FUTURE DIRECTIONS IN SOCIAL SECURITY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-FOURTH CONGRESS

FIRST SESSION

PART 20—PORTLAND, OREG.
Impact of High Cost of Living

NOVEMBER 24, 1975

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FUTURE DIRECTIONS IN SOCIAL SECURITY

MONDAY, NOVEMBER 24, 1975

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Portland, Oreg.

The committee met, pursuant to notice, at 1:45 p.m., in the BPA Auditorium, 1002 Northeast Holladay, Portland, Oreg., Hon. Frank Church, chairman, presiding.

Present: Senator Church.

Also present: William E. Oriol, staff director; Deborah K. Kilmer, professional staff member; Mike Wetherell, administrative assistant to Senator Church; John Guy Miller, minority staff director; and Patricia G. Oriol, chief clerk.

OPENING STATEMENT BY SENATOR FRANK CHURCH, CHAIRMAN

Senator CHURCH. The hearing will please come to order.

I am Frank Church, chairman of the Senate Special Committee on Aging, and I am glad to be in Portland.

I know that Portland has its share of problems that relate to the aged. It also seems to have an impressive number of people who are concerned with those problems.

When I first announced these cost-of-living hearings, I said our major goal was to hear from people who can tell it like it is.

For that reason we will hear from a large number of persons, many of them elderly, each with a point to make about the terrible economic bind in which more and more older Americans find themselves every day.

All have agreed to stay within 5 minutes. And in honor of that goal, so will I.

Today's testimony will continue a series begun in Washington, D.C., on "Future Directions in Social Security." We have dealt with what they like to call the "big-picture" issues in Washington, such matters as immediate and long-range financing issues related to the entire old-age benefit system, the treatment of women under social security, problems with making the supplemental security income, or SSI, program work, and so on. And there are many other issues, as you know.

But the big picture has meaning only if it is related to what is actually happening to people.

And let me tell you, I am very much worried about what is happening to many older people of this country.

I hear of retirees who cannot buy prescription drugs because their utility bills have gone up so much there is no money left for medicine.

I hear of people who have to choose between adequate food and paying the rent.

I hear of people who cannot find transportation that they can afford—and so they postpone or even cancel necessary trips, some necessary even for their own health.

There are things that can be done to increase retirement income, or to make it stretch further.

Automatic Cost-of-Living Adjustment

I have a bill that has been introduced to improve the cost-of-living adjustment mechanism that was originally an amendment of mine in 1972, which made it possible for automatic cost-of-living adjustments on an annual basis to reflect increases in the cost of living. I had hopes when that amendment was passed, it would make the entire social security system inflation proof, but at that time we did not anticipate two-digit inflation. And so this bill that I introduced recently would make the adjustment come more quickly, so that retirees would not have to wait a full 12-year—a full 12-month period. It must seem like 12 years before the adjustment occurs.

As you know, we did successfully in the Congress, in view of the fact we made a pledge to at least keep the adjustments and benefits in line with the increased living costs, we did make a successful fight in 1975 to obtain the 8 percent, which generally reflected the cost-of-living index rather than the 5-percent limit the President recommended.

I am glad we won that fight in the Congress.

Medicare had great promise when we voted for it 10 years ago. And it is still an extraordinarily valuable program for elderly people, there is no question about that.

But it is nevertheless true, if you examine the trends over that 10-year period, that medicare participants are paying more and more for less and less.

The trend has been wrong within the program and one of the questions we face is: How do we reverse that trend?

When do we make medicare a real program to maintain health, and to keep people out of hospitals and nursing homes, rather than one which leans so heavily toward institutionalizing people before they get the benefits of the program? And that is a very costly way to go, as you know, because of the high cost of hospitalization today, and for many people, who can stay home, if they had an opportunity through a more flexible program to receive the help they needed at home, they would be much happier, and that help could be extended at a lesser cost.

But there are other facets to the problem as well. There is transportation, and that is a long, long way from being solved.

There is inadequate housing for the elderly, which I am sure we are going to discuss during the course of these hearings.

There are other matters that I need not take your time to cover in this opening statement because I promised you when I commenced this that I would only speak for 5 minutes since I am asking everybody else to restrict their testimony to 5 minutes. I notice from my watch that I do not have time to finish my statement. But you know what I am here for, I am here to listen to you.

Senator Bob Packwood is unable to be with us today. He has presented a statement for the record which will be inserted at this point.

STATEMENT BY SENATOR BOB PACKWOOD

Senator PACKWOOD. Mr. Chairman, without an immediate massive overhaul of our social security programs we are going to saddle future generations with a crushing financial burden.

Our social security system is in danger of going broke. Beginning this year, payments for social security checks are greater than revenues from social security taxes which people pay. In the initial years of the program, the money coming into the program from taxes was always sufficient to cover the money going out to recipients in the form of social security checks.

Through the years since social security was enacted in 1935, there have been many changes to improve the protection it gives to workers and their families. In the 40 years of the program's existence, Congress has extended social security benefits to more and more deserving groups, and rightly so.

Now, however, we are faced with the problem of a possible bankrupt social security system. The question is: How is the Social Security Administration going to meet their long-term obligations? We have begun to eat into the trust funds which used to support the system. In 25 years, we will have exhausted the trust funds. By then, when the baby boom of the late forties and early fifties will be reaching the age of retirement, the number of people retired will have risen sharply relative to the working age population. At that point, the financial burden of social security taxes on people still working will become excessive. People will question why they should support retirees when there may not be any money for their own retirement. Congress cannot allow this situation to occur.

LONG-TERM FINANCING NEEDED

Mr. Chairman, Congress must begin the task of finding a stable long-term system for financing social security. We have gone beyond the stage of "evaluating" and "expressing shock and dismay." We must begin to undertake and enact meaningful reforms. I am hopeful that the 94th Congress will begin legislative work on these needed reforms during the second session.

Problems with social security financing are not just a matter of transferring Government funds from one account to another; they are deeper and much more complex than that. We must protect the rights and hopes of individuals by guaranteeing that the Social Security Administration can meet payments. We will only eliminate the insecurity of millions of Americans who rely on social security benefits by stabilizing the social security financing structure. The longer we wait, the more widespread the personal insecurity and the more complicated the financial problems become. With quick action and positive reform, we can maintain the credibility of the social security system to insure our grandchildren and great-grandchildren a financially secure retirement.

Senator CHURCH. Now let me call upon the first panel. I see that they are already in place, the panel of the city and county people, Mr. Charles Jordan, commissioner of public safety, Portland, and Mr. Donald E. Clark, chairman of the Multnomah Board of Commis-

sioners. I would like to welcome both of you gentlemen to the hearing this afternoon, and I would invite you to proceed as you wish.

But before you do so, I would like to apologize for the change in the time schedule. That was unavoidable. I know some of you who first thought the hearing would be at 10 o'clock this morning came early and have stayed a long, long time. I am very sorry for that. It was one of those unavoidable changes we had to make at the last minute, and I apologize to anyone who has been inconvenienced by it.

All right, gentlemen, you may proceed.

STATEMENT OF CHARLES JORDAN, COMMISSIONER OF PUBLIC SAFETY, PORTLAND, OREG.

Commissioner JORDAN. Senator Church, I am pleased to have the opportunity to welcome you and your panel to the City of Roses.

I have been a long-time admirer of your willingness to provide a forum for the elderly, and your visit to our city will provide our senior citizens with the visibility they need to be seen and heard.

There are some 97,000 elderly in this county with roughly 75,000 of them living in the city itself.

Of that 97,000, 15 percent are below the Federal poverty level and over 30,000 elderly have an income of less than $200 per month.

According to the 1970 census the average income for males over 75 is $3,449 per year and for females $2,947. Statistics show as age increases, incomes go down.

In Multnomah County 38 percent of the elderly poor live alone, in comparison to 20 percent nationally. Living alone and in isolation is unfortunately what many of us must look forward to.

In short, the poor are getting older and the old are getting poorer.

No single group is hit harder by severe inflation than the fixed income elderly.

COSTS OUTSTRIPPING INCOME

When the rate of inflation hit 11.9 percent in 1975 and the social security increases amounted to only 8 percent, 80,000 elderly in this county lost purchasing power.

The Consumer Price Index for Portland between 1960–74 rose 40 percent with major areas of expense for the elderly rising faster than that rate.

Currently, medical costs for the elderly average 3½ times greater than for the general population.

Housing rental costs for the elderly not in public housing run far in excess of the 25 percent national standard established for those under the Brooke amendment.

Visit a supermarket, watch the bakery counter, it is indeed a sad comment on our country that the elderly must think twice before they buy a loaf of day-old bread.

What are the city of Portland and Multnomah County doing to provide services to the elderly, and how is our partnership with the Federal Government under the revenue-sharing concept of title III of the Older Americans Act contributing to our programs?

In fiscal year 1973–74 Multnomah County received roughly $1 million in Federal assistance to provide information and referral and necessary support services through neighborhood senior centers.

These dollars came through model cities, OEO, Project Able, and other categorical sources.

Today, under title III of the Older Americans Act, we receive less than $240,000, a cut of 75 percent.

To remedy this situation and in an attempt to continue necessary services, the city and the county have equally increased their share of local tax dollars from $60,000 in 1973 to $611,000 this fiscal year.

In fiscal year 1973–74 we received approximately $170,000 from the National Council on Aging for an employment project for the elderly.

