide adequate facilities for the older people who require extensive and prolonged care. The scope and level of nursing home services are under continuous review, and there is widespread concern for improvement in their quality. Medical services and nursing care are focal points of greatest interest, but the social and psychological needs of the nursing home residents have not been entirely neglected. Nevertheless, the development of the nursing home type of accommodation has been proceeding at a rapid pace and there is a note of urgency in the attempts to define and implement standards of operation. This is suggested by the fact that in 1950 only three States required that nursing homes be licensed, but by 1958 licensing was in effect in every State.[1]

Examinations of nursing homes reveal a wide range of variation.[2] The operation of each establishment is the outcome of an interplay among numerous factors: the interests and the skills of the staff, the demands and expectations of the residents and their families, the attitudes in the surrounding community or the policies of sponsoring agencies, and the pressures emanating from organizations of professionals whose sphere of competence is involved. To these must now be added the State licensing requirements. Although the statements of requirements for a license necessarily set forth minimal rather than optimal standards, they may well be influential in defining a norm of common, acceptable procedure. Much importance is attached, therefore, to current State requirements for the licensing of nursing homes.

As a part of a series of studies on aging, the Institute of Gerontology of Mount Angel College undertook an examination of the nursing home license requirements in each of the States. The present report is restricted to the description of minimum qualifications for nursing home administrators.

Method of Inquiry

In the spring of 1961 inquiries on the minimum qualifications for nursing home administrators were addressed to appropriate officers in each of the States. Replies were received from all of the 50 States. In a few of the States uniform qualifications have not been specified, but from these, letters of explanation were received.

The State requirements for nursing home administrators can be summarized under the following headings: Age, physical health, mental health and character, education, training, and experience. The survey findings are presented in the accompanying table.

In conducting the survey the interest lay primarily in gaining an overall picture, rather than in a State-by-State comparison, but a question did arise as to whether there are regional differences in the explicit requirements for

[1] Rosen, George, "Health Program for an Aging Population," in Tibbitts, Clark (ed.), "Handbook of Social Gerontology: Societal Aspects of Aging" (Chicago, 1960), p. 539.
[2] Department of Health, Education, and Welfare, "Selected Articles on Nursing Homes," Public Health Service Publication No. 732 (Washington, D.C., 1960).

nursing home administrators. The material in the table has been organized, therefore, in terms of the nine regions employed for administrative purposes by the Department of Health, Education, and Welfare.

ROLE OF THE NURSING HOME ADMINISTRATOR

Before the survey findings are examined, it is well to underline the importance of the nursing home administrator, particularly from the standpoint of the resident.

The older person who moves to a nursing home must make a major adjustment to a different mode of life. The physical and social environment is unfamiliar and older persons frequently perceive it as threatening. Many arrive with the feeling that they are being "shelved," or "put away," and that they are no longer valued or loved. Unlike short-term hospitalization, residence in a nursing home is of indefinite duration, and it is difficult, if not impossible, for the older person to escape the feeling that it will be terminal. The idea of nursing home care is open to varied interpretations; it may mean an approach stemming from an assumption that the older persons are characteristically and irretrievably in a state of dependence, or it may mean activities aimed at stimulating the older persons to cultivate their resources and potentialities. The purpose of the nursing home, as it is conceived and transmitted by the administrator, has a profound impact on the older residents in both their initial and their subsequent adjustments.

Appropriate technical and custodial services are essential to the well-being of the older resident, but as a participant in the nursing home community he contacts the members of the staff as a person, not merely as a patient. The nursing home is the life setting for the older person throughout the day, day after day, for many years perhaps. Because of their frequency, duration, and intimacy, the social relationships between the older person and the staff members are deeply influential. Each nursing home has its own particular climate which is produced by and, in turn, is reflected in the complex of interpersonal relations.[3] On the nursing home administrator lies much of the responsibility for developing and maintaining a climate both benign and envigorating.

A positive social and emotional climate appear to be contingent on the following factors:

1. Nursing home staff members who are adequately skilled in their particular jobs. Staff members who respect the proficiency of one another create an environment of mutual respect which is communicated daily to the residents.
2. A nursing home staff that is concerned with the well-being of each resident as a whole person. The staff member who understands the value of each task performed in the home will be concerned more with the resident as a whole person than as an object on which to practice his own specialty.
3. A nursing home staff that meets together frequently and regularly to discuss ways in which to improve the climate of the home. These meetings should center on the welfare of the residents and should not degenerate into personal "gripe sessions."
4. A nursing home administrator who is concerned with the well-being of all the people in the home, staff and residents. The administrator is responsible for the climate of the home, for he is responsible for hiring all staff members and for supervising all activity.

The role of the nursing home has not been unambiguously defined, and hence, the criteria of successful administration are elusive. Moreover, in this as in other fields, some of the qualities of an administrator are so subtle as to defy attempts at formal specification. Nevertheless, it is of interest to examine the licensing requirements for nursing home administrators for the purpose of seeing to what extent there is a demand for evidence that administrators are familiar with the range of services helpful to older people, have an understanding of the aging process, and an attitude of acceptance of older persons.

---

[3] A recent study under the auspices of the Institute of Gerontology of Mount Angel College is based on intensive inquiries directed to nursing home personnel in Oregon and contributes to an understanding of the social structure of this type of establishment: see William T. Liu and Sheridan P. McCabe, "The Nursing Home in Oregon."

DISCUSSION OF RESULTS

A glance at table I shows that over half the States do not mention age as a requirement for nursing home administrators. Among the States which do refer to age, some are more specific than others. Although age cannot be equated with maturity of judgment it is one index, and would thus seem to be an important qualification.

Physical health is mentioned by more States than is age, and the great majority of the States specify the means for determining the administrator's health. Some States require both a preemployment and an annual physical examination by a licensed physician, although this is not evident in table I due to the regional presentation of the data. Physical health, then, is considered important because it is mentioned by all but eight States.

Good character in the nursing home administrator is generally required, but means for determining this is seldom specified. Mental health is not mentioned in 31 of the States and only 5 States make provision for its determination.

References to education, training, and experience as qualifications for nursing home administrators defy classification. Qualifications of this type are not mentioned by 34 of the 50 States. It is interesting that this omission is evident in all nine regions. For the remaining 16 States the qualifications in education, training, or experience are shown separately in the table. No attempt has been made to categorize these requirements so as to preserve the details of widely different State requirements.

It should be understood that these results show minimum requirements. Many States, while not setting forth certain qualifications, do recommend previous training, education, and experience and improved competency through attendance at various educational programs, meetings, and workshops. Perhaps these recommendations are a step forward to upgraded requirements.

As noted previously, when this study was undertaken it was felt that there might be differences among the regions of the country in the requirements for nursing home administrators. In using the table for regional comparisons it is necessary to keep in mind that the several regions contain differing numbers of States. Certain regional contrasts stand out.

Only two out of six States in region I require administrators to have annual or biannual physical examinations, whereas four out of five States in region VII specify physical examinations every year or once every 2 years. It becomes readily apparent that individual States in a region have similar requirements and it would seem that they influence one another. A second general observation is that no one region seems to have generally higher or more specific qualifications.

CONCLUSIONS

In reviewing the minimum requirements for nursing homes, one observation stands out as of primary significance. Many of the State requirements consist of pages of physical plant specifications: number of square feet per resident, type of door on rooms, location of laundry facilities, etc. These States have made appreciable progress within the past 10 years in their aim to upgrade nursing home standards. However, these same States include few if any requirements for the nursing home administrator. It is a strong possibility, although these requirements are not stated in the nursing home regulations as such, that they are listed in other State publications, or if not listed, are enforced by the particular licensing agency in the States. If either of the latter is the case, it would seem that minimum requirements for the administrator are not deemed important enough for inclusion in the general group of nursing home requirements. If the administrator's qualifications are left to the discretion of the licensing board, there cannot be uniformity among all the nursing homes in the State over any length of time.

RECOMMENDATIONS

Because of the importance of the role of the nursing home administrator in the lives of the residents and in creating a positive home climate through his influence on the nursing home staff, it is imperative that he be qualified for his position. Before one establishes qualifications for a position, he must first define that position. The following recommendations are based on the investigator's perception of the administrator's role in the home.

The administrator need not be a specialist in any one field as his duties are general. However, he must have an understanding of the work done by the specialists in the home: the registered nurse, the dietician, the social worker, etc. In small homes he will probably perform one of these specialties, but his understanding needs to extend beyond the one field. He is responsible for the entire operation of the home and for the welfare of each resident. He should, therefore, have a knowledge of the following: finance and budgeting, personnel administration, aspects of sociology and psychology that will aid him in his relations with home residents, and social welfare legislation. These would seem to be a minimum. The administrator should be mature, in good physical and mental health, and possess that understanding of people which makes the difference between an atmosphere of harmony or disharmony. The investigators do not attempt to suggest specific requirements; that is the responsibility of each State legislature. It is recommended that each State determine its own requirements, make these uniform, and specify how the presence of these qualities will be ascertained. The administrator should not only be required to have previous experience, training, and education in areas that will assist him in performing his duties, but he should also be required to continue his education either formally or through attendance at meetings and workshops which will both increase his understanding of specific areas of interest in the home and sensitize him to the task of general nursing home administration.

Older people need more than a comfortable room and adequate nursing care. They need understanding, respect, and friends. These needs can be met only in a nursing home wherein all of the activities and all of the relationships are centered on the welfare of the resident. A nursing home administrator who is qualified for his position can do much toward creating this atmosphere.

TABLE I.—*State minimum requirements for nursing home administrators*

	Regions									Total
	I	II	III	IV	V	VI	VII	VIII	IX	
Number of States in regions	6	4	5	6	5	7	5	5	7	50
REQUIREMENTS										
Age:										
21 to 70	2					1				3
21 or over	1	1	1	4	2	3		4	1	17
18 or over or "adult or legal"					1	1	1		1	4
Age not mentioned	3	3	4	2	2	2	4	1	5	26
Physical health:										
Preemployment physical	1	2	2	4	2	4	2	1	5	23
Annual or biannual physical	2	3	2	4	3	4	4	2	5	29
Health certificate on file or physicals as needed	1		1	1			1	1	1	6
"Good health" required, but no means of determination	1				1	2		1		5
Physical health not mentioned	2	1	2		1	1		1		8
Character and mental health:										
No felony					2	1			1	4
No misdemeanors or moral turpitude					1				1	2
No habitual use of narcotics and/or alcohol				1	1			2	1	5
General references required				1		1	1			3
Specific references required	1	1			1		1		1	5
Good character required, but no means of determination	3	3	1	3	3	4		1	2	20
Good character not mentioned	2		4	2	1	2	2	2	3	18
Examination by physician or other factual information to determine mental health	1				1	1	1			4
Good mental health required, but no means of determining	1	3		3	3	1		1	2	14
Mental health is not mentioned	4	1	5	2	1	5	4	4	5	31
Administrator must be interviewed before beginning employment					1					1

See footnotes at end of table.

TABLE I.—*State minimum requirements for nursing home administrators*—Con.

	Regions									Total
	I	II	III	IV	V	VI	VII	VIII	IX	
Education, training, and experience:										
R.N., or L.P.N., or graduate nurse, or high school graduate with training in a school of nursing and acceptable experience to tally 4 years, or 2 years of high school and 5 years' acceptable experience	1									1
"Sufficient" training and experience	1								1	2
R.N., or L.P.N., or high school graduate and be able to read, write, and understand English	1									1
Possess education, training, or experience in some or all of following: personnel supervision, planning and organization of work, financial planning and budgeting, education or experience in social work, hospital administration, nursing, or medicine given special consideration		1								1
"Duly qualified by previous training or experience"			1							1
4 years of high school education or pass general development test of the State and must be R.N. or L.P.N. if maximum bed capacity is 14 or less					1					1
Graduate from accredited high school or satisfactory employment comparable to nursing home supervision					1					1
Must present evidence of attendance at an educational program recognized and approved by licensing agency before renewal of license is issued						1				1
Licensed physician, or R.N., or L.P.N., or person of sufficient experience to be responsible for care of patients. If latter, must have sufficient experience and knowledge of simple nursing procedures including sterilization technique							1			
Recomnend: R.N., L.P.N., or 3 years of practical nursing care experience in past 5 years and 4 years of high school or its equivalent					1					1
High school education or equivalent, some previous business or nursing home experience or its equivalent									1	1
Licensed physician, or osteopath, or R.N., or graduate nurse from the State, or equivalent to R.N. by passing examination, or 4 years of college in business administration or accounting, or 3 years experience and pass written and oral exam given by licensing agency, or have 21 consecutive weeks of 40 hours per week as an administrator, or be an administrator prior to July 1, 1955									1	1
Education or professional education, or training, or experience to qualify him to be responsible for care of sick, aged, or infirm								1		1

See footnotes at end of table.

TABLE I.—*State minimum requirements for nursing home administrators*—Con.

	Regions									Total
	I	II	III	IV	V	VI	VII	VIII	IX	
Education, training, etc.—Continued										
R.N., L.P.N., trained practical nurse, or person with sufficient education and experience to insure adequate and proper care of each patient at all times								1		1
High school graduate or hold certificate of high school graduate, or be M.D., R.N., L.P.N., or vocational nurse. Should attend regional workshops and short courses provided by licensing agency							1			1
Education, training, and experience not mentioned	3	3	4	6	2	6	3	3	4	34

Source: Department of Health, Education, and Welfare regions: I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont); II (Delaware, New Jersey, New York, Pennsylvania); III (Kentucky, Maryland, North Carolina, Virginia, West Virginia); IV (Alabama, Florida, Georgia, Mississippi, South Carolina, Tennessee); V (Illinois, Indiana, Michigan, Ohio, Wisconsin); VI (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota); VII (Arkansas, Louisiana, New Mexico, Oklahoma, Texas); VIII (Colorado, Idaho, Montana, Utah, Wyoming); IX (Arizona, California, Nevada, Oregon, Washington, Alaska, Hawaii).

PREFACE AND INTRODUCTION TO THE NURSING HOME IN OREGON

(A preliminary report by William T. Liu, Ph.D., Project Director, Assistant Professor of Sociology, University of Portland, and Sheridan P. McCabe, Ph.D., Associate Professor of Psychology, University of Portland)

PREFACE

In the spring of 1960, Mount Angel College at Mount Angel, Oreg., proposed to establish an undergraduate gerontology program with a basic curriculum, training facilities, and workshops. The plan was submitted to the Hospital Facilities Division of the Public Health Service of the Department of Health, Education, and Welfare of the United States, for a 5-year project, and it was subsequently approved. The senior author was invited to conduct a pilot study of nursing homes in the State of Oregon. It was hoped that data collected and conclusions reached in the study might be of some value in the long-range training of professional geriatric workers and administrators of nursing homes.