As a model, it was one of the first programs in the Nation to employ the elderly to help the elderly. Because of the success of this program, our local decision was to expand it under CETA to a budget of $650,000.

Because of our local commitment, the National Council on Aging has cut their participation to $40,000. Under new State building codes modeled after previously endorsed HUD standards, Portland is in jeopardy of losing hundreds of low-income housing units currently occupied by our senior citizens.

Replacement housing at low-income prices is simply not available and Federal resources under the Housing and Community Development Act cannot be used for rent supplements. While the local housing authority has 308 rent certificates under section 8 of the Housing and Community Development Act, they have a waiting list of 2,500 elderly to deal with.

Additional Help Needed

In short, Senator, what I am saying is that we need help. The Federal Government can assist us in many ways to provide the needed services.

The commitment to serve the elderly is here in Portland, yet with the resources we have, we can now only serve a mere 10 percent of those who are in need.

Funding for both title III and title VII of the Older Americans Act should be increased. Social security payments for the elderly should be geared to increases in the Consumer Price Index rather than arbitrarily set at the expense of the elderly.

Medicare and medicaid should be reviewed and ultimately merged with a national health insurance program.

The Department of Transportation should increase subsidies to local transit districts through UMPTA to provide a higher level of paratransit for the mobility limited elderly.

The belt of local government is tightened to its last notch and the belts of the elderly are even tighter.

Our senior citizens deserve a better way, and they deserve it now.

Thank you.

[Applause.]

Senator Church. Commissioner, thank you for your statement.

I would like to know a little bit more about this housing problem that you mentioned.

Do I understand that housing that is now available may have to be closed because of ——

Commissioner JORDAN. Code violations.

Senator CHURCH. Code violations?

Commissioner JORDAN. Yes.

Senator CHURCH. And is that a local code problem?

Commissioner JORDAN. No, this is a State code.

We have a chapter 13. Sometime ago the city of Portland had established, if I can recall, in early October; this was in early October when we were initially going to enforce the code but the State was going to enforce theirs in January 1976, so we decided to extend ours in hope that that would give us enough time to try to work with the property owners to bring the buildings up to code because we were really faced with a dilemma.

We had one major catastrophe here in Portland but the dilemma we were faced with was, if we decided to move in on those properties and closed them, we would have the people out on the street and there is no place to send them; but January is the deadline, and I think the city will be forced to move on those properties right now.

We do have a special committee working with the property owners, trying to encourage them to bring their buildings up to code.

We do have a contingency plan just in case they do not bring them up to code, to relocate the people.

We are now here near the solution. January as you know is right around the corner, and I think we are going to be faced with a real dilemma as to what we are going to do if they do not bring them up to code.

LITTLE HELP RECEIVED FROM HUD

Senator CHURCH. And in this connection, you no doubt have been in touch with HUD (Department of Housing and Urban Development), the Federal agency, and have you found that to have been of any help at all?

Commissioner JORDAN. Senator, we have been in contact with almost everyone we possibly can.

There has been very little assistance from HUD, because of the guidelines under section VIII.

Right now we do not know where to turn, but to the local level, and we are trying as much as we possibly can to get local dollars involved, but they are just not here now.

Senator CHURCH. I find again and again that the rigidities in the standards that are set up under Federal programs so often do not meet local situations.

Commissioner JORDAN. What we discovered was that the purpose of revenue sharing was to increase flexibility on the local level, but we discovered that with all the regulations, the red tape, it is hard to get through all the maze.

We do not have the flexibility we had anticipated on the local level.

Senator CHURCH. I think if we could obtain that flexibility, and give local people a larger amount of the decisionmaking, so that they

can face the problems in their own communities, that they know most about and are best able to deal with, we might begin to make some of these programs work.

Commissioner JORDAN. It would help considerably if local government were involved in the planning stage of the regulation, and part of it coming out from Capitol Hill.

This is where we have the difficulty. If we could be involved in the planning and development of those policies, I think we could come up with some policies that are realistic, and which would speak to the needs of certain cities.

Senator CHURCH. Well, thank you very much.

Commissioner JORDAN. Thank you.

Senator CHURCH. Mr. Donald E. Clark, chairman, Multnomah Board of County Commissioners.

Mr. Clark, you may proceed.

STATEMENT OF DONALD E. CLARK, CHAIRMAN, MULTNOMAH BOARD OF COUNTY COMMISSIONERS

Mr. CLARK. I think that it is very appropriate that you are in Portland.

I welcome you as Charles did. I think that Multnomah County would like to talk about health. You have already mentioned health.

Charles mentioned the accelerated inflation in the health care area, even greater than that experienced in the economy as a whole.

Multnomah County has something called Project Health. We think you ought to hear about it.

In 1971 the county adopted a policy regarding health care, and it is made up of several different facets, the first being that health care is a right; the second that we need a positive health care concept, one that treats maladies early rather than late, and that is the most cost-effective way, and wherever possible, to prevent before the person becomes sick.

The third facet is that any health care ought to be comprehensive.

There should not be a whole lot of excludables, it should not be just to treat some exotic kind of ailment that nobody ever gets in this part of the world.

The fourth, that it should be responsible, particularly it should be debated and discussed in public, it should be accountable to the people, and oftentimes health care programs, particularly government ones that are federally run, are very difficult for the Government to get any feedback on, and if it is locally controlled, the people know how to get to the city hall or to the county courthouse.

MAIN CONCEPTS OF "PROJECT HEALTH"

Project Health has several main concepts, the first being that people ought to be treated in the mainstream, I mean the same system that you and I use, that we should not establish the separate facilities for the poor, we should not isolate the poor.

There is inherent dignity about being treated along with everyone else.

The second facet is that we ought to be able to insure the quality of care, and Project Health was the medical society's first customer for PSRO, and we do have a peer review to insure quality of care.

We should also insure access to care, and Multnomah County has access to clinics, and has public health nurses with long experience in identifying people with health needs, and insuring that they get into the system.

We should also insure there is proper utilization of health care facilities, and we do have a program to see that people are not getting needless lab tests, to run up costs, and I will speak more about that later, and that people are not abusing the system.

We also have a system to insure costs containment, which is a particularly important and vital issue to this effort of yours.

Project Health has received recognition by the National Association of Counties which gave it a special award.

The State legislature voted to have a medicaid demonstration project, being in partnership with Multnomah County to apply to HEW for funds.

HEW now is looking at Project Health as a possible model for how national health insurance should be administered, and Georgetown University National Institute on Public Health Policy has zeroed in on Project Health as one of the first two of the programs to be described nationally for people to emulate.

What are the major aspects of Project Health?

The first idea is a pooling of reimbursement, a gathering together of public moneys, using county dollars, State dollars, and Federal dollars, and particularly Federal dollars from a whole variety of places, and it is amazing the number of people that are pumping dollars out for health care, and I would speculate that there are more than enough dollars available, if they could just be brought together in one pool, and spent differently.

Multnomah County then has set up in Project Health a broker organization that attempts to take these dollars and put them together with people with needs, and get them into the mainstream for health care delivery for services.

Multnomah County uses existing county and community agencies.

We have not set up a whole new series of bureaucracies to deal with these, and we certainly have built no new institutions to deal with them.

We think that, and Project Health is an example, that these programs ought to be noncategorical.

We had to pool Federal and local health dollars, and we would hope that eventually Multnomah County would control the expenditure of medicare as well as the medicaid funds, and we are convinced we could get more for the dollar if we could do that, and be able to use our system to get people into the health facilities of this community.

And, fifth, Project Health is offering comprehensive health care.

In Multnomah County, 41,000 people are medically indigent and 12 percent, or 5,000, are 60 years of age or older.

Next year half of Project Health will provide prepaid comprehensive health service to 2,000 low-income elderly.

Health Plans for Elderly

Elderly covered by prepaid plans, such as Blue Cross, OPS, Cascade Health, Kaiser, and other community health care providers, that provide a broad range of coverage, and as you well know, these kinds of services traditionally have not been available to the elderly citizen.

Multnomah County is also exploring what it can do to be the instigator of a geriatric center, and you may hear more about that. I will not go into that at this time.

In summary, Project Health attempts to gather together dollars, dollars already being spent for health, putting together in a pool, putting those dollars together with citizens who have needs, and getting them into the mainstream of health care delivery in comprehensive health care packages from existing provider organizations.

We think that this is locally responsible, and if you will allow me, I want to close with a quote from somebody I saw in this room, and asked if I could use the quote, and I have been assured that they do not mind, although I do not believe the person will identify himself later, it is from a citizen who fits the category previously described of being over 60 years of age, and this is a quote from this person in a letter* recently sent to me:

> If it were not for Project Health Care Delivery System, I would be a hopeless invalid and on welfare today, instead of being able to work 40 hours a week and be self-sustaining.

That is the proof of the pudding. [Applause.]

Senator Church. Thank you very much.

I must say you deserve a lot of credit for this kind of initiative, and it shows what can be done at the county level.

Just to make sure that I understand how this system works, when you pool such moneys as you can together, do you then apply that money to fill the gaps that are left uncovered by medicare or medicaid?

Just how do you go about using that money to achieve your goal of comprehensive health care, for those who are within the project?

Mr. Clark. First, Multnomah County used to run a hospital, and we were running a deficit of $4.2 million a year

We got the State to take over that hospital as a portion of its teaching facility on Markham Hill.