Existing literature in the field of gerontology showed that no systematic study of the social structure and work relationships had ever been done on nursing homes, yet several important works on the work relationships had been published. These works are of tremendous importance and have shaped the entire research model of this study. Chapter 2 of this report will give the reader a brief account of these many points as a guide in interpreting the significance of this report.

Upon the invitation of the senior author, the junior author, a psychologist, joined the research team and collaborated throughout the most crucial stages of design, data collection, and interpretation of data, and in the drafting of many chapters.

It was because of the division of labor rather than differences in opinion that the senior author is primarily responsible for chapters 2, 3, 4, 5, and 6, whereas the junior author is primarily responsible for chapters 1 and 7. The conclusion (ch. 8), however, was planned jointly by the authors.

CHAPTER 1—INTRODUCTION

One of the major problems confronting civilization in the 20th century is the phenomenon of aging. Three interdependent factors play an important role in emphasizing this concern of modern society. The first of these factors is the changing demographic picture the world over, and particularly in the United States. This changing picture is characterized not only by a gross increase in the population, but more important, by a shift in the age distribution

of the population toward the older age groups. Between 1900 and 1950, the total population of the United States increased from 76 to 150.7 million, just about doubling. However, during the same time, the population aged 65 and over nearly quadrupled, increasing from about 3.1 to 12.3 million.[1] Between 1950 and 1958 the general civilian population increased 14.6 percent, and the population aged 65 and over increased 23.4 percent.[2]

On the basis of the census data over the past century, demographers have attempted to project the trends to future decades and have predicted a population profile of the future. This necessarily involves the utilization of assumptions regarding fertility and mortality trends which, dependent as they are on economic and technological developments, are difficult to assess. One such assumption is a low mortality rate. Indicating this is the increase of life expectancy for females from 51.1 years in 1900–02, to 73.7 years in 1958; for males from 48.2 years in 1900–02, to 67.2 years in 1958.[3] Table 1, taken from Sheldon, indicates the increase in population aged 65 and over between 1900 and 1950 and also gives the population projection for this age group under both the low and high mortality assumptions. From this table it is readily clear that the number of older persons in our population will continue to increase significantly, although not so rapidly as in the first half of the century. In addition, the sex differences indicating greater longevity for women appear to be playing an ever-increasing role.

TABLE I–1.[1]—*Trends in age structure, 1900–2000* [2]

[In thousands]

Subject	1900	1950	2000 (projections)	
			High fertility and mortality	Low fertility and mortality
Population, 65 and over	3,124	12,308	29,490	35,198
Male	1,579	5,827	12,008	15,209
Female	1,545	6,481	17,482	19,989
Percentages distributed by age:				
Total	100.0	100.0	100.0	100.0
Under 20	44.4	34.5	37.0	30.0
20–44	37.9	37.5	36.4	34.7
45–64	13.7	20.1	17.7	22.4
65 and over	4.0	7.9	8.9	12.9
Percentage of persons 20–64 years old:				
Under 20	86.1	60.0	68.5	52.6
65 and over	7.8	13.8	16.4	22.7
Under 20 and plus 65 and over	93.9	73.8	84.9	75.3

[1] Source: T.N.E. Greville, Illustrative U.S. Population Projections, "Acturial Study," No. 46 (Washington, D.C.: U.S. Department of Health, Education, and Welfare, Social Security Administration, Division of the Actuary, 1957), derived from tables 8, 10–I, 10–IV, 11–I, 12, and 13. From Henry D. Sheldon, "The Changing Demographic Profile," in Clark Tibbitts (ed.), Handbook of Social Gerontology (Chicago: The University of Chicago Press, 1960), p. 50.

[2] Figures are for the United States and its offshore areas and therefore will not agree exactly with census figures for continental United States.

The second important factor in the social problem of the phenomenon of aging is the impact on civilization of the technological changes produced by the industrial revolution. One way in which this has influenced the phenomenon of aging is by providing a highly developed environment and perfected medical science which has made greatly increased longevity possible. Far more importantly, however, the industrial revolution has had powerful effect on the social structure with far-reaching implications for the roles of the individuals who make up

[1] Henry D. Sheldon, "The Older Population of the United States" (New York: John Wiley & Sons, Inc., 1958), p. 10.

[2] Taken from Current Population Report, Population Estimates, Series P–25, U.S. Census Bureau (Washington, D.C.: U.S. Printing Office). At the time of this report, no age breakdown of the 1960 census report has been received.

[3] U.S. National Office of Vital Statistics, "Abridged Life Tables, United States, 1954," Vital Statistics—Special Reports, vol. 42, No. 10 (Oct. 14, 1955); U.S. Bureau of the Census, Statistical Abstract of the United States, 1960 (Washington: U.S. Government Printing Office, 1960), p. 58.

that society. Thus the 20th century has witnessed vast changes: There has been a geographic as well as demographic shift in the population picture with large numbers of people migrating to urban centers; this mobility is accompanied by a corresponding social mobility with the result that there is a gravitation toward a general middle-class value system. Embodied in these changes, there was a particularly profound development. With the change from an agrarian society to an industrial society, and as the factory replaced the home as the site of production, the hold of the family over its individual members was weakened. With this change in the structure of the institution of the family, the roles of the members changed correspondingly. In the family of yesteryear, there was a definite role for the older member to play, a specific contribution to the common effort to make. Likewise, the family unit met the needs of the older person. Today, the situation has changed. The older member has little or no role in the home. His functions have been removed largely as a result of modern innovations. If present in the home of the children, he becomes as a fifth wheel. Correspondingly, the family of today is largely unable to meet the needs of the older persons.[4] This situation is highlighted by the aforementioned increased longevity. In modern families, most men and women are completing their parental roles during the 45- to 55-year decade of life. The average couple marrying in 1890 could look forward to 31 years together, although one spouse would die 2 years before the last child was married. In 1950, however, the average couple could anticipate 41 years of married life, one-fourth of it coming after the last child had left home.[5] Thus, for many years the older people must find new roles.

The third factor playing an important role in the phenomenon of aging is also related to the effects of the industrial revolution. It is the changing patterns of participation in the work force manifested today in highly industrialized societies. The mechanization and automation of processes along with rising productivity have resulted in a large reduction in the hours in the average workweek. The average workweek declined from about 68 hours in 1890 to 40 hours in 1950 and is still declining.[6] In addition to this, the participation of the older worker in the work force is also diminishing. The participation of men 65 and over declined from 68.3 percent in 1900 to 35.6 percent in 1958.[7] Thus the squeeze put on the labor market as a result of the improved technology has been felt most heavily on the older age groups. The trend toward earlier and earlier retirement ages observed in modern times is supported by several forms of social pressure. An economic factor is also involved in that, as the worker's age increases, the value of his services on the labor market depreciates correspondingly. These trends in the modern labor market, coupled with the fact of increasing longevity, have greatly increased the amount of leisure time for the older person. This person must now turn elsewhere for the satisfaction of needs once met in his occupational role.

The picture of the phenomenon of aging as presented here delineates in a very general way the problem of the older person in modern society. The discussion must now turn to more specific considerations to complete the background for the research to be reported here. The general area of the research problem is the health and the medical needs of the older citizen. Within the overall picture of the problems of aging, health occupies a central position. Health problems are significantly greater in the later years than at any other time. The very medical progress which has produced the greater longevity which contemporary man enjoys has, in itself, created a very significant medical problem. The aging process had long been considered a disease. Today, however, a sharp distinction is made between senecence and senity. However, it is true that the maturation process in later years is such that it renders the individual more susceptible to many disorders, particularly those which are classified as chronic.

Of every 1,000 persons who are well at age 45, about 100 will need medical attention during the next 5 years because of the onset of some chronic illness or major impairment. Of those who are well at 60, almost 25 percent will

---

[4] For an extended treatment of this topic, see Gordon F. Streib and Wayne E. Thompson, "The Older Person in a Family Context." In Clark Tibbetts (ed.), ibid., pp. 447–488.
[5] Sheldon, op. cit., p. 6.
[6] Sheldon, op. cit., p. 5.
[7] Fred Slavik and Seymour L. Wolfbein, "The Evolving Work-Life Pattern." In Clark Tibbitts (ed.), Handbook of Social Gerontology, op. cit., pp. 298–329.

develop a chronic illness within 5 years, for which continuing medical care will generally be necessary.[8]

Because of the economic condition characteristic of much of our aging population, due to their reduced participation in the labor force and the social condition consequent upon the changing family pattern, health care for the aged presents a difficult problem. The typical medical status of the older person requires greatly increased medical care, yet the resources of such a person for obtaining such care are lessened. For reasons such as these, medical care must be sought by the aged outside the home setting. The data on the utilization of institutional medical facilities reveal this to be the case. The medical facilities widely utilized by older people with long-term illnesses are general hospitals, tuberculosis hospitals, mental hospitals, and nursing homes.

With respect to general hospitals, Rosen points out that while persons over 65 account for only 8 percent of the total population in 1955, 20 percent of the patients occupying hospital beds that year were in that age group. After an extensive review of the available data, Rosen concludes "In short, many general hospitals have become long-stay facilities for the chronically ill and particularly the aged."[9]

In tuberculosis hospitals across the country, there is a definite trend in the age groups being hospitalized in these facilities. At present, most patients in tuberculosis hospitals are over the age of 40 and more than 20 percent are 60 years of age and over. Rosen illustrates this trend with data from Minnesota. "At Glen Lake Sanitorium in 1925, only 9 percent were above the age of 50; in 1955 over 40 percent were in this age group. Comparable figures are reported from nearby institutions."[10]

Admissions to mental hospitals have always reflected significantly larger proportions drawn from the older age groups, but this trend has increased in recent years, indicating a far greater emphasis on geriatrics in these institutions. Again Rosen supplies data to demonstrate this trend. "The proportion of those over 65 to total admissions to State hospitals rose from 19 percent in 1938 to 24 percent in 1948. For later years, figures as high as 36 percent have been reported."[11] Commenting on this trend, Rosen states that it is due not to the process of aging alone, but can be attributed more significantly to a number of social factors including the changing nature of the family, the attitude of the community to old age, the admissions practices of hospitals, and the availability of housing.

Rosen's observation is undoubtedly valid for other types of hospitalization of the aged as well. To be sure, most patients are admitted for purely medical reasons. However, there are socioeconomic and psychological factors which lead to the continued hospitalization of these patients. Despite the great expense of hospital care and the urgent need for beds to provide for patients suffering from acute disorders, the patients with chronic illnesses are not discharged because the family cannot or will not care for the patient and there is no one else to do so. Many such patients simply have no place to go. In order to provide for the needs of such patients, the nursing home facility is coming into even greater popularity. It is the nursing home which is the primary focus of this research.

Before proceeding to a descriptive survey of the status of nursing homes in the United States, it would be well to clarify the functional definition of this facility. The most complete classification for nursing homes was utilized by the National Inventory of Nursing Homes.[12] This classification is based on three levels of care and results in four types of homes. The following are the three levels of care:

> "Skilled nursing care" includes those procedures employed in caring for the sick which require some technical nursing skill beyond that which the ordinary untrained person can adequately administer. These may include full bed baths, enemas, irrigations, catheterizations, application of dressing or bandages, administration of medications by whatever method the physi-

[8] George Rosen, "Health Programs for an Aging Population." In Clark Tibbits (ed.), Handbook of Social Gerontology, ibid., pp. 521–548.
[9] Ibid., p. 529.
[10] Ibid., pp. 529–530.
[11] Ibid., p. 530.
[12] Jerry Solon and Anna Mae Baney, "Inventory of Nursing Homes and Related Facilities," Public Health Reports, Reprint No. 3248, vol. 69, No. 12, December 1954. Taken from Department of Health, Education, and Welfare, "Selected Articles on Nursing Homes," Public Health Service Publication No. 732 (Washington, D.C., U.S. Government Printing Office, 1960).

cian orders (oral, rectal, hypodermic, intramuscular), and carrying out other treatments prescribed by the physician which involve a like level of complexity and skill in administration. They may be provided by either professional or practical nursing personnel, so long as they extend beyond "personal care" as described below.

"Personal care" includes such personal services as help in walking and getting in and out of bed, assistance with general bathing, help with dressing or feeding, preparation of special diet, supervision over medications which can be self-administered, and other types of personal assistance of this order.

"Shelter" includes room and board and minimum services of a domiciliary nature such as laundry, personal courtesies as occasional helping hand, short of the routine "personal care" described above.[13]

This breakdown of levels of care is then used to provide the following types of nursing homes:

Skilled nursing home: Provides skilled nursing care as its primary and predominant function.

Personal care home, with skilled nursing: Provides some skilled nursing care, but only as an adjunct to its primarily domiciliary or personal care function.

Personal care home, without skilled nursing: Provides personal care, with no skilled nursing care.

Sheltered home: Provides shelter with its associated minimum services to aged residents who essentially manage their own care and affairs.

It is the skilled nursing home which is to be the primary object of this research. However, in order to illustrate the extent of the availability of this intermediate medical facility for the care of the aged afflicted with chronic diseases, some data on all types will be presented. Table I–2 presents estimates of the number of each type of nursing home in 1954.

TABLE I–2.—*National estimates of the number of nursing homes and related facilities, 1954* [1]

Type of facility	Number		Percent distribution		Approximate average number of beds per home	Number of beds per 1,000 population
	Homes	Beds	Homes	Beds		
Total United States [2]	25,000	450,000	100	100	20	2.8
Skilled nursing homes	7,000	180,000	28	40	25	1.1
Personal care homes:						
With skilled nursing	2,000	80,000	8	18	40	.5
Without skilled nursing	7,000	110,000	28	24	15	.7
Sheltered homes	9,000	80,000	36	18	10	.5

[1] Ibid., p. 4.
[2] Includes territories.

Estimates rather than actual data are presented here because exact and reliable information is not available due to the lack of research on nursing homes in the past. Solon and Baney further estimate that about one-fourth of the beds in the personal care homes with skilled nursing are devoted to the skilled nursing service. Since these homes have an estimated total number of 80,000 beds, there are an additional 20,000 beds available for skilled nursing care, or a total of 200,000. Likewise, with respect to the number of beds available for personal care without skilled nursing, the overall total would be 170,000 beds available. Since this report is primarily concerned with the skilled nursing service, attention will be restricted to the first category. It was pointed out above that very little accurate information is available on the status of nursing home care in this country. This is due in part to the recent development of this facility in this country. Nursing homes have been developed to meet a new but widespread community need. Solon and Baney comment: [14]

[13] Ibid.
[14] Jerry Solon and Anna Mae Baney, "Ownership and Size of Nursing Homes," Public Health Reports, Reprint No. 3260, vol. 70, No. 5, May 1955. Taken from Department of Health, Education, and Welfare, "Selected Articles on Nursing Homes," Public Health Service Publication No. 732 (Washington, D.C.: U.S. Government Printing Office, 1960).