We took that $4.2 million and put that into the pot.

We have since then identified other county moneys that were categorical kinds of money, and put those into the pot.

In addition, we have picked up an old OEO grant, recently administered by HEW, that was given through Model Cities, it used to be $1.5 million, if I am not mistaken, which is now about $800,000, and that comes to the county.

We are in the final stage of application with SRS and HEW, for waivers to the medicaid program.

There is no medicaid program in Oregon except for welfare eligibles.

State-County Coordination

This last session of the legislature agreed to be in partnership with Multnomah County to put up $1.5 million State dollars in order

*See appendix, item 3, p. 1829.

for Multnomah County to match that with over $2 million, to apply for $5 million in Federal medicaid dollars, for a 2-year program.

We hoped to get that going in January, and that would provide up to 115 percent of welfare eligibility, for full comprehensive health care, to get these people into something like Kaiser.

In addition, we are picking up people in medicare who have exhausted their benefits.

We are also exploring how we can supplement in certain cases, and are on an experimental basis, where there are excludables under medicare, and in our programs, you mentioned pharmaceuticals and home health care, both of those are benefits under Project Health.

We are convinced if we were able to first of all identify all of the dollars being spent in the public sector, and get those together in one place on the table, and then identify the folks out there that need this care, that the number of folks divided into those dollars is more than enough dollars to provide a full comprehensive health care package, but we are not spending them that way, and I think it is no news to anybody that this country spends more money than any other country in the world, both in raw dollars and the percent of national wealth for health care, but we are not getting the health care back that we need to get back.

Senator CHURCH. There is no question about it; and for those who cannot pay the high cost of health care, they are getting some of the poorest health care in the world, and that is the travesty for one of the richest countries in the world.

Mr. CLARK. It certainly is. I agree.

Senator CHURCH. Well, this effort you have made in this county really interests me very much, and I am happy to learn more about it. I would certainly appreciate receiving any further information you may have on this health plan.*

I think it could be a kind of model for many, many other counties in the country, and perhaps we can get a movement going in this direction.

Mr. CLARK. Senator Church, you do not know what you are letting yourself in for, because we are very evangelical about this.

Senator CHURCH. If you will help, I certainly will help.

Well, thank you very much, both of you gentlemen, Commissioner Jordan and Mr. Clark, for very, very helpful testimony.

[The prepared statement of Donald E. Clark follows:]

PREPARED STATEMENT OF DONALD E. CLARK

Mr. Chairman, members of the subcommittee, I am Don Clark, chairman of the Multnomah County Board of County Commissioners, and I appreciate this opportunity to tell you about a unique program we have in Multnomah County called Project Health.

It is especially timely that I am speaking to you today because the impact on the elderly of the rising cost of living and the future of government programs are topics of particular relevance to the health care field. And, what we are doing in Multnomah County—building a health care delivery system to provide "mainstream" health care to the County's low-income and elderly residents, while at the same time demonstrating methods of cost containment in the management of health care funds—is especially relevant to the topic of these hearings.

Let me begin by briefly telling you what the public policy is in Multnomah County.

*See appendix item 2, p. 1830.

The Board of County Commissioners in December, 1971 adopted a policy which designated health as the number one priority of the county. The 1971 policy statement had five major points:

Health Care as a Right.—Public policy in Multnomah County is that health care is a right of all people in a society, and is not dependent on social, financial, age, or other categorical delineations.

A Positive Health Concept.—Low-income residents have a right to health care in existing community health institutions. They have a right to health maintenance in the mainstream, rather than being treated in separate county facilities which offer separate services for the poor only when they are sick.

A Comprehensive Health Concept.—Access to comprehensive services in the mainstream can result when existing funds are pooled, rather than categorized, to serve whole people, rather than select ailments or particular groups.

A Responsible Health Concept.—Health is a matter of community well being, the assurance of which is the role of local government.

An Accountable Health Concept.—Access to health care is a matter of public concern and must be determined and debated in an open forum. Local government must accept the responsibility for formulating and implementing local health policy in such a way that it is socially responsible, fiscally accountable, and publicly acceptable.

Thus, Multnomah County has established a philosophy, a public policy, a foundation for the establishment of a "health care delivery system." This program seeks to "pool" Federal, State, and local funds under a local government administrative unit which will channel low-income County residents into mainstream health care facilities to insure quality of care; to insure access to care; to insure proper utilization of health care services; and to insure cost containment.

In the beginning of my remarks, I said that "project health" is unique. Let me tell you briefly exactly how it is so; what specific innovative and exciting departures this program makes, and what we hope to test and demonstrate as a possible model for national health insurance.

But let me first add that we are not the only ones who feel this program is "unique." The National Association of Counties has cited our project with a New County Achievement Award. The State of Oregon has appropriated $1.5 million to be matched with county and Federal funds to finance a "medicaid demonstration project." The Committee on National Health Insurance and the Department of Health, Education, and Welfare are looking towards our program as a model for national health financing.

So, what we have here in Multnomah County is a health care delivery system that provides health care services for the poor through existing community institutions. It is a system which does not build separate facilities for the poor; it does not create financial, physical, or social barriers for access to health services; it does not categorize people or services; and it does not promote the costly, inefficient use of scarce health and government resources.

Project health has existed now for 3 years and has been operating on a hospital inpatient basis since May of 1974. We currently have contracts with 10 community hospitals and are serving approximately 50 county residents per day on a hospital inpatient basis.

The major issues in health care delivery and financing seem to center around the question of health resource allocation, especially cost control and client access to health care. Our experiences indicate that the relationship between mechanisms for reimbursing health care providers and client access and utilization of health services are a key concern.

The major innovative aspects of Project Health which address these issues are:

POOLING REIMBURSEMENT

Pooling reimbursement is a mechanism for cost control. A prenegotiated rate is credited to a "pool" every time an authorization for service is given by the county. At the end of the month, health care providers bill the county their normal and customary fee. At the end of the month, the county adds up the amount credited to the pool. The percent of the total amount credited to the pool, to the actual amount of billed charges is computed. That percentage is paid on each individual bill.

This method in a fee-for-service system puts risk assumption on the part of the provider. It thus provides cost incentives to the provider to see that services

rendered are in fact medically necessary, and also instills peer group pressure among providers participating in the pool. It has potential for advancing knowledge in the areas of provider reimbursement, provider incentive for cost containment, and thus allocation of health resources.

THE BROKER ORGANIZATION

The management unit for project health is a broker organization, whose function is to pool Federal, State, and local funds to buy health care for the county's medically indigent. The county, then, does not propose to provide health services directly, but to broker with the private health sector to provide needed services.

The key point here is the use of a local government administrative unit to manage Federal, State, and local funds to provide mainstream health care. The implications of this broker function include the interjection of a local government unit into a private market place economy and the potential for change in that sector by providing incentives for price competition among providers.

USE OF EXISTING COMMUNITY AND COUNTY AGENCIES

By brokering with existing community agencies, the county is not only providing mainstream care but is buying existing services for people, rather than constructing new buildings and institutions. Additionally, the county will utilize the existing county health clinics and community health nursing staff to facilitate access to services and provide followup for clients. By providing funds for health care, the county can alleviate one barrier to health care. However, money is not the only barrier, as many previous government-financed programs for providing health services have proven. Ignorance, fear, inexperience, age and transportation are but a few of the other barriers which prevent people from seeking needed care. The community health nurses are professionals who not only have years of experience and expertise in the health care field, but know the community, the needs and the problems and will be an important component in aiding clients to overcome some of these other barriers which prevent their utilization of health services.

Finally, these county clinics along with day-care centers, manpower offices, sheriff's deputies, and welfare offices, will be used as intake and referral points for the project.

NONCATEGORICAL

Multnomah County will pool Federal, State, and local funds to provide comprehensive services for medically needy people in such a way that provider and client are minimally aware of funding source or broker organization operations. The key here is comprehensive, not select, services for people in the mainstream, rather than in separate facilities.

Multnomah County is hopeful that eventually all local, State, and Federal dollars being spent for health care within its jurisdiction could be integrated into Project Health. This would allow a basic comprehensive benefit package of health services for all within the mainstream. Citizens could choose among the various provider groups for their coverage. Every provider group that agreed to meet minimum standards could be included to allow a choice for the client. Kaiser, Cascade Health Care, Portland Metropolitan Health, Inc., and Oregon Physicians Services are either now under contract or in the process of final negotiations with Project Health. Some, of course, will not enroll in these plans and will only come forward on an episodic basis. They will be given the service they need and desire in any hospital or clinic under contract through whose doors they enter.

I have avoided up to this time of speaking directly to the issue of the elderly, for I wanted to make the point that what we are trying to do in Multnomah County is to pool funding to provide comprehensive health services for all people, rather than initiating separate programs, separate funding, separate institutions for any one group of people.

In Multnomah County, we have identified 41,000 County residents as "medically indigent." These individuals do not meet the criteria set by welfare for eligibility either because they make enough money to put them right above the welfare limit or they are not related to a specific, categorical welfare program. Most of the time they do not have any medical insurance, or they have inadequate medical insurance and do not have enough money to purchase their own care. This is the target population for Project Health.

Of these 41,000 individuals, approximately 12 percent, or 5,000, are age 60 or over; and about 10 percent, or 4,100, are age 65 or over. This low-income elderly population is not eligible to receive welfare health benefits, some are not eligible for medicare and many who are eligible cannot affort to pay the high deductibles or find that the coverage is full of loopholes and inadequacies.

At the same time, the Department of Health, Education, and Welfare has identified health as the number one need of people age 60 and over, and the Consumer Price Index indicates that medical expenses are 3.5 times greater for persons over 65 than for younger persons. This is made more critical by the fact that low and fixed incomes represent one of the most serious problems for elderly persons, particularly with the current rate of inflation.

In the next year and one-half, project health will provide prepaid, comprehensive health care services to 2,000 of the county's low-income elderly population through its medicaid demonstration project. This represents a unique pooling of government health care funds and programs to provide mainstream, comprehensive care.

The elderly have traditionally been excluded from prepaid plans either because of high cost or deliberate unavailability. The county through the pooling concept of its broker organization has negotiated contracts with providers on a community rated basis. That is to say, premiums are paid to providers based on a rate which reflects an entire community and not one category of people. Prepaid plans are allowed to bill medicare to balance the cost and the county is able to provide the same level of comprehensive care to all people. This is an important step in furthering access for the elderly into prepaid, comprehensive health care from which they traditionally have been excluded.

The elderly, like all Project Health participants, will have a choice of four plans to choose from, all of which provide the full range of medical services. Community health nurses will follow up to see that individuals are not only receiving the appropriate care but that they are able to fully utilize the health options open to them.

The staff of Project Health at my direction is also investigating the possibility of a geriatric center for the elderly in Multnomah County. This would again be based on the concept of mainstream, equal care, and the county's role would again be that of a broker, a catalyst, a negotiator, rather than a direct service provider. It would include not only medical facilities, but recreational, residential training, and educational components, and would again be available to people not by category, but by need.

Pooling Government Funds

In conclusion, Project Health is a unique program. It is the first time that government funds have been pooled to purchase health care services from the private sector of health care providers. It is the first time that an attempt has been made to coordinate diverse and fragmented government programs with equally diverse and fragmented private programs. And it is the first time that the entire package has been tied together with an access system which eliminates barriers to care and insures that people know how and are able to use the medical resources they need.

Most importantly, Project Health represents the idea that human dignity is achieved by providing all citizens with the opportunity to participate in the mainstream of life. It represents a new direction, a new commitment, a new concept of government. It is a commitment to serve people rather than deal with categories; it is a commitment to spend as much money to keep people healthy and out of institutions as we spend to keep them in; and it is a commitment to the belief that health care is a right and not a privilege.

A letter I received last week from a Project Health recipient perhaps says it best, "If it were not for Project Health care delivery system, I would be a hopeless invalid and on welfare today, instead of being able to work 40 hours a week and be self-sustaining."

Senator Church. We have a second panel which is going to deal with housing and utility costs, and it consists of William Saenger, who is the housing director of the northwest pilot project here in Portland; Mr. Howard Willits, who is the chairman of the Committee To Lower Utility Rates in Portland; and Charles Littlehales, who is the

medical consultant of the Health Center for the Elderly and associate professor in preventive medicine of the Health Sciences Center of the University of Oregon; and Hon. William McCoy, who is the State senate representative of the Governor's Committee on Aging.

I would like to mention before we get started with the second panel, folks, that Mr. Saenger brought Mr. Jess Proffer here.

I do not know whether all of you are acquainted with Mr. Proffer, but he is about to become one century old on July 4, 1976, which will then make him just half as old as the United States.

He is here in the room. I have already had the pleasure of meeting him. He is a wonderful gentleman.

Why don't you ask if he will stand up. He might recognize your voice.

Mr. SAENGER. Jess Proffer, can you hear me?

Can you stand up, Jess Proffer?

He is in the back row on the aisle, way in the back.

Senator CHURCH. Have him stand. There he is. [Applause.]

I would also like to make another announcement before we proceed with the next panel.

Senator Hatfield could not be here personally, but he has sent his personal representative, Mr. Ken Leadstone, who is here on Senator Hatfield's behalf, and I wonder if Mr. Leadstone would please stand.

He is at the back of the room.

Mr. LEADSTONE. I merely wish to represent the Senator, and be recognized, and a statement may be forthcoming at a later date.

Thank you for the opportunity, Senator.

Senator CHURCH. Very well. We are very happy to have you.

Mr. LEADSTONE. Thank you, sir.

Senator CHURCH. Now, Mr. Saenger, are you going to be the first member of this second panel to speak?

PANEL ON HOUSING AND UTILITY COSTS

STATEMENT OF WILLIAM SAENGER, HOUSING DIRECTOR, NORTHWEST PILOT PROJECT, PORTLAND, OREG.

Mr. SAENGER. I believe I am, Senator.

I am not a very devout man, and my wife asked me this morning where I was going.

I said I was going to church and very proud of it.

I am Bill Saenger, director of housing for Northwest Pilot project.

Those who come to our door are at or near the poverty level. Over 90 percent are on one form or another of social security or public assistance.

They pursue one of three living patterns: (1) They live in sleeping rooms; (2) they live in light housekeeping facilities; and (3) room and board, and all avoid, as they would the plague, living in nursing homes.

The first is the cheapest, since no cooking is allowed. Since the cost of eating out has risen manyfold in the last 2 years, cooking is now done in these rooms, but illegally.

Because it is illegal, these householders do not qualify for food stamps. If their hotplate blows a fuse, they are caught and evicted or have to surrender their stove.

They now have to spend at least $4 a day for at least one hot outside meal, and two cold room-fixed meals.

This costs $120 a month. Because of increased costs of heat and building maintenance, the $45 sleeping room is becoming as obsolete as the dodo bird.

Costs Passed On to Tenants

On January 1, when new fire safety regulations take effect, those that can afford to comply will pass the rehab costs on to the tenants.

I already know of 70 units that will be raised to $60 and this is only the beginning.

That is about a 34-percent raise from $48 that a lot of them are paying now—$120 plus $60 equals $180, which is $4.30 over SSI and welfare allotment for a single individual.

Meanwhile, no mention of costs of clothing, transportation, laundry, over-the-counter drugs, incidentals, and so forth. So much for No. 1.

For those desiring to cook for themselves, there is living pattern No. 2: Light housekeeping.

Two years ago there was still an occasional studio apartment, consisting of a bed, chair, table, vintage refrigerator, and two-burner stove for $55 to $60.

Today, a place like that rents from $70 to $85, but not all have private bath.

One lady, 76, had a monthly income 3 years ago of $128.

She was paying $55 for a light housekeeping apartment. Today, she gets $174.70 a month and is paying $65 for a facility that permits no cooking of any kind.

She finds further that the social security raises over the last 3 years have not kept pace with spiraling food costs.

Living pattern No. 3: Room and board for those who can no longer help themselves, while still remaining free and independent.

These, too, are beset by rising food and operating costs.

Another lady, residential hotel—70 years old and diabetic—3 years ago her rate was $154, it is now $169.

She feels she is paying too much for having to share bath facilities with several other roomers. When not able to get to the dining room, she has to pay extra for her meals. Her rent has been raised twice since Christmas. She has $5.70 left for discretionary spending a month.

In conclusion, let me try to bring home what we mean when we talk about striving to maintain the dignity and independence of older Americans on this, the eve of the 200th anniversary of our country.

On January 1, 1974, I found a room and board situation for an old man who was no longer able to manage for himself.

Until then, except for me, he was alone and without friends.

He is now happy and well-cared for. His room and board was $185 a month, shortly thereafter it rose to $200, today he is paying $225.

He has some savings, and I hope they last as long as he does.

His name is Jess Proffer, and he is very special to me.

Although hard of hearing, he reads the newspaper and his Bible every day.

He is 99 years old. He was born on the 4th of July, 1876. I painted this portrait of him.

[Demonstrates portrait.]

[Applause.]

Mr. SAENGER. He is just as dignified and independent as his country, and I hope both will share their birthdays together in 1976.

In his honor, and in honor of all older Americans, let us strive to develop the kind of legislation that will enable all to live in dignified maturity in the natural systems of their choice.

Thank you.

[Applause.]

Senator CHURCH. Thank you very much, Mr. Saenger.

What do you think we could do that would most help solve these three problems which you referred to?

DWELLING REHABILITATION FEASIBLE

You know, sometimes it is argued that instead of trying to build new housing for the elderly, new projects, which takes so long, and there is never enough, that we ought to try to rehabilitate existing structures, we ought to try to find some other way, and yet, it is said that is very expensive too.

You have had a lot of experience in this. What do you think?

Mr. SAENGER. Well, from what we find in our every day searchings for places that are growing less and less, and more expensive, we do find that the efforts to rehabilitate a lot of the older buildings in the city is a very worthwhile cause, not only those which are in violation of fire code, this merely accentuates the problem, it has always existed, but one of the problems that we have in the city of Portland is that we have, at the level of which we speak now, the economic level, there is about a 2-percent vacancy rate, which is about 300 percent worse than the average for the whole United States, and that is pretty terrible, so the accent and the drive to want to rehabilitate and encourage owners in neighborhoods, not only the inner city core, but outlying areas of Portland, to rehabilitate, is very much the thing we are trying to do.

Senator CHURCH. Can you get any Federal help when it comes to rehabilitation of old places?