"So rapidly has the nursing home developed during the past 20 years that its history seems more like an eruption than an evolutionary development. Its rapid growth was influenced by the convergence of a number of social and economic circumstances * * *. When society turned from almshouses and chose to place cash assistance in the hands of the needy aged, the resulting expanded demand for private living quarters for older people, many of them infirm or ailing, stimulated a significant response.

"The easiest and quickest response came from sources requiring the least immediate outlay in capital and organization. Expediency led to the widespread use of existing family structures, not otherwise fully occupied, with the homeowner or lessee often having an applicable skill such as nursing and an interest in such an activity as a source of income. Here then was an opportunity for small proprietary ventures.

"Some actually started as nursing homes. Some started as boarding homes for elderly people. But in historical background, even as in contemporary operation, the line between homes which offered nursing care and those which provided domiciliary services was not sharply drawn. With the passage of time, homes which had begun as room-and-board enterprises gradually, sometimes imperceptibly, assumed responsibility for meeting personal care and nursing needs as these arose among their aging residents. Thus, many of today's nursing homes are yesterday's small private boarding homes for older people."

From this historical viewpoint, it can be seen that nursing homes grew up as small, commercial enterprises to meet an existing demand. The extent of such service has already been presented. Now questions arise concerning the size, ownership, and regulation of these facilities. Ownership can be generally classified into three categories:

Public: This refers to those skilled nursing homes which are under governmental auspices and tax supported; about 3 percent of the homes and 15 percent of the beds fall into this category.

Voluntary: This category includes those homes which are sponsored by church-related, fraternal, or nonprofit organizations; 6 percent of the homes and 14 percent of the beds are found here.

Proprietary: This includes the privately owned and operated home which functions as a commercial enterprise as well as medical service; 91 percent of the skilled nursing homes and 71 percent of the beds are in this category.

It can readily be seen that the implications of the historical development of nursing homes is borne out and that the vast majority of nursing service in nonhospital institutions is provided in small privately owned nursing homes. Although the number of skilled nursing homes under public and voluntary auspices is much fewer, typically these institutions tend to be larger than the proprietary homes. The median number of beds in a public skilled nursing home is 69; in the voluntary home, 43; and in the proprietary home, 18.[15]

The data on the ownership of Oregon's skilled nursing homes is given in table I–3.

TABLE I–3.—*Distribution of skilled nursing homes and beds by type of ownership, in the State of Oregon, 1954* [1]

Number of homes				Beds			
Total	Type of ownership			Total number	Percent distribution by type of ownership		
	Proprietary	Voluntary	Public		Proprietary	Voluntary	Public
171 [2]	159	6	5	3,914	81.3	4.3	13.7

[1] Ibid, p. 15.
[2] Includes 1 home (22 beds) of unknown ownership.

[15] Ibid.

With respect to the regulation of nursing homes, practice seems to vary widely over the United States. Generally the responsibility for this control is placed in the State's health department. However, the specific practices are by no means uniform. Nursing homes are licensed by all States and territories except Puerto Rico and the Virgin Islands. These two territories and the State of South Carolina do not license homes for the aged. States' agencies responsible for licensure programs are:

Type of agency	Nursing homes	Homes for the aged
State health departments	42	34
State welfare departments	6	14
Other State agencies	3	2
None	2	3

The cost of care in a nursing home varies widely, but averages $150 a month. Public funds pay for the care of about one-half of nursing home residents. Public assistance payments range from $55 to $155 a month.[16]

In the national survey of nursing homes reported by Solon and Baney,[17] the relationship between the availability of skilled nursing home service to certain other factors was investigated. The results of this investigation indicate that supply of nursing-home beds by State is positively related to the proportion of the population over 65, and the per capita income. It is negatively related to the percent of rural population. The study also explores the relationship between the nursing home availability and the availability of related medical facilities. In this regard it is found that there is no relationship to the availability of general hospitals. There is a relationship of States having many chronic hospital beds also having proportionately more skilled nursing-home beds. A trend was also found suggesting a positive relationship to the availability of medical personnel, particularly, professional nurses.

These findings suggest the role that nursing homes play in the social and economic aspects of the phenomenon of aging as well as in the medical aspects. This focus of the research which will be reported here will be on these non-medical needs. The dimensions of the modern social problem of the aging have been sketched here. The development of the nursing home has been shown as a product generated by a need. This research will constitute a scientific investigation from the viewpoint of the behavioral sciences of the potentiality of the nursing home as a social institution to meet these needs.

Attachments Submitted by Hon. Grace O. Pekt, Member, Oregon House of Representatives

Medical Assistance for the Aged in Oregon

(Information leaflet, November 1, 1961, Oregon State Public Welfare Commission, Salem, Oreg.)

What is medical assistance for the aged?

MAA means payments to doctors, hospitals, and nursing homes for specified services received by individuals 65 years of age and over who have been found eligible by the county public welfare department.

How is MAA financed?

The plan is financed by Federal, State, and county taxes.

---

[16] Jerry Solon et al., "Nursing Homes, Their Patients and Their Care," Public Health Monograph No. 46, 1957.

[17] Solon and Baney, "Inventory of Nursing Homes and Related Facilities," op. cit., pp. 8–10.

Who can qualify for MAA?

Any person who meets the following requirements can receive this type of assistance:

1. Is 65 years of age or older. (Age must be verified.)
2. Is a resident of Oregon.
3. Individual person having less than $1,500 annual income or a married couple with less than $2,000 annual income.
4. Has liquid assets (such as stocks, bonds, savings) of less than $1,500 for a single individual or $2,000 for a married couple. Cash surrender value of life insurance in excess of $1,000 is a part of liquid assets.
5. An individual or couple may own their own home and may also have additional real property with a fair market value of up to $5,000. Liens, mortgages, or other encumbrances are deducted in arriving at the market value figure.

How to apply for MAA

1. Applications are made at all county welfare department offices.
2. If a person is physically unable to come to the county office, call the county office to arrange for an interviewer to visit the patient in the home or hospital or wherever may be necessary.

It is best to make application while well and not in immediate need of MAA. It is not necessary to wait until one is ill to apply for MAA. Early application is a big advantage because, from the date of application on, medical expenditures with your doctor or hospital will count toward the deductible amounts which must be satisfied before the plan begins to pay.

However, financially eligible persons can apply and be accepted after illness occurs if they have neglected to do so earlier. It is important to act quickly in making such application, since the MAA benefits cannot start prior to the date when the county office is first notified that application is desired.

Other factors

An applicant has a right to appeal if he thinks action concerning his application, or services under the plan, or request for care was incorrectly made, or too much time was taken in acting on the applicant's request.

There are no durational requirements pertaining to residence, and there will be no liens imposed against the property of a recipient until after the death of the recipient and his surviving spouse.

BENEFITS OF THE MEDICAL ASSISTANCE FOR THE AGED PROGRAM

Subject to the rules and regulations of the Oregon State Public Welfare Commission, the basic benefits during a single benefit year are:

Note: A benefit year begins with the day application is made by the recipient and he is found eligible and ends on the last day of that month 1 year hence.

Example: Recipient applies on January 15, 1962, and is found eligible. The year extends from January 15, 1962, through January 31, 1963. A new year begins February 1, 1963, provided reapplication has been made.

Note: The benefits, deductibles, and limits are all on an annual basis and apply to each year for which application is made.

Hospital inpatient care

Up to 14 days per year, with the patient assuming responsibility for $7.50 of charges for each of the first 10 days to satisfy an annual deductible requirement of $75. The 14 days per year total applies regardless of the number of times the recipient enters and leaves the hospital.

Hospital outpatient care

Limited coverage for hospital charges when the physician provides certain specified care. Hospital outpatient care does not count against the 14 days' hospitalization.

If the hospital outpatient facility is utilized prior to satisfying the annual $75 hospital inpatient deductible, the recipient is responsible for up to $7.50 of charges for each outpatient hospital visit until he has assumed responsibility for $75 of charges. The $75 can be made up of charges for hospital inpatient care or hospital outpatient care or both.

Hospital outpatient care is made up of such items as use of emergency surgery, anesthesia, dressings, sutures, casts, etc.

Drugs and medicines are the patient's responsibility.

X-ray and laboratory services received as a hospital outpatient are included with physicians' services and are not included with hospital services.

Nursing home care

Four days care in a licensed nursing home can be substituted for one inpatient hospital day provided the recipient:

1. Transfers to the nursing home after a period of hospitalization under the MAA plan;
2. Has unused hospital days remaining in his annual benefit;
3. Is transferred on order of his physician for medically essential care in the nursing home; and
4. Is admitted to the nursing home by direct transfer and with less than 24 hours elapsed since hospital discharge.

Under the plan there is no deductible requirement during nursing home care. The intent of this benefit is to encourage use of the nursing home to a maximum degree in the convalescent phase of a hospital illness. Present available funds do not permit the provision of nursing home care on any other basis.

Physicians' services

The recipient assumes responsibility for the initial $50 of charges each benefit year. The $50 can be made up of charges for surgery, charges for visits and care in sickness cases, charges for X-ray and laboratory services, or a combination of these three services.

All fees and rates (both deductibles paid by the patient and benefits paid by the plan) are calculated on the basis of fees established by the State public welfare commission for MAA.

After the patient has assumed responsibility for the first $50 of charges by the physician in the benefit year (the "$50 annual deductible"), the following benefits are available in the following amounts:

Type of service:	*Dollar maximum*
Surgery—any place and any time	[1] $500
Medical care and visits—any place and any time	[1] 150
X-ray and laboratory—in the physician's office or hospital outpatient facility	[1] 100

[1] A year.

EXCLUSIONS AND LIMITATIONS OF THE MEDICAL ASSISTANCE FOR THE AGED PROGRAM

Note: These items are not paid by the MAA plan:

1. Home health care services, except covered physicians' visits.
2. Private duty nursing services.
3. Dental services, except the treatment of a fractured jaw.
4. Eyeglasses.
5. Dentures.
6. Prosthetic devices such as artificial legs, arms, etc.
7. Blood for transfusion.
8. Diagnostic services when symptom free and not ill, and screening and preventive services.
9. Ambulance services.
10. Any available medical benefits to which the recipient may be entitled from a Federal, State, or other public facility shall be exhausted before MAA benefits may be utilized.
11. Drugs, other than those consumed during the 14 days of hospital benefits provided by the plan.
12. Medical care and services in excess of minimum adequate health services as defined by the State public welfare commission.
13. Any item of care not specifically included as a benefit is excluded.
14. Services available to recipient under other private medical insurance.
15. Benefits are limited, during the recipient's lifetime, to 42 days of care in a general hospital for tuberculosis or psychosis.

OTHER HEALTH INSURANCE OR MEDICAL CARE COVERAGE

You are encouraged to retain your personal health insurance policy. When you apply for MAA you agree to assign these benefits in the event you use hospital or physician services. This assures their use for their intended purpose—meeting doctor and hospital costs.

Your private health insurance will be used first to meet the expense of MAA deductibles. What is not required in paying deductibles will be used as an offset to MAA coverage. Services and days provided by MAA will be correspondingly extended in order to increase the total services available to you during the year.

HOW TO RECEIVE CARE

In the county where you live

You should call in person at your local county public welfare office and secure a vendor invoice and certificate of eligibility form which you present to the hospital, nursing home, or physician.

If an emergency arises and you cannot go to the county public welfare office in person, have your spouse, a relative, or a close friend do this for you. If no one can go in your behalf, then contact the welfare office by phone or letter and ask their assistance. Identify yourself to the county public welfare office by your name and the identification number on your identification card.

Out of the county where you live

If you take ill while outside your home county and need medical care, contact the nearest county welfare office, identify yourself by name and the identification number on your identification card, and proceed as though you were in your home county.

Out of Oregon

If you are temporarily out of Oregon, take ill, and need medical care, proceed as follows: Request the physician or hospital to contact your local county welfare office where you live, stating your name and identification number. Your local county welfare office will advise the physician or hospital as to how to proceed.

Important

Contact your county public welfare department about any questions or difficulties.

MEDICAL ASSISTANCE FOR THE AGED ("MAA")—GUIDE FOR PUBLIC WELFARE MEDICAL SERVICES

(Oregon State Public Welfare Commission, Salem, Oreg., November 1961)

FOREWORD

"MAA" is a program administered by the welfare department and financed by a combination of Federal, State, and county tax funds to assist persons of limited means, age 65 and beyond, in meeting some of the most important costs of sickness.

Application is made at the county public welfare department. Early enrollment is urged, but it is possible to enroll and qualify at any time including after illness or accident occurs. Persons to qualify need to meet the following criteria:

Must be residing in Oregon.

Must be 65 years of age or over.

May not have an annual income of more than $1,500 ($2,000 for a married couple).

May not have in the form of cash and liquid assets more than $1,500 ($2,000 for a married couple).

May (as an individual or couple) own their own home and also have additional real and personal property with a fair market value of up to $5,000.

Persons who are receiving old-age assistance from the public welfare department are ineligible for MAA. Persons over age 65 who are receiving other kinds of public assistance (aid to the disabled, aid to the blind, general assistance, or aid to dependent children) will also be eligible for MAA, and their enrollment will help to provide better care and a more adequate payment to providers of health services.

Benefit and deductible provisions of the plan are on an annual basis. Benefits unused in one benefit year cannot be carried forward and added to those of the next year. Deductibles must be satisfied as a precondition in each benefit year.

Benefits include:

PHYSICIAN

$150 per year for medical visits, examinations and medical treatment. $100 per year for X-ray and laboratory studies required in diagnosing illness. $500 per year for surgical services.	Are available to pay for necessary services of the physician each year under the plan. *But* the patient must assume as a personal responsibility the first $50 of expense for physician services each year before the benefits of the plan begin.

HOSPITAL INPATIENT

Fourteen days of hospitalization per year, but the patient must assume responsibility for $7.50 per day of the hospital cost for the first 10 days in the hospital under the plan. $75 per year is the patient's total responsibility for this purpose; MAA covers the rest of the hospital expense for the 14-day benefit period.

HOSPITAL OUTPATIENT

Hospital "outpatient" service may be used under the plan if the patient requires service there and does not have to enter the hospital as a bed patient.

Charges for use of emergency room, minor surgery, sterile tray and sterile supplies, cast room, materials for cast, etc., are covered if the physician service provided at the time of the visit is covered under the patient's physician benefit.