Mr. SAENGER. Yes, again, in the words of Commissioner Jordan, there are some strings attached to these, that sometimes the investors, who, after all, use their money to make a living, are turned off by all of the red tape.

They need a cash flow to operate a building, and if their down payment and costs and interests costs are so high, and they are cut off from having the cash flow they want, they simply cannot operate.

You can get 8 percent in the bank so why risk your neck in trying to open a hotel at that rate.

Senator CHURCH. What about that section 8 provision of the law, as a means of helping older people find suitable quarters, the rent supplement program, what is your experience?

You have had experience with that. Have you any suggestion to make or advice to give on that?

Mr. SAENGER. Well, I wish I had some intelligent suggestions to make.

The rent supplement program, are you speaking of the Housing Authority of Portland, the rent supplement program, there is such a thing which according to the Federal guidelines, spells out that no one should have to pay more than one-quarter of his income for rent, and that is very good.

Senator CHURCH. Right.

Mr. SAENGER. Unfortunately, even though there are nice places, there are hundreds of such nice places in the city built and leased by the Housing Authority of Portland, but there are thousands waiting to get in, and they are waiting for somebody to die so they could move in.

Senator CHURCH. You know, that problem is just coming up all over the country, and we are certainly making slow progress getting it solved.

I think we will have to find other ways of doing it, and perhaps rehabilitation of existing structures to make them safe, to make them comfortable.

Mr. SAENGER. I think they are in line for some renovation.

Senator CHURCH. They have some good potential.

Mr. SAENGER. Correct.

Senator CHURCH. Well, thank you very much.

Mr. SAENGER. Thank you.

Senator CHURCH. Mr. Howard Willits, chairman of the Committee to Lower Utility Rates of Portland.

STATEMENT OF HOWARD WILLITS, CHAIRMAN, COMMITTEE TO LOWER UTILITY RATES, PORTLAND, OREG.

Mr. WILLITS. Thank you.

Mr. Chairman, Senator Church, we are very pleased that you are very evidently concerned for the problems of the aging.

I am glad to have had the opportunity to participate so far and listen.

My subject is privately owned utilities and problems of the aging.

They have been referred to to some extent before, but I will specify a little more distinctly.

My name is Howard Willits, former State representative for 12 years until 1975 in district 21. I am now chairman of the Committee to Lower Utility Rates. We have about 150 persons who have worked with us at one time or another getting 50,000 signatures on our petition to the public utility commissioner and to the Portland City Council also distributing 60,000 informative fliers to the general public.

We are an ad hoc committee formed to fight inflation at the point of the private utilities whose rates and profits keep increasing with the blessing of the public utility commissioner. The ratepayers are increasingly angry and the poorer people suffering more and more. We have an organization in each of the three metropolitan counties and believe we are making good headway.

Utilities and Problems of the Aging

Listed are a few examples of need on the part of some elderly poor. Mrs. R., 69 and asthmatic, with ulcers, heats with oil, has only small electric appliances, electric bill ranges from $7 or $8 up to $43. Now must choose between "breathing, freezing, medicine, and food," as she says.

Mrs. J., 73, oil heat, two broken hips, was beaten and robbed because she must live in a poor area with a tendency to much crime, tries to live on social security income, must cut down on food and medicine, has two cats for company, must cut down their food also. Cats help keep mice quiet as well. Older people living alone need something to care for to keep their sanity.

Mr. T., 71 without telephone, heart condition, has collapsed several times, afraid of dying with no one to help, skimps on food and heat, very weak and unhappy.

Other people are dying from a combination of cold, hunger, and lack of medicine and attention.

1. I do not advocate so-called energy stamps for the elderly poor at the expense of other ratepayers. The stockholders should bear this expense. We don't want welfare for the rich monopolists and free enterprise to starve on the part of the poor.
2. Social security payments should be brought up to parity with the cost of living. Originally social security was intended to provide for one's old age.
3. Food stamps should be continued, increased, and the difference paid immediately. Stamps have been very helpful.
4. Utility rates should be lowered considerably by those responsible for regulation. The regulators now are all on the side of the investors, neglecting the people's interests as they are, by law, supposed to uphold.
5. In the long run these monopolies, which are not free enterprise at all, should be returned to the people. Numerous communities, such as Vancouver, Wash., now maintain their own power systems and retain the profits themselves, saving about 50 percent.
6. In the even longer period I would heartily recommend that the military-industrial complex be broken up and their hundred or so annual budget of a hundred billion be drastically cut. This vast sum in itself is highly inflationary and in reality does not contribute to national defense. With this sum devoted to social needs our elderly poor would be much more adequately cared for and our country safer in addition.

Utility Rate Structure Inequitable

Senator Church. Thank you, Mr. Willits.

I am sure you are familiar with what is sometimes called lifeline rates.

That is, changing the way that the rate structure tends to give those who use the most electricity the cheapest rates, and those who use the least the highest rates.

Mr. Willits. That is very unfair.

Senator Church. It is very unfair, and it seems to me that if we could get that just turned around, so that if you are using just enough

fuel to get by on, the minimum amount you need, you should be able to pay the smallest rate for that, and then people who could afford to use more fuel, or waste fuel, let them pay a higher rate.

Now, I see no reason at all why public utility commissions could not change these rate structures, and take into account the special problems faced by people with limited means, and who just use it for what they have to have it for.

Mr. WILLITS. There is one person who could do that in the State of Oregon, but he needs pushing.

Senator CHURCH. Well, I hope he gets a lot of pushing.

Well, I commend you for your efforts, because, you know, this is fuel and food inflation, and more than anything else, these are the two things that hit the elderly people more than anything else, when you come right down to it—food, fuel, medicine, housing—those are the four basic expenses, and as far as fuel is concerned, I think that a change in the rate structure could help people a great deal.

Mr. WILLITS. And it could be, it could come out of the profits, because they are making quite a bit.

Senator CHURCH. Oh, yes, they are doing pretty well.

Mr. WILLITS. They are doing all right.

Senator CHURCH. I never knew it otherwise.

All right. Well, thank you very much.

Mr. WILLITS. Thank you.

Senator CHURCH. We will now hear from Dr. Charles Littlehales, medical consultant, Health Center for the Elderly and associate professor in preventive medicine, Health Sciences Center, University of Oregon.

Please proceed, Doctor.

STATEMENT OF DR. CHARLES LITTLEHALES, MEDICAL CONSULTANT, HEALTH CENTER FOR THE ELDERLY AND ASSOCIATE PROFESSOR IN PREVENTIVE MEDICINE, HEALTH SCIENCES CENTER, UNIVERSITY OF OREGON

Dr. LITTLEHALES. I am the medical consultant, Senator Church, ladies and gentlemen, for a pilot project in the community outpatient care for the elderly in the northeast section of the town.

I do not belong in this part of the agenda. I do not know anything about housing and utility costs.

I am, like Will Rogers used to say, all I know is what I read in the newspapers, and I am going to read something from the newspaper, and I know that many of my friends out in the audience read the *Oregonian*, and I am reasonably sure that Senator Church doesn't and I want him to hear this.

This is from the day before yesterday morning's *Oregonian*, an Associated Press release from Seattle.

[The article follows:]

[From the *Oregonian*, Nov. 22, 1975]

WOMAN FREEZES AFTER GAS CUT OFF

PITTSBURGH (AP).—An elderly woman was found frozen to death in her suburban home two weeks after her gas was turned off because she didn't pay her bill, the Allegheny County coroner's office says.

Officials said the body of Sophia Easer, about 70, was found by Munhall Borough police. She was on the floor covered with rags and a carpet, apparently in an attempt to escape subfreezing temperatures.

Dr. LITTLEHALES. I think this should suggest that all the problems that are present in other places also happen here in the mild Northwest.

On October 17, 1975, I testified before the Oregon Legislative Assembly at Salem, Oreg., regarding the effects of inadequate heating in dwellings of the elderly.

I researched the medical literature by the University of Oregon Health Science Center library staff which yielded no reports in the American literature and only two reports in the entire world literature in regard to under-heating of homes of the elderly.

Both of these reports were from England, one being a survey by the British National Health Service in 1973.

HYPOTHERMIA IN ELDERLY

The British survey estimated that about 9,000 admissions of elderly people to hospitals per year were due to hypothermia, a condition in which the body temperature is lowered below 95° Fahrenheit, which as most of you know about 98.6° is the usual normal.

At this point, blood pressure, pulse, mental function, and in fact all vital functions are lowered. If uncorrected, death may occur.

Based on that study the British National Health Service found hypothermia to occur frequently when the dwelling temperature was continuously below 65° Fahrenheit and almost invariably so when the temperature was below 60° Fahrenheit.

Based on their studies, the National Health Service recommended a room temperature of 70° Fahrenheit for the elderly.

Hypothermia of elderly people, when questioned by the National Health Service, often stated that they did not feel cold or uncomfortable, suggesting that hypothermia in the elderly can be life threatening without the involved person realizing it.

Such people are more susceptible to potentially fatal respiratory and cardiac disease.

Although I have had no personal experience with illness stemming from inadequate heating in the homes of the elderly, I have had experience with marginal income elderly people who fail to take necessary drugs—as Senator Church has alluded to twice before this afternoon—drugs that I have prescribed because of lack of sufficient money.

As one elderly patient stated to me not too long ago: "I can live without medicine, and I can cut down on groceries, but the rent has to be paid, or I'll be evicted."