If the $75 annual hospital deductible has not yet been satisfied, the patient is required to assume responsibility for the first $7.50 of charge at each visit which will count toward satisfaction of the annual $75 total. (If the outpatient charge in such a circumstance is less than $7.50, the entire amount will be a patient responsibility.)

X-ray and laboratory services which are billed by the hospital as part of an outpatient charge are treated by the plan exactly as if they had been provided in a physician's office; i.e., they are paid for by the plan at 90 percent of the rates appearing in the "Physicians' Section," "Guide for Public Welfare Medical Services," if the patient has already satisfied the $50 annual deductible requirement for physicians' services and has not used up the $100 annual maximum in this category of service. Otherwise they will be the personal responsibility of the patient.

NURSING HOME

Four days' care in a licensed nursing home can be substituted for 1 inpatient hospital day, provided the patient—

1. Transfers to the nursing home after a period of hospitalization under the MAA plan;
2. Has unused hospital days remaining in his annual benefit;
3. Is transferred on order of his physician for medically essential care in the nursing home; and
4. Is admitted to the nursing home by direct transfer and with less than 24 hours elapsed since hospital discharge.

Under the plan there is no deductible requirement during nursing home care.

The intent of this benefit is to encourage use of the nursing home to a maximum degree in the convalescent phase of a hospital illness. Present available funds do not permit the provision of nursing home care on any other basis.

EXCLUSIONS

1. Home health care services, except covered physicians' visits.
2. Private duty nursing services.
3. Dental services, except the treatment of a fractured jaw.
4. Eyeglasses.
5. Dentures.
6. Prosthetic devices such as artificial legs, arms, etc.
7. Blood for transfusion.

8. Diagnostic services when symptom free and not ill, and screening and preventive services.
9. Ambulance services.
10. Any available medical benefits to which the recipient may be entitled from a Federal, State, or other public facility shall be exhausted before MAA benefits may be utilized.
11. Drugs, other than those consumed during the 14 days of hospital benefits provided by the plan.
12. Medical care and services in excess of minimum adequate health services as defined by the State public welfare commission.
13. Any item of care not specifically included as a benefit is excluded.
14. Services available to recipient under other private medical insurance.
15. Benefits are limited, during the recipient's lifetime, to 42 days of care in a general hospital for tuberculosis or psychosis.

Specific Procedures and Rules for MAA Services

PHYSICIANS

I

Rate of payment

Rate of payment for physicians' services has been set at 90 percent of the printed schedule appearing in "Physicians' Section," Guide for Public Welfare Medical Services, July 1960, rounded off to the nearest half dollar.

For convenience in billing, a mimeographed table is appended to this guide which gives the rounded off 90 percent values for all items in the fee schedule by marginal code number. Examples follow:

Subsequent office visit, item No. 0006, is printed at $3.50 and would be billed at $3.

Lumbar puncture, item No. 5060, is printed at $7.50 and would be billed as $7.

Unilateral inguinal hernioplasty, item No. 3631, is printed at $112.50 and would be billed as $101.50.

II

Identification

(1) ID card: Each MAA beneficiary has been provided with an ID card giving name, ID number, dates of benefit year, etc. Use this ID number in all communications and contacts about the case.

(2) Vendor invoice and certificate of eligibility (form 498), issued currently by the county public welfare department, may either be secured by the patient before his visit or may be requested by your office direct from the county public welfare office if the patient does not present one.

This form 498 is conclusive evidence that the patient is an enrolled MAA beneficiary, but it does not indicate his status insofar as deductibles and maximums are concerned.

This form is used for billing all MAA services.

(3) Patient not yet enrolled in MAA: When a patient over 65 who has not yet enrolled in MAA comes to your office and indicates a wish to apply, your office or the patient should promptly call the county public welfare department, since coverage by the plan cannot be extended retroactively to services occurring before such a call. (Medically emergent services provided when immediate contact with the county public welfare department is not possible because it is closed, after hours, or because of weekend or holiday, can be covered if the county public welfare department is notified promptly at the time it is next open for business.)

The county public welfare department will in most cases be able to make a decision within 5 days as to whether the patient who applies under these circumstances will be able to qualify. If eligible, a vendor invoice and certificate of eligibility (form 498) will be sent to you immediately for use in submitting your bill.

III

Deductibles

When responsibility for payment is separated from the person or family receiving medical services, problems of utilization often develop.

Deductibles are used to counteract the tendency toward overutilization. Fee-for-service arrangements under Kerr-Mills legislation need not be inflationary if the deductible mechanism is meticulously planned and executed.

Under MAA in Oregon the patient is required to assume responsibility for the first $50 of physician services each year. After these services have been provided, the plan pays for physician services up to the established maximums. The welfare agency and the medical profession must work closely together for uniform application of this deductible requirement if MAA is to succeed in our State.

Sometimes when a patient comes in, it may seem fairly obvious that the service provided will be a "deductible," because the patient has just enrolled in MAA or because he reports that he has had little or no physician service since he became an MAA beneficiary.

Nevertheless all services provided, whether part of the deductible or part of the MAA benefits, must be billed to the State public welfare commission on a vendor invoice and certificate of eligibility (form 498).

A voucher in payment of services which are properly a part of MAA benefits will be sent to the physician. Both physician and patient will be promptly notified of services which are part of the "deductibles."

Be sure the staff in your office understands this rule: The MAA deductible requirement is only satisfied through services that are billed to the State public welfare commission on a vendor invoice and certificate of eligibility (form 498). Prompt notice is returned to physician and patient when a charge that has been submitted is part of the deductible and is to be the personal responsibility of the patient.

IV

Steps in billing and payment

(1) *Payment in full.*—Physicians who treat patients under the MAA plan agree to accept the established fees as payment in full for benefits of the plan. There is no way under Federal and State law and regulation by which the patient can be indemnified for medical expenditures.

(2) *Vendor invoice (Form 498).*—The physician must bill all his services to each MAA recipient on a vendor invoice and certificate of eligibility (form 498) mailed directly to the State public welfare commission. The patient may present this vendor invoice and certificate of eligibility to you when he comes to your office, having secured it in advance from the county public welfare department. If he does not a telephone call or written request should be made to the county public welfare department to verify the eligibility of the patient and to secure the vendor invoice and certificate of eligibility for submission of the billing.

(3) *Payment procedures.*—The State public welfare commission will promptly handle all such billings by—

(*a*) Payment by check when the service is in keeping with the benefits defined, when the deductible requirements have been met for the case, and when maximum benefits for the current benefit year have not been exceeded.

(*b*) Notification to the physician when the charge is one that must be the responsibility of the patient, either as a deductible or because the maximum annual benefit has been used up.

The patient will also be notified by the State public welfare commission when it is his responsibility to plan for payment of a charge not included in MAA benefits. The amount charged by the physician to the patient for deductible items and services beyond the maximums is strictly between the doctor and patient and is not subject to the MAA fee schedule, although the $50 credit for deductible will be calculated on that schedule.

(*c*) Prompt notice to the physician if for any other reason the charge must be adjusted in amount or disallowed.

(4) *Prompt billing.*—Billings will be processed strictly in the order of their receipt in the State public welfare department office. Order of receipt will determine which bills will be returned to the physician to be collected from the patient as deductibles; which bills will be paid by the MAA fund as part of the annual benefits; and which bills will be returned to the physician to be the responsibility of the patient because they fall beyond the maximum limits set for each year's benefits. Every physician is urged to bill promptly and in any event must not hold bills beyond the end of the month.

V

Other health insurance

Federal regulations and Oregon State law are both very specific in requiring a full use and accounting for other health insurance benefits which may be available to the MAA beneficiary. The Oregon MAA plan has been designed to see

that these other benefits are fully used to meet the cost of deductibles, to cover the cost of services beyond the maximum limits of the plan, and to reimburse MAA funds expended.

Assignments: When the beneficiary applied for MAA benefits he agreed to assign to his physician or hospital any benefits which may become available to him as a result of physician or hospital services provided and for which payments under MAA are also being sought.

In brief the following steps are relevant when you provide services to an MAA beneficiary who also carries other medical or health insurance:

(*a*) Secure an assignment from the patient (forms are available from your county public welfare department. If the need arises when the patient is hospitalized, the hospital office carries a supply of the blanks).

(*b*) Bill as in any other MAA case. Payment will be made from MAA as in any other case.

(*c*) When payment is received under the other plan you must make an accounting to the State public welfare commission on the form provided for the purpose, indicating:

Total amount received under other plan	$_____
Less amount applied to meet cost of deductibles	*_____
Less amount applied to meet cost of services beyond the maximum benefits	*_____
Balance, remitted to the State public welfare commission	_____

*Itemization required.

VI

Audit and review

Primary processing and payment of MAA billings is accomplished by IBM methods using a magnetic tape system for storing data and for comparing bills currently submitted with established fee schedules, with previous charges in the case, and with the deductible, and benefit limit status of the case.

Bills which show obvious departures from the rules or conditions of the fee schedule will be rejected in this primary IBM mechanical review, e.g.:

Fee listed exceeds the fee schedule item number.

Hospital or office visits charged postoperatively in a flat fee case.

Repetitive "first" office visit charges in a case.

The physician is not required to secure "prior authorization" of individual services provided to eligible MAA recipients, nor is he required to submit a medical report with his billing. In lieu of such cumbersome and complex control measures, a system of random sampling and spot review of case records and accounts is planned.

MAA applicants agree to such review in signing their applications:

"I hereby apply for medical assistance for the aged and consent to the release to the State or county public welfare departments of any and all information and records in the custody or control of any practitioner of the healing arts or of any other person or public or private corporation, association, agency or institution, which either department may request at any time for the purpose of determining my eligibility for public assistance, or the validity of any claim for payment of any care, goods, services or needs provided to me, notwithstanding that the same may be confidential or privileged."

Such reviews and audits will be carried on in close cooperation with representatives of the medical society so that the profession and the agency may be provided with the information necessary to intelligent direction and control of the MAA program and its costs.

The physician will be asked to submit a clinical report or synopsis and a summary of services provided in the case selected for review and audit.

The case will also be studied in the light of expenditure and accounting records belonging to it.

VII

General

Communications, problems, and complaints: Contact your county public welfare department, where an MAA representative will receive your inquiry and answer your problem.

In case of an emergency and you wish to contact the State welfare office, write or call: Oregon State Public Welfare Commission, Division of Medical Care, State Public Service Building, Salem, Oreg. Telephone Empire 4–2171, extension 1544.

Examples of billings forms, assignment forms, and other communications used in the administration of the MAA program with physicians are to be found in the appendix of this guide.

HOSPITALS

I

Rate of payment

Rate of payment for hospitals will be the inclusive per diem rate set by the hospitals' statement of reimbursable cost. Payment will be made for the day of admission, but not for the day of discharge.

II

Identification

(1) ID card: Each MAA beneficiary has been provided with an ID card giving name, ID number, dates of benefit year, etc. Use this ID number in all communications and contacts about the case.

(2) Vendor invoice and certificate of eligibility (form 498), issued currently by the county public welfare department, may either be secured by the patient before his visit, or may be requested by the hospital direct from the county welfare office if the patient does not present one.

This form 498 is conclusive evidence that the patient is an enrolled MAA beneficiary, but it does not indicate his status insofar as deductibles and maximums are concerned.

This form is used for billing all MAA services.

(3) Patient not yet enrolled in MAA: When a patient over age 65 who has not yet enrolled in MAA comes to the hospital for service and indicates a wish to apply, a hospital representative or the patient should promptly call the county public welfare department, since coverage by plan cannot be extended retroactively to services occurring before such call. (Medically emergent services provided when immediate contact with the county public welfare department is not possible because it is closed, after hours, or because of weekend or holiday, can be covered if the county public welfare department is notified promptly at the time it is next open for business.)

The county public welfare department will in most cases be able to make a decision within 5 days as to whether the patient who applies under these circumstances will be able to qualify. If eligible, a vendor invoice and certificate of eligibility (form 498) will be sent to the hospital immediately for use in submitting the bill.

III

Deductibles

The patient is responsible for $7.50 per day of the charge for each of the first 10 days in the hospital, or an annual total deductible of $75. However the hospital must always bill for its full per diem charge, and the deductible will be subtracted by State public welfare commission before payment is made. A statement accompanying the payment will make evident to the hospital what charges are to be the responsibility of the patient. Application of deductibles to outpatient charges is covered in part V.

IV

Steps in billing and payment

(1) *Vendor invoice (form 498).*—The hospital must bill all services to each MAA recipient on a vendor invoice and certificate of eligibility (form 498) mailed directly to the State public welfare commission. The patient may present this vendor invoice and certificate of eligibility when he comes to the hospital, having secured it in advance from the county public welfare department. If he does not, a telephone call or written request should be made to the county public welfare department to verify the eligibility of the patient and to secure the vendor invoice and certificate of eligibility for submission of the billing.

(2) *Payment procedures.*—The state public welfare commission will promptly handle all such billings by—

(*a*) Payment by check when the service is in keeping with the benefits defined, when the deductible requirements have been met for the case, and when maximum benefits for the current benefit year have not been exceeded.

(*b*) Notification to the hospital when the charge is one that must be the responsibility of the patient, either as a deductible or because the maximum annual benefit has been used up.

The patient will also be notified by the State public welfare commission when it is his responsibility to plan for payment of a charge not included in MAA benefits.

(*c*) Prompt notice to the hospital if for any other reason the charge must be adjusted in amount or disallowed.

(3) *Prompt billing.*—Billings will be processed strictly in the order of their receipt in the State public welfare department office. Order of receipt will determine which bills will be returned to the hospital to be collected from the patient as deductibles: which bills will be paid by the MAA fund as part of the annual benefits; and which bills will be returned to the hospital to be the responsibility of the patient because they fall beyond the maximum limits set for each year's benefits. The hospital is urged to bill promptly and in any event must not hold bills beyond the end of the month.

V

Outpatient care

Outpatient charges for use of the examining room or use of emergency surgery, for sterile tray, for dressing, sutures, and the like, for cast room and cast materials, will be charged at the established rate the hospital charges the public for such items and services.

If the $75 annual deductible for the hospital has not yet been completely satisfied at the time the outpatient bill is received in the State public welfare department office, then the deductible will be charged against the outpatient service and will help to satisfy the $75 annual deductible. The amount of a deductible for a single outpatient visit will be $7.50 or the total amount of the charge, whichever is less.

When X-ray or laboratory services are provided by the hospital as a part of an outpatient visit, these are to be billed in accordance with the fees allowed for these services in the billing table provided to physicians and set at 90 percent of the printed amount appearing in the "Physicians' Section, Guide for Public Welfare Medical Services," July 1960. A copy of this billing table is attached for your convenience.

VI

Other health insurance

Federal regulations and Oregon State law are both very specific in requiring a full use and accounting for other health insurance benefits which may be available to the MAA beneficiary. The Oregon MAA plan has been designed to see that these other benefits are fully used to meet the cost of deductibles, to cover the cost of services beyond the maximum limits of the plan, and to reimburse MAA funds expended.

Assignments: When the beneficiary applied for MAA benefits, he agreed to assign to his physician or hospital any benefits which may become available to him as a result of physician or hospital services provided and for which payments under MAA are also being sought.

In brief the following steps are relevant when the hospital provides services to an MAA beneficiary who also carries other medical or health insurance:

(*a*) Secure an assignment from the patient (forms are available from your county public welfare department).

(*b*) Bill as in any other MAA case. Payment will be made from MAA as in any other case.

(*c*) When payment is received under the other plan, you must make an accounting to the State public welfare commission on the form provided for that purpose, indicating:

Total amount received under other plan	$------
Less amount applied to meet cost of deductibles	*------
Less amount applied to meet cost of services beyond the day maximum	*------
Balance, remitted to the State public welfare commission	------

*Itemization required.

VII

Audit and review

IBM mechanical review—primary processing and payment of MAA billings is accomplished by IBM methods using a magnetic tape system for storing data and for comparing bills currently submitted with established fee schedules, with

previous charges in the case, and with the deductible, and benefit limit status of the case.

Bills which show obvious departures from the rules or conditions outlined above for inpatient and outpatient charges will be rejected in this primary IBM mechanical review.

Diagnostic coding: The hospital is not required to secure prior authorization of individual services provided to eligible MAA recipients. However, it is necessary that the vendor invoice submitted for hospital billing indicate the diagnosis of the case at the time of discharge or at the time the period of hospitalization covered by the bill ends. This diagnosis should be the one recorded by the attending physician in the hospital chart as the patient's major diagnosis and should be in terms of the international list. Consult the "List of Three Digit Categories, 1955 Revision" which will be sent to you under separate cover specifically for diagnostic coding in MAA. (Similar coding is required in other public assistance hospital cases.) Billing forms which do not contain this information under "Description of Goods or Services" cannot be paid and will be returned to the hospital for completion. See the sample billing form in the appendix.

Process of review and audit: There will be review and audit of hospital billings and of clinical information substantiating the necessity for hospitalization under the plan. MAA applicants agree to such review in signing their applications:

"I hereby apply for medical assistance for the aged and consent to the release to the State or county public welfare departments of any and all information and records in the custody or control of any practitioner of the healing arts or of any other person or public or private corporation, association, agency, or institution, which either department may request at any time for the purpose of determining my eligibility for public assistance, or the validity of any claim for payment of any care, goods, services, or needs provided to me, notwithstanding that the same may be confidential or privileged."

Such reviews and audits will be carried on in close cooperation with representatives of the medical staff so that the profession and the agency may be provided with information necessary to intelligent direction and control of the MAA program and its costs.

The physician will be asked to submit a clinical report or synopsis and a summary of services provided in the case selected for review and audit.

The case will also be studied in the light of expenditure and accounting records belonging to it.

VIII

General

Communications, problems, and complaints: Contact your county public welfare department where an MAA representative will receive your inquiry and answer your problem.

In case of an emergency and you wish to contact the State welfare office, write or call Oregon State Public Welfare Commission, Division of Medical Care, State Public Service Building, Salem, Oreg. Telephone, EMpire 4-2171, extension 1544.

Examples of billing forms, used in the administration of the MAA program with hospitals are to be found in the appendix of this guide.

NURSING HOMES

I

Extent of benefits

An MAA beneficiary may use the nursing home as a source of care under the plan for the convalescent phase of a hospital illness, provided that his hospital benefit of 14 days per year has not been exhausted. Four nursing-home days will be allowed for each remaining unused day of hospitalization if admission occurs by transfer from a hospital and within 24 hours of hospital discharge.

II

Rate

The rate of payment for nursing home care has, by agreement, been set at $6 per day under the MAA plan. Cooperating nursing homes agree to take patients under the MAA plan on discharge from the hospital if there are remaining benefits applicable to the nursing home and if the attending physician has certified that nursing home care is adequate to the patient's medical needs.

Notification

Upon transfer of a patient believed to be an MAA beneficiary from the hospital to the nursing home, the nursing home administrator should promptly call the county public welfare department to report the transfer and to request the vendor invoice and certificate of eligibility (form 498).

Verification

The county public welfare department will check with the general hospital from which the patient has transferred to verify transfer status. A vendor invoice and certificate of eligibility will be issued to the nursing home as soon as the maximum number of days which may be provided under the MAA program to the named beneficiary has been determined.

III

Services covered

The nursing home will provide general nursing-home care to the patient along with such common items of every day usage as aspirin, mineral oil, minor bandages, rubbing alcohol, ointments of common use, etc. This will be the same list of items and supplies which are provided by nursing homes under the basic public assistance programs. Drugs and other items or sundries for which the nursing home is entitled to charge in addition to the payment made from MAA funds will be the financial responsibility of the patient. Please note that there is no deductible charge in relation to the nursing home care under MAA.

IV

Steps in billing and payment

Billing.—The nursing home will bill for up to the maximum number of days allowed under the MAA benefits at the per diem rate of $6.

Voucher.—The State public welfare commission will promptly handle all such billings, making payment by voucher as soon as it is verified that the number of days billed and the rate of billing are correct. Please note that in nursing homes, as in other institutions, when payment is made on a daily basis the agency pays for the day of admission but does not pay for the day of discharge.

V

Other health insurance

Federal regulations and Oregon State law are both very specific in requiring a full use and accounting for other health insurance benefits which may be available to the MAA beneficiary. The Oregon MAA plan has been designed to see that these other benefits are fully used to meet the cost of deductibles, to cover the cost of services beyond the maximum limits of the plan, and to reimburse MAA funds expended.

Assignments: When the beneficiary applied for MAA benefits, he agreed to assign to his physician or hospital or nursing home any benefits which may become available to him as a result of physician or hospital or nursing home services provided and for which payments under MAA are also being sought.

In brief the following steps are relevant when the nursing home provides services to an MAA beneficiary who also carries other medical or health insurance:

(*a*) Secure an assignment from the patient (forms are available from your county public welfare department).

(*b*) Bill as in any other MAA case. Payment will be made from MAA as in any other case.

(*c*) When payment is received under the other plan, you must make an accounting to the State public welfare commission on the form provided for that purpose, indicating:

Total amount received under other plan	$------
Less amount applied to meet cost of deductibles	*------
Less amount applied to meet cost of services beyond the day maximum	*------
Balance, remitted to the State public welfare commission	------

*Itemization required.

VI

Review and audit

Primary processing and payment of MAA billings is accomplished by IBM methods using a magnetic tape system for storing data and for comparing bills currently submitted with established fee schedules, with previous charges in the case, and with the deductible and benefit limit status of the case.

A system of random sampling and spot review of cases, financial records and accounts is planned for the MAA program. This will be done with the full cooperation of all of the providers of service and will enable the professional groups concerned to make a rational review of experience and to plan intelligently for control of utilization and improvement of quality of service. The MAA beneficiary signs a release which authorizes access to financial and case records for audit and review.

VII

General

Communications, problems, and complaints: Contact your county public welfare department where an MAA representative will receive your inquiry and answer your problem.

In case of an emergency and you wish to contact the State welfare office, write or call Oregon State Public Welfare Commission, Division of Medical Care, State Public Service Building, Salem, Oreg. Telephone, Empire 4–2171, extension 1544.

Examples of billing forms used in the administration of the MAA program with nursing homes are to be found in the appendix of this guide.

LICENTIATES OF THE STATE BOARD OF CHIROPRACTIC EXAMINERS
LICENTIATES OF THE STATE NATUROPATHIC BOARD OF EXAMINERS

I

Rate of payment

Rate of payment for chiropractic physicians and for naturopathic physicians will be $5 for an initial office visit in a series of treatments and $3 for subsequent office visits, with no more than four such visits to be covered by the plan in any one month.

Laboratory and X-ray services will be covered up to a maximum of $10 in any one month, with rate of payment to be at 90 percent of the fees listed in the radiology and laboratory sections of the "Physicians' Section, Guide for Public Welfare Medical Services," July 1960.

II

Identification

(1) Identification card: Each MAA beneficiary has been provided with an identification card giving name, identification number, dates of benefit year, etc. Use this identification number in all communications and contacts about the case.

(2) Vendor invoice and certificate of eligibility (form 498), issued currently by the county public welfare department, may either be secured by the patient before his visit, or may be requested by the doctor direct from the county welfare office if the patient does not present one.

This form 498 is conclusive evidence that the patient is an enrolled MAA beneficiary, but it does not indicate his status insofar as deductibles and maximums are concerned.

This form is used for billing all MAA services.

(3) Patient not yet enrolled in MAA: When a patient over age 65 who has not yet enrolled in MAA comes to the doctor and indicates a wish to apply, a call should be promptly made to the county public welfare department, since coverage of the plan cannot be extended retroactively to services occurring before such call.

The county public welfare department will in most cases be able to make a decision within 5 days as to whether the patient who applies under these circumstances will be able to qualify. If eligible, a vendor invoice and certificate of eligibility (form 498) will be sent to the doctor immediately for use in submitting the bill.

III

Deductibles

When responsibility for payment is separated from the person or family receiving medical services, problems of utilization often develop.

Deductibles are used to counteract the tendency toward overutilization. Fee-for-service arrangements under Kerr-Mills legislation need not be inflationary if the deductible mechanism is meticulously planned and executed.

Under MAA in Oregon the patient is required to assume responsibility for the first $50 of doctor services each year. After these services have been provided, the plan pays for doctor services up to the established maximums. The welfare agency and the health professions must work closely together for uniform application of this deductible requirement if MAA is to succeed in our State.

Sometime when a patient comes in, it may seem fairly obvious that the service provided will be a "deductible," because the patient has just enrolled in MAA, or because he reports that he has had little or no health service since he became an MAA beneficiary.

Nevertheless all services provided, whether part of the deductible or part of the MAA benefits, must be billed to the State public welfare commission on a vendor invoice and certificate of eligibility (form 498).

A voucher in payment of services which are properly a part of MAA benefits will be sent to the provider of service. Both doctor and patient will be promptly notified of services which are part of the "deductible."

Be sure the staff in your office understands this rule: The MAA deductible requirement is only satisfied through services that are billed to the State public welfare commission on a vendor invoice and certificate of eligibility (form 498). Prompt notice is returned to the provider of service and the patient when a charge that has been submitted is part of the deductible and is to be the personal responsibility of the patient.

IV

Steps in billing and payment

Payment in full: Chiropractic physicians or naturopathic physicians who treat patients under the MAA plan agree to accept the rates herein established as payment in full for benefits of the plan. There is no way under Federal and State law and regulation by which the patient can be indemnified for such expenditures.

(1) *Vendor invoice (form 498).*—The provider of service must bill all services to each MAA recipient on a vendor invoice and certificate of eligibility (form 498) mailed directly to the State public welfare commission. The patient may present this vendor invoice and certificate of eligibility when he comes to your office, having secured it in advance from the county public welfare department. If he does not, a telephone call or written request should be made to the county public welfare department to verify the eligibility of the patient and to secure the vendor invoice and certificate of eligibility for submission of the billing.

(2) *Payment procedures.*—The State public welfare commission will promptly handle all such billings by—

(*a*) Payment by check when the service is in keeping with the benefits defined, when the deductible requirements have been met for the case, and when maximum benefits for the current benefit year have not been exceeded.

(*b*) Notification to the doctor when the charge is one that must be the responsibility of the patient, either as a deductible or because the maximum annual benefit has been used up.

The patient will also be notified by the State public welfare commission when it is his responsibility to plan for payment of a charge not included in MAA benefits. The amount charged by the doctor to the patient for deductible items and services beyond the limits of the plan is strictly between the doctor and patient, and is not subject to the MAA fees herein outlined, although the $50 credit for deductibles will be calculated on these fees.

(*c*) Prompt notice to the doctor if for any other reason the charge must be adjusted in amount or disallowed.

(3) *Prompt billing.*—Billings will be processed strictly in the order of their receipt in the State public welfare department office. Order of receipt will determine which bills will be returned to the doctor to be collected from the patient as deductibles; which bills will be paid by the MAA fund as part of the annual benefits; and which bills will be returned to the doctor to be the responsibility of the patient because they fall beyond the maximum limits set. The doctor is urged to bill promptly and in any event must not hold bills beyond the end of the month.

V

Other health insurance

Federal regulations and Oregon State law are both very specific in requiring a full use and accounting for other health insurance benefits which may be available to the MAA beneficiary. The Oregon MAA plan has been designed to see that these other benefits are fully used to meet the cost of deductibles, to cover the cost of services beyond the maximum limits of the plan, and to reimburse MAA funds expended.

Assignments: When the beneficiary applied for MAA benefits, he agreed to assign to the provider of service any benefits which may become available to him as a result of services provided and for which payments under MAA are also being sought.

In brief the following steps are relevant when you provide services to an MAA beneficiary who also carries other medical or health insurance:

(*a*) Secure an assignment from the patient (forms are available from your county public welfare department).

(*b*) Bill as in any other MAA case. Payment will be made from MAA as in any other case.

(*c*) When payment is received under the other plan, you must make an accounting to the State public welfare commission on the form provided for that purpose, indicating:

Total amount received under other plan_____ $____
Less amount applied to meet cost of deductibles_____ *____
Less amount applied to meet cost of services beyond maximums of the plan_ *____
Balance, remitted to the State public welfare commission_____ _____

*Itemization required.

VI

Review and audit

Primary processing and payment of MAA billings is accomplished by IBM methods using a magnetic tape system for storing data and for comparing bills currently submitted with established fees, with previous charges in the case, and with the deductible and benefit limit status of the case.

A system of random sampling and spot review of cases, financial records, and accounts is planned for the MAA program. This will be done with the full cooperation of all of the providers of service and will enable the professional groups concerned to make a rational review of experience and to plan intelligently for control of utilization and improvement of quality of service. The MAA beneficiary signs a release which authorizes access to financial and case records for audit and review.