I have my greatest problem in the treatment of the elderly with hypertension, where I started out with a blood pressure of 200 over 100, and it goes on and on and on and eventually I get them to admit they are not taking the medicine.

The reason is they are not on welfare, their incomes are marginal, and not being on welfare, the drugs are not paid for, so they just do not take them, so the hypertension goes essentially untreated, except when I step into the breach and go out and scrounge medicine on my own and get it for them.

If power rates are increased, it is my considered opinion that this kind of person will turn down the heat or go without heat and become a candidate for hypothermia and its sequelae, which I have described. [Applause.]

Senator CHURCH. Thank you, Doctor.

I have been trying for several years now to get the medicare program amended so that it would cover prescription drugs for people who are chronically ill. That is to say, people who need to take the medicine continuously, and you have mentioned one such kind of case, hypertension cases, and there are many others as well.

Now, I think that all of the things that could be done in the medicare program, that might help more than anything else.

MEDICARE SHOULD PAY FOR CERTAIN DRUGS

The proposal that I now have before the Senate would be based upon the recipient person who qualifies needing to take this medicine, and having a necessary prescription for it, would pay $1 toward the price, and the rest of the price would be paid by, or would be covered by, medicare.

And I just wish we could get that done, because it is a terrifically bad gap in the program. Medicines have gone up to the point where I have had people tell me that in many cases in order to buy the medicine they need it costs sometimes a fifth or even a fourth of their income.

Dr. LITTLEHALES. May I say one thing more: That is just half of the problem. Even when our people get the medicine, we have to have a team go out and monitor that they are getting it, and that costs money, too.

Senator CHURCH. Yes.

Dr. LITTLEHALES. People have to be paid.

We have had the social service workers who are working with us go out and buy sacks full of medicine that I have prescribed, that have not been used, and we have to monitor it. That is part of the problem.

Senator CHURCH. Well, the present program, as you know, covers medicines and drugs only if you are institutionalized, and if we had a little more flexible program, perhaps we could keep a lot of people out of the hospitals.

Dr. LITTLEHALES. This is our prime objective—keep them out of the hospitals, keep them out of convalescent homes if we can.

Senator CHURCH. All right. Thank you very much.

Dr. LITTLEHALES. Thank you.

Senator CHURCH. We will now hear from Hon. William McCoy, State Senate representative, Governor's Committee on Aging, North Portland, Oreg.

STATEMENT OF HON. WILLIAM McCOY, STATE SENATE REPRESENTATIVE, GOVERNOR'S COMMITTEE ON AGING, NORTH PORTLAND, OREG.

Senator MCCOY. Thank you, Senator Church, and staff members of the Special Committee on Aging, I know you have been welcomed here

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by the city and county, so I will take the opportunity to welcome you too on behalf of the State of Oregon.

Senator CHURCH. Thank you.

Senator McCOY. We are pleased that you are conducting these hearings in our State, especially at this time of economic stress.

Also, I think that your coming here today will spur us on as well as those who are on the Governor's Committee on Aging, to hurry up and get it organized and staffed.

You have heard Mr. Jordan on the city council mention to you that we are now in a housing crisis in this community.

On December 31 of this year, all substandard and unsafe housing must be closed if the owners do not agree to renovate their property.

In Portland, 189 units are unlikely to comply. Seventy-four have said they might or will partially comply, 55 will close, and 27 are unsure what they will do.

This will leave this community with 345 residents out in the cold. Something has to be done, but we do not know where to go.

Now, this is throughout the State of Oregon. This substantiates the fact that housing for the elderly is also, without doubt, an unmet need.

RENT REBATES NOT ADEQUATE

The legislature has tried to address itself to the problem by providing rent rebates for both homeowners and renters.

We find that this is not enough. From what I have been able to learn, from builders, contractors, and real estate people throughout the State, section 8 of the New Housing Act does not help at all, but further complicates the problem.

We are hoping that the Federal Congress will take care of the rehabilitation, the new housing, and the existing housing parts of section 8 so that we will be able to move with some degree of efficiency and help to the people of this State, and also——

Senator CHURCH. Senator, tell me, I understand the State legislature authorized $1 million for action to help older Oregonians. Is that money available now, and what use will be made of it?

Senator McCOY. Yes, that money is available, and it is being used very rapidly.

Senator CHURCH. In what way is it being used?

Senator McCOY. For those persons who are over 65 years of age who pay more than 60 percent of their income for rent. They are the people who would be helped.

Senator CHURCH. So it is a rent supplement kind of approach?

Senator McCOY. That is correct, House bill 2008, rent supplement.

Senator CHURCH. Is this the first time that the State has undertaken to assist in rent supplements?

Senator McCOY. We have a rent supplement program which really is attached to the income tax. It is for persons who earn from zero to $15,000. It is set up so that they can get some rebate, both homeowners and renters.

Senator CHURCH. I see.

Senator McCOY. Yes.

Senator CHURCH. Well, I worry about what will happen the first of the year.

A VOICE FROM AUDIENCE. You are not alone, sir.

Senator CHURCH. You are a member of the Governor's panel?
Senator McCOY. Yes.
Senator CHURCH. You are meeting on this problem, and would you——

Senator McCOY. Well, actually the Governor's panel is just organizing, and I said here in my opening remarks, I am very glad that you are here, because I think you will give us some incentive to proceed with deliberate speed on organizing the staff of the committee.

Senator CHURCH. When you do that, if you have some findings and recommendations to make, I wish you would send a copy to me, to the Senate committee. I would appreciate having it.

Senator McCOY. Thank you.

Senator CHURCH. Now, before we go to the next panel, I want to thank you very much, gentlemen.

Before we go to the next panel, I would like to recognize Mrs. Jules Baker. She has come with a group of senior citizens from Eugene, Oreg., and I would like her and those who came with her to be recognized.

Will you stand, please, and be recognized.

Look at that. [Applause.]

Are there any other groups here that have come by bus from outside of Portland?

If there are, I would like them to be recognized too.

All right. We thank you all for coming. [Applause.]

Our next panel has to do with health costs, and before I introduce the members of that panel, I want to call your attention to this green sheet that is available to all of you.

Anyone who wishes to advise the committee of their own problems, or wishes to make recommendations, may do so. Give us suggestions that you think might be helpful. If you have not had an opportunity to testify, and it is not possible for everyone to testify because of the time limits that we have, please use these sheets which are made available for you to use. We will collect them before the end of the hearing today, and also tomorrow, or you can take them home with you and mail them to us. We have the address right at the top. You can give them to us after the hearing or put them in an envelope and mail them to us, either way, whichever suits your convenience. We do look at them, and we often get good ideas and guidance from them, so please remember that we want to hear from you individually and this is one way you can get your message to us.

All right, our next panel, which will deal with health costs, consists of a dear friend of mine and former colleague in the Senate, Mrs. Maurine Neuberger.

Also on the panel is Mrs. Lee Miller, retired public health nurse from Columbia County, and David Brown, accompanied by Ron Widen of the Oregon Research Institute at Eugene; Joyce Osika, the staff captain of the Volunteers of America, from Portland; and Dr. James S. Bennett, professor and chairman of the Division of Extramural Programs, School of Dentistry, University of Oregon Health Services Center.

Maurine, I am really pleased to see you again, and to have you here participating at this hearing.

I would like to invite you to lead off, please.

PANEL ON HEALTH COSTS

STATEMENT OF HON. MAURINE NEUBERGER, FORMER U.S. SENATOR, STATE OF OREGON

Senator NEUBERGER. Thank you, Frank.

It is so wonderful to have a U.S. Senate committee come to our State, our territory, and our neighborhood. Because we live way out here on the west coast, I think we can feel that that big government, that bureaucracy under that big dome, does not know about little people, about the people who live in a State that only has 1 percent of the population. So it is very reassuring to us to have an important Senator and a Senate committee come and to talk to us and meet with us and hear our problems.

Senator CHURCH. Maurine, when I was growing up in Boise, Idaho, my idea of the biggest city in the world was Portland, Oreg.

Senator NEUBERGER. As I sat here and listened to our eminent witnesses who preceded us, I could not help but feel a great surge of pride in our elected officials—namely, our City Councilman Jordan and Commissioner Clark—and I am sure you are impressed with the fact that these people whose names we see on the ballot now and then, are not just some amorphous person. They really are caring and are concerned, and I felt as I thought about the testimony I planned to give, that I really could not add anything in the way of factual information or statistics to what has already been presented. But I think I can comment a little bit on sort of philosophy, as I have worked in this field for a long time.

We welcome you, Senator Church, in being interested in the problems of the aging, and we appreciate your continuing concern for the welfare of all elderly citizens.

The impact of the cost of living on the elderly weighs most heavily, and any threat to reduce their benefits could be disastrous.

I serve on a local county task force investigating a county-maintained nursing home and home for the elderly.

On a recent site visit, many of us thought, "There, but for the grace of God, go I." I recalled a quotation from Shakespeare: "And he that doth the raven feed, yea, providently caters for the sparrow. Be comfort to my age."

Prior to the passage of the medicare bill in 1965, I went to the Scandinavian countries to observe their plans and systems for administering to the health needs of the elderly, and I was impressed by their programs and chagrined that my own wealthy country had no such programs. Therefore, the passage of the medicare bill was a landmark, as had been the social security legislation 20 years earlier.