VII

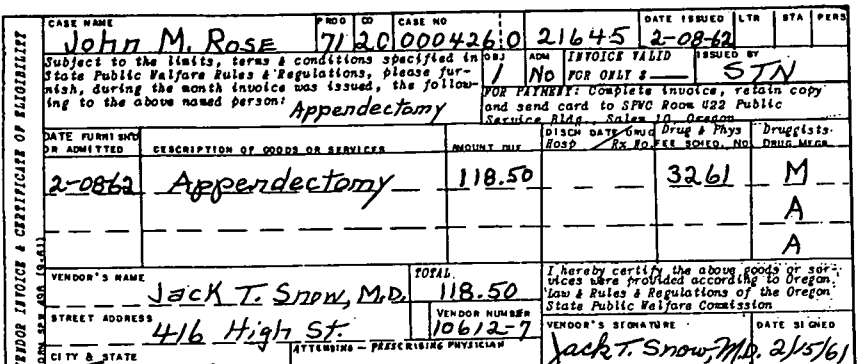
General

Communications, problems, and complaints: Contact your county public welfare department where an MAA representative will receive your inquiry and answer your problem.

In case of an emergency and you wish to contact the State welfare office, write or call Oregon State Public Welfare Commission, Division of Medical Care, State Public Service Building, Salem, Oreg., telephone: EMpire 4–2171, extension 1544.

VENDOR INVOICE (Form 498)

Properly filled out for Physicians' service.



VENDOR INVOICE & CERTIFICATE OF ELIGIBILITY

CASE NAME: John M. Rose | PROG: 71 | CO: 20 | CASE NO: 000426 0 | 21645 | DATE ISSUED: 2-08-62 | LTR | STA | PERS

Subject to the limits, terms & conditions specified in State Public Welfare Rules & Regulations, please furnish, during the month invoice was issued, the following to the above named person: Appendectomy

OBJ: 1 | ADM: No | INVOICE VALID FOR ONLY $ | ISSUED BY: STN

FOR PAYMENT: Complete invoice, retain copy and send card to SPWC Room 422 Public Service Bldg., Salem 10, Oregon

DATE FURNISHED OR ADMITTED	DESCRIPTION OF GOODS OR SERVICES	AMOUNT DUE	DISCH DATE Hosp	DRUG Rx No.	Drug & Phys FEE SCHED. NO.	Druggists DRUG MFGR.
2-08-62	Appendectomy	118.50			3261	M
						A
						A

VENDOR'S NAME: Jack T. Snow, M.D. | TOTAL: 118.50

STREET ADDRESS: 416 High St. | VENDOR NUMBER: 10612-7

CITY & STATE: Eugene - Oregon | ATTENDING — PRESCRIBING PHYSICIAN

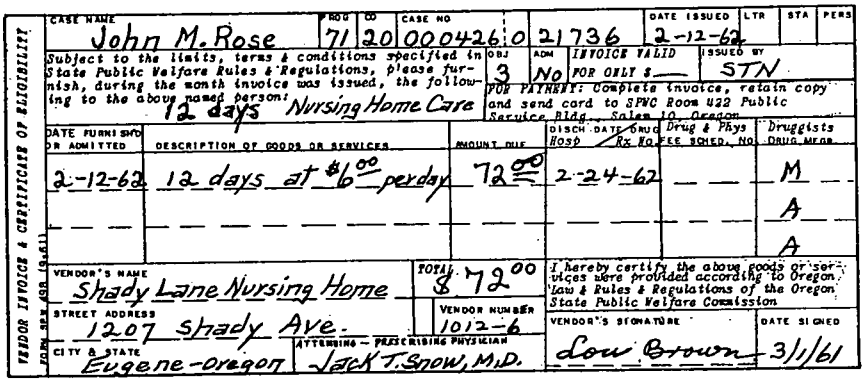
I hereby certify the above goods or services were provided according to Oregon Law & Rules & Regulations of the Oregon State Public Welfare Commission

VENDOR'S SIGNATURE: Jack T. Snow, M.D. | DATE SIGNED: 2/15/61

Note that code number and amount due correspond with listing for this item in fee schedule and billing table.

VENDOR INVOICE (Form 498)

Properly filled out for Nursing Home Care.



VENDOR INVOICE & CERTIFICATE OF ELIGIBILITY

CASE NAME: John M. Rose | PROG: 71 | CO: 20 | CASE NO: 000426 0 | 21736 | DATE ISSUED: 2-12-62 | LTR | STA | PERS

Subject to the limits, terms & conditions specified in State Public Welfare Rules & Regulations, please furnish, during the month invoice was issued, the following to the above named person: 12 days Nursing Home Care

OBJ: 3 | ADM: No | INVOICE VALID FOR ONLY $ | ISSUED BY: STN

FOR PAYMENT: Complete invoice, retain copy and send card to SPWC Room 422 Public Service Bldg., Salem 10, Oregon

DATE FURNISHED OR ADMITTED	DESCRIPTION OF GOODS OR SERVICES	AMOUNT DUE	DISCH DATE Hosp	DRUG Rx No.	Drug & Phys FEE SCHED. NO.	Druggists DRUG MFGR.
2-12-62	12 days at $6.00 per day	72.00	2-24-62			M
						A
						A

VENDOR'S NAME: Shady Lane Nursing Home | TOTAL: $72.00

STREET ADDRESS: 1207 Shady Ave. | VENDOR NUMBER: 1012-6

CITY & STATE: Eugene - Oregon | ATTENDING — PRESCRIBING PHYSICIAN: Jack T. Snow, M.D.

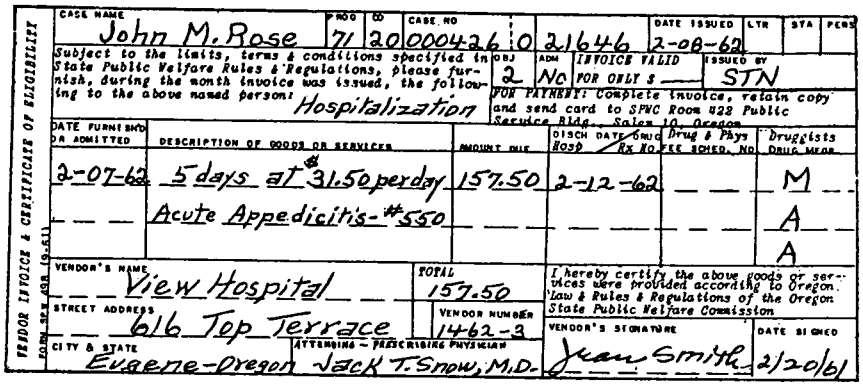
I hereby certify the above goods or services were provided according to Oregon Law & Rules & Regulations of the Oregon State Public Welfare Commission

VENDOR'S SIGNATURE: Lou Brown | DATE SIGNED: 3/1/61

Note that billing includes charge for day of admission, but not for day of discharge.

VENDOR INVOICE (Form 498)

Properly filled out for Hospitalization



VENDOR INVOICE & CERTIFICATE OF ELIGIBILITY

CASE NAME: John M. Rose | PROG: 71 | CO: 20 | CASE NO: 000426 | 0 | 21646 | DATE ISSUED: 2-08-62 | LTR | STA | PERS

Subject to the limits, terms & conditions specified in State Public Welfare Rules & Regulations, please furnish, during the month invoice was issued, the following to the above named person: Hospitalization

OBJ: 2 | ADM: No | INVOICE VALID FOR ONLY $ ____ | ISSUED BY: STN

FOR PAYMENT: Complete invoice, retain copy and send card to SPWC Room 422 Public Service Bldg. Salem 10, Oregon

DATE FURNISHED OR ADMITTED	DESCRIPTION OF GOODS OR SERVICES	AMOUNT DUE	DISCH DATE Guid Hosp	Drug & Phys Rx NO.	FEE SCHED. NO.	Druggists DRUG MEDS
2-07-62	5 days at @ 31.50 per day	157.50	2-12-62			M
	Acute Appedicitis - #560					A
						A

VENDOR'S NAME: View Hospital | TOTAL: 157.50

STREET ADDRESS: 616 Top Terrace | VENDOR NUMBER: 1462-3

CITY & STATE: Eugene-Oregon | ATTENDING - PRESCRIBING PHYSICIAN: Jack T. Snow, M.D.

I hereby certify the above goods or services were provided according to Oregon Law & Rules & Regulations of the Oregon State Public Welfare Commission

VENDOR'S SIGNATURE: Jean Smith | DATE SIGNED: 2/20/61

Note that hospital bills for the number of days times its full per diem rate. If these are the first hospital days used by this patient in current benefit year, payment will be made less the $7.50 per day deductible which is the responsibility of the patient or in an amount of 5 times $24.00.

Also note that the diagnosis has been recorded and coded in accordance with the three digit code supplied to hospitals for this purpose.

Description and Procedures for Processing Welfare Grant Recipients From Oregon Mental Institutions

(By Oregon State Board of Control, July 1961)

A. PROGRAM

The 1961 legislature provided funds in the 1961–63 biennial welfare commission budget, for the care of an average of 153 older patients who require financial assistance, to be discharged from the Oregon State mental hospitals. Such assistance will be provided under old-age assistance grants. Under this welfare program, in addition to the funds for patient care in nursing homes, foster homes, or homes for the aged, there will be provided a caseworker assigned full time to the Oregon State Hospital and the Eastern Oregon State Hospital, to assist with the evaluation of patients for welfare placement. Dammasch State Hospital and Columbia Park State Home will utilize the services of their respective county welfare offices.

Both State and Federal, as well as county funds, will be used to support this program. Such a program will provide considerable advantages to the State mental hospitals by relieving crowded conditions and providing less costly care for a large group of chronic patients who are able to receive adequate care in community placements. It is also the aim of this program, to place recipients in close proximity to relatives and friends so that visitations will be less burdensome.

The board of control estimate of the number of patients over 65 years of age at the State mental and retarded institutions is indicated in the following schedule. Approximately one-half of these are considered appropriate for community placement.

Patients in residence 65 years and over

Institution	Male	Female	Subtotals
(a) Mentally ill in State:			
Oregon State Hospital	498	656	1,154
East Oregon State Hospital	262	309	571
Dammasch	24	22	46
Columbia Park	0	95	95
Total	784	1,082	1,866
(b) Mentally retarded in State:			
Fairview Home	20	38	58
Columbia Park	56	31	87
Total	76	69	145

Because the transfer of patients from State institutions to community facilities requires the close cooperation of the board of control, the various State institutions, public welfare commission and the county welfare departments, it is important that carefully drawn policies and procedures be developed for operation of the program. It is for this purpose that the following material has been prepared.

It should be emphasized that careful and judicious preplanning be done in each individual case. This is the cornerstone of a successful program from both economic and humanitarian considerations.

There are two phases in this program. (1) The first is the mental hospitals program which will use the $471,000 specifically designated by the 1961 legislature for this purpose. This program is designated as program A in this report. (2) In addition, an attempt will also be made to move a small number of 65-year-old and older mentally retarded patients from Columbia Park State Home as well as mentally ill patients on a pilot program basis with welfare funds which would have been available to the mental hospitals for the discharge of patients based on 1959–61 caseloads. This program is designated as program B in this report.

The instruction in this procedures outline apply to both programs but a division will be made as to the statistics. Each program will be examined independently.

B. TYPE OF PATIENT TO BE DISCHARGED FROM INSTITUTIONS UNDER THIS PROGRAM

1. Patient must be 65 years of age or older.

2. Patient should carry a diagnosis which is nonpsychotic, whenever possible. Federal regulations prohibit use of Federal funds for support of a patient with a psychotic diagnosis in a facility classified as medical institution; e.g., nursing home.

3. The physical and mental conditions of the patients must be sufficient to permit placement within community facilities such as homes for the aged, nursing homes, and foster homes.

4. Patients must meet welfare requirements to receive financial assistance. The board of control collections section will supply information to either the State hospital or to the welfare agency to assist in determination of the financial resources of the patient or his responsible relatives.

C. PROCEDURE FOR REFERRAL OF PATIENTS FOR WELFARE EVALUATION

1. Processing of possible placements within institutions. The method of screening probable candidates for placement within the institutions will vary according to established procedures and lines of communication acceptable to the individual institutions. The following is the procedure which operates at the Oregon State Hospital and is indicated only as a guide.

(*a*) Obtain name of patient through participation in team planning or by referral from ward doctor.

(*b*) Obtain completed "Evaluation of patient" from charge aid and their remarks regarding patient's present behavior. (App. A.)

(*c*) Determine probable need for welfare financial assistance.

(*d*) Discuss placement with the patient and obtain his consent and willingness to sign the welfare application.

(*e*) If there are any interested relatives, acquaint them with the plan and give them an opportunity to assist with the plan or object.

2. Writing of plan letters to county welfare agency (addressed to caseworker assigned) when probable financial assistance has been determined.

Write letters to county welfare agency in duplicate, indicating the following items. The county welfare agency will use this letter as a basis for an evaluation of the patient and possibility of placement. Each institution will include the following information in its letter.

(*a*) The fact the patient states he does not have sufficient income or resources to maintain himself and would like to apply for financial assistance.

(*b*) The patient's full address before entering the hospital and the intended place of residence following release. Give length of hospital stay and length of residence in Oregon if possible, for use as proof of residence. Use commitment papers as reference and include the date of the papers (any over 5 years old are acceptable as proof of residence). Give names and addresses of interested relatives. Give social security number.

(*c*) Give admission date, statement regarding adjustment in community, family interest before hospitalization, and possible reaction upon return, any prior contacts with welfare and age.

(*d*) Give diagnosis and prognosis.

(*e*) Progress in hospital.

(*f*) Current mental and physical condition.

(*g*) Current behavior—what can the nursing home expect. Including "Evaluation of patient" completed by charge aid.

(*h*) List medications at time of discharge and followup recommendations. Check with ward aid for medications.

(*i*) Statement regarding type of facility in which the patient could probably be placed.

(*j*) Request a reply from welfare when application has been completed notifying the institution of the date and place where public assistance will be available so the institution can arrange transportation.

3. Setting up departure from institution after reply is received from welfare stating grant is available.

The institution will arrange for transportation of the patient from the institution after notice has been received from welfare stating the grant has been approved and indicating the local placement facility. It will be the county welfare office which will have the final decision with respect to the type of living arrangement for the patient in the community. The following is the procedure utilized at the Oregon State Hospital for arranging release for the patient:

(*a*) Call the supervisor's office giving them details.

(*b*) Call reception desk giving time of departure so they can obtain release slip from the patient's doctor.

(*c*) Patients are paroled to themselves with the understanding that they can be returned if they do not adjust.

4. If the patient requires medication, the staff physician prepares a medical report addressed to the community doctor who will handle patient cases. If the community doctor is not known, the welfare representative will supply his name. The objective of this procedure is to establish a physician-to-physician

relationship with regard to the medical needs and problems of the patient. This will be essential in all instances when the patient requires medical supervision. The staff physician at the institution will always be available to give consultation to community physicians regarding released patients.

D. STATUS OF PATIENT DISCHARGED FROM INSTITUTION

1. Court-committed patient—Mental hospitals:
   (*a*) Patient is released on "trial visit" (parole) status for 1 year. At the end of the year the patient is "discharged" or the "trial visit" is extended after review by an institutional physician.
   (*b*) If it is necessary for a court-committed patient to be returned to the institution, it is at the expense of the institution. The patient may be received by the institution only after a notarized affidavit has been signed and filed with the parent institution to the effect that the patient is no longer suited for the welfare placement.
   (*c*) If it is necessary to return a court-committed patient to the institution after "discharge," it can be only through court commitment or the patient signing as a voluntary admission.
2. Voluntary patient—mental hospitals:
   (*a*) A voluntary patient leaves the hospital only as "discharged."
   (*b*) If it is necessary for a voluntary patient to be returned to the institution, it can only be made by the patient signing as a voluntary admission or through court commitment.
3. Retarded patients—Columbia Park State Home:
   (*a*) Retarded patients will be handled the same as mentally ill court-committed patients; i.e., they leave the institution on "trial visit" (parole) and at the end of the year, the patient is "discharged" or the "trial visit" is extended after review by the institutional physician.
   (*b*) Return to the institution will be in the same manner as provided for court-committed mentally ill patients.
4. Responsibility permits for patients going into welfare placements are to be signed by the patients.

E. STATISTICAL SYSTEM FOR MAINTAINING PATIENT MOVEMENT STATISTICS

It is important for the board of control as well as welfare to know the status of the program and to evaluate its effectiveness. In order to accomplish this, a statistical system has been developed to provide this information.

Oregon's mental hospitals have had their patient movement and vital data recorded on punchcards for several years. It is an easy matter to incorporate in the present system, information pertaining to those individuals released through welfare placement grants.

1. Procedure: When a placement is made, the hospital social service department informs the medical records librarian of the action. She records this information on a document which is transmitted to the board of control research section. It is then punched into a release card and the card filed.

At the end of each quarter, a machine listing will be made of the outgo and return of patients under this program; a copy of this listing and report will be sent to the welfare commission. It is requested that this agency, in turn, remit to the board of control the following items each quarter:

   (*a*) Type of living unit assigned to patients released during the quarter.
   (*b*) Quarterly notification of termination of care (other than the return to the institution) or demise of all those released through the welfare program to date during the biennium.
   (*c*) An accumulative accounting of the expenditure of funds (Federal, State, county) on the welfare placement program for the biennium beginning July 1, 1961.

From this information the board of control will be able to have a measure of program effectiveness, to regulate referrals to welfare, and to determine the total number of months of patient care from the Oregon mental institutions. All the information prepared by the board of control and the welfare commission will be segregated according to the two programs, program A or program B referred to in item A of this manual.

F. SCHEDULE OF RELEASE FROM INSTITUTIONS INTO WELFARE PLACEMENTS

The board of control research section has analyzed the total number of months care provided by the legislature and has also considered the number of welfare placements which would normally be cared for under the regular welfare placement program. The following represents the number of months care available for the 1961–63 biennial period by program for patients over 65 years of age.

Program A: Number of additional months care provided by legislative act 1961–63	3,672
Program B: Normal welfare placement load, months of care	1,344
Oregon State Hospital actual experience 1960–61 projected through 1961–63, 56 placements (average during 1960–61) 2 years × 12 average months of care.	
Total	5,016

The total number of months care available by special legislative appropriation has been scheduled on a straight line projection so that an equal number of releases into welfare placements are made each month (see schedule I). The same sort of schedule has been prepared for the normal welfare placement load (see schedule II). The overall effective release rate for welfare placements has been calculated at 18.4 per month. The actual rates for each release program referred to above is 13.51 and 4.9 respectively. Included in these two amounts is the estimated return of a certain number of patients from community placements to the institution. This return rate is estimated at 6 percent of those released, based on actual experience of Oregon State Hospital during 1960. Experience indicates that most patients returned within 2 months afer placement. (See schedules below for detail of each program.) No estimate has been made of the probable number of deaths, but it is anticipated that there will be very few the first biennium.

Rates

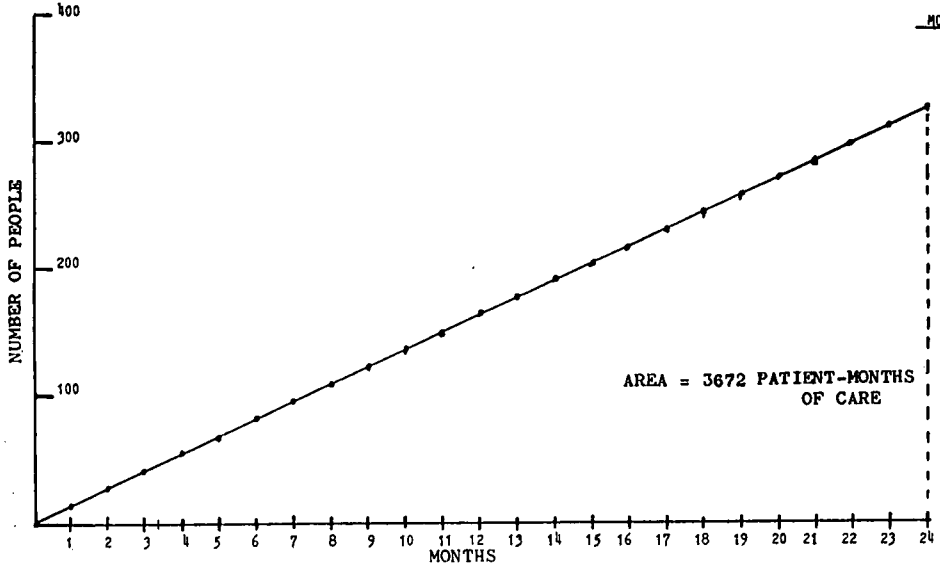
Program A:	
Basic outgo rate for special legislative program (patients per month)	12.75
Additional outgo caused by 6 percent return within 1st 2 months	.76
Total scheduled to leave the institution per month after 2 months of operation (patients per month)	13.51

The total release for the 24 months may be seen on schedule I.

SCHEDULE I

PROGRAM A

RATE OF RELEASE LINE: Y = 13.51 X



	VALUES	
MONTHS	X	PEOPLE Y
	0	0.00
	1	13.51
	2	27.02
	3	40.53
	4	54.04
	5	67.55
	6	81.06
	7	94.57
	8	108.08
	9	121.59
	10	135.10
	11	148.61
	12	162.12
	13	175.63
	14	189.14
	15	202.65
	16	216.15
	17	229.67
	18	243.18
	19	256.69
	20	270.20
	21	283.71
	22	297.22
	23	310.73
	24	324.24

FORMULA FOR RATE OF RELEASE LINE:

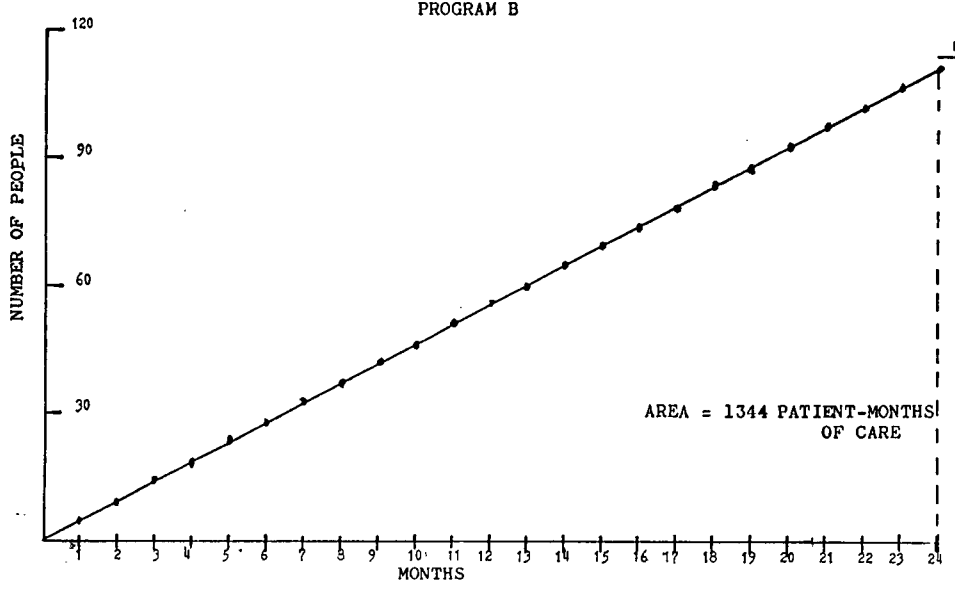
$$Y = \left[306/24 + (306/24)\ (.06)\right] X$$

PROPOSED RATE OF RELEASE FOR
OLD AGE ASSISTANCE GRANT RECIPIENTS
FROM OREGON MENTAL INSTITUTIONS
FOR JULY 1, 1961—JULY 1, 1963—
ADDITIONAL WELFARE PLACEMENT CASELOAD

SCHEDULE II

PROGRAM B

RATE OF RELEASE LINE: $Y = 4.66\dot{6}\ X$



VALUES

MONTHS X	PEOPLE Y
0	0.00
1	4.66̇
2	9.33̇
3	14.00
4	18.66̇
5	23.33̇
6	28.00
7	32.66̇
8	37.33̇
9	42.00
10	46.66̇
11	51.33̇
12	56.00
13	60.66̇
14	65.33̇
15	70.00
16	74.66̇
17	79.33̇
18	84.00
19	88.66̇
20	93.33̇
21	98.00
22	102.66̇
23	107.33̇
24	112.00

FORMULA FOR RATE OF RELEASE LINE:

$$Y = \left[\frac{(1344)\ (2)}{(24)^2}\right] X$$

PROPOSED RATE OF RELEASE FOR
OLD AGE ASSISTANCE GRANT RECIPIENTS
FROM OREGON MENTAL INSTITUTIONS
FOR JULY 1, 1961—JULY 1, 1963—
CURRENT LEVEL WELFARE PLACEMENT CASELOAD

Program B:
Basic rate for normal release rate based on 1960–61 experience 4.66
Additional outgo caused by 6-percent return in 1st 2 months ..... .27

Total (scheduled to leave institution after 2 months operation) (per month) 4.93
24-month releases may be seen on schedule B.
Combined total outgo for programs A and B (per month) 18.44

The 18.4 patients leaving the institutions per month have been scheduled as follows by institutions. Under program A, it is noted that all available patients over 65 years of age will be taken from Dammasch State Hospital. This is intended to reduce the number of beds occupied by chronic patients. This will lessen the need to transfer Dammasch patients to the other mental hospitals.

Patients released according to institution

	Rate per month	Rate per fiscal year
Program A:		
Oregon State Hospital	5	60
Dammasch State Hospital	5	60
Eastern Oregon State Hospital	4	48
Total, program A	14	168
Program B:		
Columbia Park Home:		
Mentally retarded	1	12
Mentally ill	4	48
Total, program B	5	60

Under program B it will be noted that one mentally retarded patient is scheduled for release from Columbia Park State Home per month as part of a pilot program for retarded placements. The remainder from the Columbia Park State Home will be mentally ill patients.

The board of control has requested the welfare agency to approve only the planned number of patients over 65 years of age from each institution monthly. However, if the accumulated number of patients scheduled to leave the institution has not been released at any given time, the number accepted by welfare may exceed the above monthly amounts.

In addition to the planned releases per month by institution, approximately two-thirds of the patients released should be suitable for nursing home placements and one-third for foster homes or homes for aged placements. This is necessary in order to live within the budgeted funds. The cost per type of placement varies considerably, as indicated below:

	Per month
Homes for aged (elderly, minor nursing care, ambulatory)	$101 to $115
Nursing homes (have physical and mental problems, need nursing care)	$145 to $192
Foster homes (minimum care and self-help)	$85 to $145

G. PROVISION FOR PERIODIC REVIEW OF STATUS OF PROGRAM

Because this program is new, a periodic review of the actual progress in terms of number of referrals, accountability of statistical system, procedures for referral, etc., will be required. It will also provide for an examination of the release rate and a general barometer of program progress. It is suggested this review be made quarterly, at least during the first year, and be made by welfare, board of control, and institution representatives.

APPENDIX A

EVALUATION OF PATIENTS TO BE REPORTED TO WELFARE

Name_____. Age:_____. Ward:_____.

Circle Appropriate Remark

Appearance: Well kept. Neat. Clean. Indifferent. Sloppy. Dirty.

Socialization: Is friendly. Likes people and others like him. Visits with others. Enjoys recreational privileges. Is a nuisance. Disliked by others. Stays by himself. Is surly. Strikes out at others occasionally.

Attitudes: Cooperative. Welcomes visitors. Enjoys relatives. Complains about hospital. Complains about relatives. Quarrelsome. Stubborn. Critical. Irritable. Hoards possessions.

Thought: Imaginary ideas. Thinks people cause him trouble. Suspicious. Jealous of others. Foolish talk. Grandiose.

Mood: Happy. Even disposition. Easy to get along with. Restless. Anxious, Hostile. Strikes out. Tears clothing. Destroys property.

Memory: Remembers past life. Recognizes visitors. Forgetful. Misplaces things.

Dress: Can dress self. Needs some help. Must be dressed.

Activity: Walks well. Can climb stairs. Walks with help. Needs help to get out of chair. Uses wheelchair by self. Uses wheelchair with help. Bed patient.

Eating habits: Clean. Neat. Feeds self. Must be helped. Must be persuaded. Poor. Sloppy.

Speech: Understandable. Mumbles. Overtalkative. Shouts. Verbally abusive.

Hearing or vision: Any defects.

Sleeping habits: Sleeps soundly. Wakeful but quiet. Naps during day. Sleeps poorly. Gets up and wanders at night. Noisy. Keeps others awake. Needs sedation.

Toilet behavior: Helps self. Needs help. Preoccupied with elimination. Wets self. Soils self.

Sexual behavior: No problem. Exposes self. Careless in keeping properly clothed. Masturbates.

Work habits: Has hospital job. Helps with ward duties. Likes to be busy. Works well. Lazy. Refuses to do anything. Unable to work. Too feeble to work.

Skills and hobbies: Does he have any skills or hobbies? Yes. No. If so, name them.

Medications: Does he take medicine? Yes. No. If so, what kind? Does he cooperate in taking medicine? Yes. No.

Physical health: (Refer this question to ward doctor).

Social Security: Does he receive social security? Yes. No. Unknown.