MANY EARLY MEDICARE PREDICTIONS NEGATIVE

All of us who served at that time will never forget the well-financed lobby that fought to defeat the legislation that we are discussing now.

The dire things that were predicted have not come to pass.

I am happy for these 10 years of "comfort to the aged."

But as "new occasions teach new duties," so we must reevaluate the program and note that the aged population is increasing, that costs

are increasing, and that the administration proposes to increase the medicare deductible from $92 to $104.

We have been reared to seek regular dental care before it is too late, to have eye examinations, and to have a regular physical examination.

Preventive measures insure better health and less likelihood of prolonged illness, and the witnesses that have preceded have testified to that.

If the increase in the deductible is allowed to take effect, many aged persons will delay seeking necessary hospitalization or wait until treatment is no longer effective, and here I very much appreciate the bill Senator Church has introduced to freeze the medicare deductible.

All of us who served in those years will also recall poignant letters we received concerning individual cases of hardships that old people were enduring and pleading for a program like medicare. Howard Willits brought you some more of those today.

And these letters came from young people faced with the care of their aged parents and not really seeing how to make ends meet with their own family responsibilities.

They also came from people who were middle aged and middle income, who could foresee their inability to meet the costs of illness.

So it is not just the aged population in this county that is concerned with these programs.

This county facility—Edgefield Manor—is providing excellent service. The patients are happy although there is concern for their mental health; yet the county is finding it beyond its means to continue operation.

What one wonders is how so many private facilities make money on their operation.

The comprehensive studies made by the Special Committee on Aging have looked into many of these proprietary homes and have accumulated much evidence in answer to that question, and it is available in the reports which Senator Church sent me.

Medicare and medicaid have been a boon to the health needs of a segment of the population.

Where would we be without them, but all the testimony points up to the need for a national health insurance program.

I was committed to this, and I was pleased when City Councilman Jordan said the same thing.

Long-term care, an annual physical examination, and home services are badly needed.

If more home services were provided, many of the elderly could be well cared for without placing them in nursing homes. That should be a last resort.

There are many devoted people in this State, county, and city who are employed to administer to the needs of the elderly, but I am overwhelmed by the number of agencies which are involved.

Could some of the money consumed by office rent, utilities, carpools, and employees be better used for direct aid to the needy recipients?

Critics of any and all Government programs generalize about the "vast Government bureaucracy."

When I hear this, I kind of always rise to the defense, but the bulk of that criticism is focused on the welfare program and the humanitarian services that Government provides.

I am hoping that the programs will not be curtailed because of such complaints and that reexamination of the handling of public funds will take away the perjorative bureaucracy.

Senator CHURCH. Thank you very much.

I just want to say it was my pleasure when Maurine Neuberger served in the Senate to serve with her on the Committee on Aging. She was one of the most valuable members of the committee in those years, and it is obvious from what she said today, her interest has not lagged at all since she left the Senate.

So we thank you very much.

Senator NEUBERGER. Thank you.

Senator CHURCH. We have a last-minute change here, folks. That is the reason for the long pause.

Our next panelists are Mr. Ron Wyden and Mr. David Brown.

STATEMENT OF RON WYDEN, OREGON RESEARCH INSTITUTE AND COCONVENOR, OREGON GRAY PANTHERS, EUGENE, OREG.

Mr. WYDEN. Good afternoon, Senator Church.

I appreciate your having Mr. Brown and myself here today.

I am representing the Gray Panthers of Oregon. As you may know, the Gray Panthers represent age and youth in action.

My coconvenor is 81 years old and she says she represents the youth, and I the aged.

The Oregon Gray Panthers began to organize in support of your bill, S. 2446, that would freeze medicare costs 1 week after you introduced it.

The very large stack of letters and petitions that I brought here today represents the fact that Oregon's elderly are behind your bill 100 percent.

Senator CHURCH. Good.

[Applause.]

Mr. WYDEN. Mr. Brown is a retired, Eugene, Oreg., custodian, who is covered by medicare, but he has approximately $15,000 in hospital bills and owes physicians another $30,000.

He received a bill on Friday that looks like this, and I am glad that you cannot see it, because it really makes my stomach turn.

Medicare, which was intended to provide comprehensive medical benefits for the elderly, is obviously removing less and less of the crushing burden of health costs from the aged.

MEDICARE COVERAGE MUST BE EXPANDED

Your own committee has found that medicare covers only 38 percent of the medical costs of our seniors, and that the elderly now pay $179 more a year in out-of-pocket expenses for personal health care than they did in the days preceding the enactment of medicare.

Medicare's failure to provide assistance for extended illnesses such as Mr. Brown's, prescription drugs, dental care, hearing aids, and eyeglasses, is well documented statistically.

Because of the tremendous increase in medical costs, medicare has gotten to be less than half a loaf, and without the enactment of S. 2446, Oregon seniors know that efforts will continue to keep slicing it away.

The increased deductibles, copayments, and part B premiums have been bitter news for those on fixed incomes. Those seniors who need regular physicals or diagnostic services still must fend for themselves.

The Gray Panthers have helped to organize a senior citizen drug co-op in Lane County where older people can save from 30 to 50 percent on their prescription drugs and the suffering that comes into that pharmacy every day is a strong indictment of how medicare failed when it did not include prescription drugs.

Some have argued that medicare was not intended to provide complete medical coverage for the elderly and that seniors should take out private medical coverage to fill in the gaps of medicare.

However, when the food, utility, and housing bills are paid, approximately 40 percent of Oregon's elderly have nothing left over to buy insurance.

And if they could buy insurance, what would they get from an industry that, in the area of medical coverage, has done little but to produce policies with 150-word sentences that are so unreadable you do not know what your coverage is until you get a medical bill that says you are not covered, and that you owe some more money.

The insurance industry has sanctioned unnecessary expenditures when it should have been policing rising costs in the consumer's interest.

Many elderly realize that because of the failings of the private insurance industry medicare is all they have got. Perhaps most disturbing to the elderly is the arbitrariness with which this program is administered.

Aetna Life & Casualty Insurance Co. administers part B of medicare in the State of Oregon and has failed to spell out clearcut guidelines as to what extent services will or will not be compensated for.

This has produced a kind of guessing game where seniors try and pick among the various medical treatments they need in conjunction with those treatments that Aetna will cover under part B, while ignoring medical needs that are not fully compensated.

Too often the elderly must have emergency medical care and then are left to the whim of some claims clerk who must somehow be persuaded to pay the full claim that should be covered under part B.

The part B insurance carriers moreover always find a way to conclude that either the doctors overcharged or the hospitals overcharged or perhaps some elderly person got a little too sick for full compensation.

In the letters I place before you today you will find seniors saying again and again that they are tired of going round and round with the State of what services are to be compensated for under part B.

Guidelines Needed

We desperately need guidelines and clarification, congressional or State, of what services are to be compensated for under part B.

This year medicare is celebrating its 10th anniversary. It is a much needed program, and a good one with the limitations noted here. Despite its shortcomings, it has put older people far ahead of other segments of our population in the collective American struggle to obtain quality health care at reasonable prices and older people are appreciative.

Nevertheless, we can do better. We could adopt a comprehensive national insurance program for all Americans and make medicare a part of it.

Or we could make the Congress realize this year that—for the next fiscal year—medical care for seniors who have used up savings and gone without necessities to pay the medical bills you see here today is more important to this country than weapons and defense systems that do not work and would not offer us any more security from foreign powers if they did.

We can freeze the medicare deductibles where they are and try and write legislation that would fill in the many gaps discussed here. We can do many or all of these things if we work together.

Thank you.

Senator CHURCH. If you are a member of the Gray Panthers, all I can say is may your numbers multiply.

You made a reference to medicare being half a loaf, and that is what it was when it started, it was just half a loaf.

It covered about 50 percent of the total cost of medical care for elderly people, and since then, that percentage has constantly fallen off until today it is covering about 38 percent, and pretty soon, it will be covering only a third. You know, we are losing ground, folks.

We are not gaining ground, we are losing ground.

We have to turn this around.

A VOICE FROM THE AUDIENCE. We are ready.

Senator CHURCH. I know you are ready, but first of all, as Ron pointed out, we have a rear guard action to fight, because every year we are faced with a new adjustment that the medicare administration we are presented with, which means that the deductibles are going to go up, out-of-pocket costs are going to go up, and the percentage of the coverage by medicare, therefore, will go down. And that is why I appreciate the support for the bill that Senator Kennedy and I have introduced, which is to freeze this, so we stop that business of increasing these deductibles every year and then we have to start filling the gaps in this program, and if we cannot devise a program in this country that takes care of the medical needs of the elderly people, who have the least to pay with, and have the most need, well, how are we going to ever solve the problem for all of the people.

FIRST PRIORITY SHOULD BE PROGRESS

And after all of these years of experience, it seems to me we ought to be making progress and going forward, instead of going backwards all the time, so that ought to be a first priority, and when Ron speaks of the money we are wasting, it just brought to mind the fact that they are now talking about spending money for a whole new fleet of bombers.

Nobody can quite explain what they are needed for, because the missiles are so much more efficient and so much harder to shoot down, but there are a lot of pilots, and the bombers they are flying are becoming obsolete, so a whole new fleet of bombers is being proposed, and you know how much they will cost: $100 million apiece.