PORTLAND, OREG., *November 14, 1961.*

Senator WAYNE MORSE,
Portland, Oreg.

DEAR SENATOR: Regarding the hearing on the problems of the aged held here in Portland, Oreg., November 6th, in which I took a small part by explaining that what I had to say was not of direct concern of the committee at this time but might be in the near future. The problem which I had in mind, was that of the continual increases of taxes on the homes of the elderly retired people, as well as the unemployed and small income and no income groups.

If what is taking place in this county in regards to taxes, is any criterion of what is going on in other parts of the country, we will soon have a hoard of landless and homeless people with no place to go, except to the welfare agencies or the insane asylums. I have heard statements on every hand of where taxes on the homes of working people have this year, been increased as much as 100 percent, in my own case, which is a fair example, my taxes on my home were $54.30 in 1948–49 then were increased to $164.49, in 1960–61 and on the same identical property, were jumped to $258.65 for 1961–62. The excuse by the tax assessor for this increase was, that certain public improvements, which cost me more than $3,000, added to the value of the property and therefore more taxes had to be paid.

Another problem, which I mentioned at the hearing, is the suspension of the automobile driver's license of elderly motorists. If a motorist driving a car is involved in an accident with another car, no matter how insignificant, they are required to make a written report within 24 hours, to the department

of motor vehicles. If they have two such accidents within the space of 1 year, they are then notified that they are required to take an examination to determine their fitness to operate a motor vehicle safely. If one happens to be an elderly person, the examinations are so rigged that the slightest error on the part of the motorist is an excuse for the department to suspend, which is, as a matter of fact, complete cancellation of one's driver's license.

I am one of the victims of that department and am in close touch with several others who are likewise victims. Some of these cases have been taken to court and some have had their licenses restored while others who have taken the same procedure and received the same favorable decisions in the lower courts are now confronted with the expense of taking their cases to the State supreme court. In this situation the department has the advantage of having the services, without any expense to them, of the taxpayer-paid lawyers, while the laymen in most cases, are not in a financial position to employ counsel to carry their cases to a final conclusion and therefore must submit to the dictatorial policy of the department.

Many prominent lawyers are known to declare that the rule, or law, under which the department operates in this connection is unconstitutional.

To deprive a person of their right, apparently because of their age, to use the vehicle which has been their means of transportation for years and which interferes with their social activities and business opportunities, is demoralizing beyond description and breaks down the morale of those affected.

As a supplement to what I have stated above, the hearings, which took place on November 6th, in regard to convalescent homes and residences for the aged, only revealed part of the picture. As a matter of fact most elderly people would prefer to live the balance of their lives in their own homes, where they can pursue their regular mode of living and not be subjected to the supervision and dictation of institutional authority either private or public. I have visited some of these homes and have observed the blank and hopeless expressions on the faces of the people residing there with nothing to do or think about and just waiting for death to overtake them. It is not a pretty picture and is not the thing to be contemplated. I prefer my own home for which I have struggled long and hard to possess and I believe other people also do, but the future is not bright when I look at my tax statement and realize that my savings will soon be gone and there will be nothing left to pay taxes with, so I will be compelled to give up my home and seek shelter in a commercialized home, at the expense of some welfare agency.

It is not commercialized homes for the aged, that range in cost around $200 a month per person, that are desirable by the elderly people, it is security in their own homes which is preferred.

When it has been testified to, by proprietors of homes for the aged, that it costs at least $2 a day to house and feed an individual on a group basis, how can a person or two persons as in a case of man and wife maintain a home and pay taxes with an income, which in millions of cases is no more than $40 a month under social security.

What the elderly people want, and what they are entitled to, is an increase in social security allotments sufficient to provide for them in their own homes, a decent standard of living including ordinary medical expenses. Such a plan would do more to boost the economy of our country and restore the morale of our people, than anything else that has been suggested.

It is no commendation for a country, which is rated as the richest in the world, to have 7 million or more elderly citizens existing in poverty or on the borderline.

Respectfully,

CHAS. E. WOODWARD,
5003 SE. 44th Avenue.

PORTLAND, OREG., *November 6, 1961.*

DEAR SENATOR MORSE: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

I am George W. Ankeny of 4766 North De Pauw Street, Portland, Oreg. I was born June 21, 1878. I am an active delegate member of the United Brotherhood of Carpenters of America, Local Union No. 583, since 1917.

From my experience I believe that a good and fair medical and hospital plan could best give the greatest coverage for the most people, that needed it, through FICA or social security. I would prefer that, actually, the plan should be along

the same general plan as that of the Railroad Retirement Act. I have many reasons supporting some such plan as outlined above.

Some years ago the carpenters negotiated a health and welfare plan, and, although it is quite good for a large number of our members, still there is a goodly percentage of our members who cannot qualify by reason of the fact that they cannot get in enough hours in a required quarter to get benefit out of the plan as required. Why is it that such a large number of our members cannot qualify? The answer seems to be that age prevents them from being able to work the required number of hours in a quarter, hence no benefit. Just yesterday one of our members informed me that he did not have enough money to give him the needed hospital care that his doctor advised and this same member cannot qualify under the medicare program passed by the Congress.

At your meeting of November 6, 1961, I noted that emphasis there seemed to be in favor of the nursing homes and like institutions. That of course has its merits, still that represents but a small number of our senior citizens of our land.

As to the medicare now in effect, I cannot view that program with the respect that a good program should have.

Again, Senator, I urge you and the rest of the committee to support a plan that is patterned after the Railroad Retirement Act if possible or a plan that will give the greatest benefit to the most people. That is my belief.

Sincerely and truly,

G. W. ANKENY,
4766 North DePauw Street.

JACKSONVILLE, OREG., *November 8, 1961.*

Hon. WAYNE MORSE,
U.S. Senate, Washington, D.C.

MY DEAR MR. SENATOR: We notice that you presided at a special subcommittee hearing regards nursing homes for the aged in Portland on Monday.

We see great need for nonprofit institutions as suggested by Dr. Morton J. Goodman, statewide, and an elimination of avarice and greed, for the welfare of the oldsters. There are some hard things going on in these private institutions now, I assure you, and these conditions should be remedied as soon as possible.

Competence and mercy are the necessary factors and the urgent need. Competent management and merciful nurses, good food and time to eat it.

May the Lord bless you as you minister along these lines.

Your friend and admirer,

JAMES J. WILLIAMS,
203 G Street.

PORTLAND, OREG., *November 18, 1961.*

DEAR SENATOR MORSE: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

It was our privilege and pleasure to be present, and to appreciate your talk on the aging while in Portland, Oreg. We are grateful for the splendid contributions you have made to our country and State. It makes us very hopeful for the future, particularly for Oregon's State welfare problems.

Before completing your findings on the care of the aged we hope you will visit Portland again, at which time, we cordially invite you to visit our home: Mount St. Joseph's Residence (home for the aged and nursing home), 3060 Southeast Stark Street, Portland, Oreg. We promise you it will be time well spent. Our residents ranging in age from 60 to 98 years, most of whom are well spirited and alert will be grateful for your visit to come and see how things have changed for them during their later years.

Mount St. Joseph's Residence, conducted by the Sisters of Mercy, was established in 1897. Many thousands of sick and dying spent their last years therein, previous to the time of welfare aid or any assistance, when the support of the poor and helpless was made up only by voluntary charity and the personal endeavors of the sisters. The advancement of medical care and the needed facilities for the increasing number of both men and women requiring accommodations, made building replacements urgent and necessary to protect the aged from fire hazards.

We now have a home—newly erected in 1960—which is worthy of a special visit. This was financed on borrowed money in the sum of $850,000 plus Hill-

Burton grant in the amount of $235,000. Many people have told us they have found nothing like it in New York or elsewhere. The new modern nursing home accommodates 120 patients. The rooms are double or single with high-low hospital beds. Baths are private or general, shower or tub—with wheelchair facilities to showers, and hydraulic Hoyer lifts to tubs or showers for the patients who are totally incapacitated. A solarium on each floor affords patients many comforts, with a beautiful view in the sunshine where they can enjoy the company of others.

There is a physical therapy department with the basic equipment for rehabilitation: walkers, parallel and trapeze bars, exercise wheels, and so forth; also hydrotherapy department with whirlpool and therapeutic shower baths, and so forth. An occupational therapy department in crafts and weaving is another helpful addition where guests spend several hours each week with gratifying results. The barber and beauty shops are splendid factors much to the satisfaction of ambulatory as well as bed patients. The dietary department supplies special diets and we have "Diet-Liners" to carry the patients' foods, hot, refrigerated or frozen, and with facilities to make hot toast right at the patient's door.

Apart from the nursing home, but joined thereto, we have a residential home for the retired elderly, men and women, single or couples, over 60 years of age, accommodating 106 guests. An excellent dining room is provided for all ambulatory residents. We have excellent recreational features for all, well or ill. Movies, entertainments, musical, social functions and a birthday dinner every month for all who have a birthday within the month, with a special card room for the men, alley ball machines, and so forth.

Everyone partakes of the services and facilities enumerated, regardless of all varied rates paid, private or welfare, also regardless of race, color, or creed.

Our chief problem is: 1. Many welfare patients, whom we have always with us, on welfare rates ranging from $101 to $192, allows an overall average rate of only $144 per month. No well standardized home for the aged or nursing home can meet the cost of operation on this rate. In view of this overall average maximum rate ($144) allowed by State welfare, we find that of 48 patients, 24 receive full nursing or ambulatory rate care from State welfare funds—the remaining 24 supplement their own cost of care either by social security checks or parent-responsibility contributions. Consequently from State welfare funds only $104.25 is actually being paid as an average rate applicable to 48 guests, 28 of whom require heavy nursing care, but paid on a rate which actually does not pay the per capita day cost of even an ambulatory guest.

Our suggestion is:

1. That the State welfare allocate a maximum rate for nursing and ambulatory patient care, and permit whatever social security or parent-responsibility checks now being credited to the welfare fund be granted to the homes giving the care at costs greater than welfare renumeration. Families be permitted to place their dependent ones in homes of their choice or particular needs and supplement what they could afford above welfare fund allocation. This would increase the rate to at least what welfare sets as the average maximum: $144.

2. That the State welfare provide for medicines and tranquilizers prescribed by the physician for mentally disturbed and confused patients, which, at present, it is claimed welfare is unable to do. In this way many nursing homes could adequately care for these patients from State institutions but who do require psychopathic medicines and nursing care.

3. Revise the State welfare point system to cover the cost of physical or hydrotherapy treatments for the rehabilitation of many needy cases.

Recognize the additional need for shaves, haircuts, ladies' shampoos and hair styling, which are necessary morale builders for the patient, but very costly for the homes trying to budget this facility—having to engage a licensed operator to give these services on the overall average welfare rate: $104.25.

It has been the policy at Mount St. Joseph's Home to care for as many welfare patients as possible according to demand, which is usually between 50 and 60. At the present date there are 48 guests due to temporary building plans.

Thanking you for your splendid services rendered and begging God's blessing on all your endeavors for the aged and chronically ill, we remain

Gratefully yours,

SISTERS OR MERCY,
By: SISTER MARY STANISLAUS, *R.S.M. Superior.*

SACRED HEART GENERAL HOSPITAL,
Eugene, Oreg., November 15, 1961.

Hon. WAYNE MORSE,
Special Committee on Aging, U.S. Senate, Washington, D.C.

DEAR SENATOR MORSE: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

You are to be congratulated for your efforts on behalf of our senior citizens. These many hearings must present an arduous task for you and your committee, and yet they also must be invaluable to you in your decisions.

As a member of the administrative staff of Eugene's Sacred Heart General Hospital, we have been vitally interested in providing the needs of the aging who are unfortunate enough to be sick and infirm. The stroke rehabilitation program is conducted here and only one part of what we hope will be a broad program.

As you listened to senior citizens' testimony you could only be impressed that not one stated they were not able to get medical care, or in any way denied medical attention. These people are being taken care of not only here in Eugene but in entire Oregon. They are not paying for their care, they have no means, nor sufficient income.

This situation places a tremendous financial burden upon the hospital. A hospital whose only income is from its patients, can only look to the paying patient for help. Is it fair to place the burden upon those already unfortunate to be "down" and now out of work? Hospitals don't think so. However, we are placed in this position, and if we are to continue to maintain the hospital we must recover our expense.

As a nonprofit hospital our billing reflects only the cost of providing the care. We appreciate that hospitalization is expensive, but only because it is expensive to provide. At the present time it costs us $34.11 to maintain one patient per day. However, this is for all services and if you divide by 24 hours care you will find that all services in a modern fully accredited hospital costs just over $1.50 an hour.

The Kerr-Mills bill, we feel, is a step in the right direction, but it is far from providing our hospital needs. There are many Lane County indigents who are brought to our door, and yet we receive no help from Lane County unless it is a welfare recipient, and then the bill is prorated to a very minimum budget. Hospitals are put in the position of subsidizing the State, although no other supplier is forced to take a 30 percent or more discount on their service or equipment. Most suppliers of course are on a profit basis, while hospitals have no margin for profit.

The attached contains some interesting statistics about our hospital and about the financial loss imposed upon us in caring for Lane County indigents. We sincerely hope these facts will assist you.

It was a pleasure to witness your Eugene hearing, and the enthusiastic and courteous manner in which you conducted the meeting.

RAY L. CAVAGNARO,
751 East 12th Avenue.

Here are some facts about Sacred Heart's 1960 service to the community that we feel may be of interest.

There were 13,182 patients admitted to the hospital; this is an alltime high and exceeds the 1959 total by 332 patients.

In addition, 2,390 babies were born at Sacred Heart in 1960. This total was exceeded only in 1954 and 1955.

The emergency room cared for 8,683 patients. This is a decrease of 343 patients from the previous year.

Of the patients admitted, 5,810 underwent surgery.

The average patient remains only 5.3 days. However, in the age group over 65, the average patient stays 8.9 days.

It took 496 employees to maintain the hospital. The payroll for 1960 was just over $1,500,000.

The total operating expense to provide the community with a modern fully accredited hospital was $2,172,233. This was an increase of $192,958 from the previous year.

Application for free, charity care by those who had no income or no means of payment and were not eligible for county welfare assistance totaled $36,907.

In addition, and not included in the free care figure, $41,186 of care was provided county welfare recipients for which the hospital was not reimbursed. This is due to the medical budget limitation of the welfare program. Hospitals in Lane County have only been reimbursed on an average of 70 percent of their costs for county patients.

This totals then. $78,093 in hospital care for those totally unable to reimburse the hospital for care. (This figure does not include bad debts.)

In 1961, the Sisters of St. Joseph will celebrate their 25th year of service to the community at Sacred Heart.

○