Now, nobody can figure out what damages the bomber could do that anywhere would compensate for its cost, and we are building submarines now that are costing $1,800 million apiece.

Now, that is the way the military is gobbling up the money, and these things have got to be changed.

The needs of the American people have to be attended to, and, you know, we have already got enough nuclear arms to kill all those Russians 20 times over, and they are well behind us, they have got enough to kill all of us 12 times over. And, you know, this thing is just getting silly; so I really appreciate, Ron, what you have said, and for all of your help.

I wonder, Ron, if you could introduce Mr. Brown.

Mr. WYDEN. Yes.

Mr. David Brown has lived in Eugene for over 20 years, and I think his case is very representative of what some seniors are forced to have to pay under medicare. As you know, medicare covers only 60 days per illness, and I will let Mr. Brown take it from there.

STATEMENT OF DAVID S. BROWN, RETIRED CUSTODIAN, EUGENE, OREG.

Mr. BROWN. My name is David S. Brown. I am 68 years old, and I live in Eugene, Oreg.

For 24 years I worked in Eugene, Oreg., for the Eugene School District 4–J as head custodian.

I retired at the age of 65 to take care of my medically ill wife and today my income is approximately $400 a month.

In September of 1974 my wife went into the Eugene Hospital and Clinic for a type of spinal paralysis. She was in that hospital for 9 months, including approximately 1 month in intensive care.

She died on August 10, 1975.

As you know, medicare covers only the first 60 days of hospital care plus 60 days lifetime reserve. I now have hospital bills totaling approximately $15,000.

There is absolutely no way a man in my position can pay these bills. I am barely getting by as it is, never spending any money on the nonessentials.

My house rent and utilities come to over half my income. I try to get some meat once a week and have the rest of my money left over to buy medicine.

Since I am on a fixed income I will never have any more money than I have now.

I cannot pay my medicare bills now so if the medicare deductible is raised it will only make a bad situation worse. It does not seem right that someone who works all their life now has to spend their retirement trying to pay medical bills.

We need comprehensive medical coverages for all older people in the United States. Other countries have it, and so should we.

Please do not increase medicare costs or restrict its coverage any more.

Your attention should aim to broaden medicare benefits rather than restrict them. [Applause.]

Senator CHURCH. I certainly could not agree more, Mr. Brown. Thank you.

Mr. BROWN. Thank you.

Senator CHURCH. We have three more members of the panel to hear from.

Our next panelist is Mrs. Lee Miller.

STATEMENT OF MRS. LEE MILLER, RETIRED PUBLIC HEALTH NURSE, COLUMBIA COUNTY, OREG.

Mrs. MILLER. I do not know whether you know where Columbia County is or not, Senator Church, but we are a very small rural county.

There is about 40 percent of our population which are elderly people. I am now just joining this group.

The only reason I am retired, by the way, is because on July 1 of this year our health department was closed. Until that time, I was supervisory nurse in the health department. We were able to give some service, but because the county lacked funds, our entire health department was closed.

Sanitation, mental health, and public health nursing was all discontinued. In Columbia County, we have two factors that add to the problems of care for the elderly.

We have 10 physicians in the county, and they are not available to all of the citizens. Seven of the 10 are located in St. Helens.

We have one hospital in the county, and that is also in St. Helens.

We have several specialists who work part time possibly one afternoon a week, who come out from Portland. They are also in St. Helens.

Our Columbia County people want to be taken care of in the mainstream. They do not want to have to go to Portland or to the University of Oregon Medical School for care, and they do not want to go to the big clinics in Portland. They want to go to their own private physicians, but they cannot afford it anymore.

Up until the time the health department was closed, we had three public health nurses, and we were able to conduct clinics in the entire county. We gave some services, and probably could have given more had we known more of the problems of the senior citizens.

PREVENTIVE CARE CRUCIAL

In the county we need preventive care, a lot more than we need curative care. Curative care is too expensive. No one can afford that. It gets to the point where one might as well die as even consider getting good medical care that one can afford.

Charges for medical care have increased as much as 50 percent. Medicare is supposed to pay 80 percent of reasonable charges, but in viewing some of the statements we find that only about 60 percent of the charges made by our doctors are considered reasonable. Therefore, the elderly sometimes pay as much as 50 percent.

Columbia County needs a good ongoing program of homemaker service, which would be available especially to the elderly. One hundred persons now need this service. Capable people, nurses and teachers, are willing and able to teach both men and women to care for people in their own homes.

Many elderly people could spend their remaining years in their homes if someone was ready to come in and do the things with which an old person needs.

This service, as well as dental, optical, and hearing, should be covered by medicare. Medicare and social security need a complete overhaul.

If we could assist these people in their home, they would be happy, they would want to live, and they would be independent. They have worked a good many years to earn this independence.

Most of the drugs are so expensive, that many people cannot afford them, and the answer to this problem usually is that they do without.

You may be told you have high blood pressure. The medication is going to cost you possibly $7 or $8 a month at the least. You do not have that much left over after you pay your rent, your light bill, your fuel oil, and after you buy some food. So you do not buy the medicine.

Some people that I talked to told me that their health is so bad that their medication bill for the month will average as high as $50. That is a lot of money out of a small income. A doctor's office call has increased now in our county; they vary from about $8.50 to $11.

Possibly all the patient goes to see the doctor for is to have his blood pressure checked, and sometimes the nurse does that. They do not even see the doctor, but he charges the same.

A podiatrist charges for minimal care, possibly nail trimming, which a lot of elderly people need; his charge is about $13.

What do they do when they cannot afford this? Their nails are not cared for.

A home health agency nurse makes a visit to observe, evaluate the general health needs, evaluate nutrition, and give advice, and her charge is just about $21 minimum.

The insurance costs to supplement medicare is also increasing all the time, making it almost impossible for many senior citizens to buy it.

We have an ongoing program now where we go around to the senior centers and take blood pressure as volunteers, but this cannot go on forever.

Too Many Persons in Need of Limited Services

There is no way this service could be given to a large group of people by our few home health agency nurses, who sort of sneak around, without letting their boss know that they are out visiting some senior citizens. They are giving some services, as long as they can get away with it.

There are just too many people who—and I am sure our county is no different from any of the rest of them—because of the high costs, are just not getting the service. They are doing without it.

Thank you.

Senator Church. Just to give you an example of our own household, we are fortunately able, as long as people keep us in the Senate, we will be able to take care of my mother-in-law and her sister who live in our house in Boise. But when you were talking about these various things that are not covered, I was just thinking about Mrs. Clark and Mrs. Patterson. One of them is 88 years old, and the younger sister is 86. They are fortunately able to take care of one another, and still get about, but everything they need is not covered. They need eyeglasses; that is not covered.

They have denture work that needs to be done, and of course, that is not covered.

They are both hard of hearing now, and, of course, that is not covered.

They have, as many elderly people, problems with their feet, and they need to have foot treatment every once in a while, which really does give them lots of relief, and that is not covered.

They have been fortunate enough to stay out of the hospitals, because we can get them the medicines they need, but that is not covered.

Now, you see, if we had an adequate program to cover these things that so many elderly people need, we could keep an awful lot of them out of the hospitals where the price is over $100 a day for hospitalization. It seems to me that this is the obvious need. We just have a program that is so full of gaps that it is not doing the job. Even when you mention home nursing help, or some kind of help in the home that could prevent institutionalization, that is practically not covered, because the regulations are now so restrictive that almost any kind of help that is available is not covered, and I think this whole program has to be completely overhauled, and greatly expanded, and we might even manage to get that done, and get a few of those items covered.

[Applause.]

Mrs. MILLER. Let me make one more remark, Senator.

I hope when these things are talked about and planned, that people realize the abilities of nurses.

NURSES COULD RELIEVE DOCTORS IN SOME AREAS

For a long time, a lot of the things that we have been allowed to do, are so routine that we could teach other people to do it.

We, for a long time, have been doing work that the doctors are paid to do, but we do it.

They get the pay, we do the work. There is no reason in the world why a lot of the care that people have to go to a doctor to get cannot be done by nurses.

After 46½ years as a nurse, I know that both in hospitals and in public health work, the nurses could do a lot. Heaven knows, we never get rich and our pay would be so much less than what must be paid to doctors, and more people could be taken care of for half the money.

I hope this is considered when someone works out a way. There are many people, many retired teachers, as far as education and health is concerned, who could do this. They have good backgrounds for it, but we are put on the shelf when we reach age 65 as being a recipient.

I will be darned if I am going to take any of it. We have been able to save some money [applause], and if things do not go too much higher, we will be able to take care of ourselves.

To tell you the truth, I hope it does not last too long. It is getting to the point that I hate to face the future.

But other people do not want to be a recipient either. We just want to get what is coming to us. We have built the schools, we have built the highways, we have built everything else, and now we are entitled to this, and not as a recipient.

[Applause.]

Senator CHURCH. That is what the social security system was supposed to be all about. It is not a charity, it is an earned right.

Well, thank you very much.

Mrs. MILLER. Thank you.

Senator CHURCH. Now, let's hear from Joyce Osika, staff captain, Volunteers of America, Portland, Oreg.

STATEMENT OF JOYCE OSIKA, STAFF CAPTAIN, VOLUNTEERS OF AMERICA, PORTLAND, OREG.

Ms. OSIKA. Thank you, Senator Church.

I would like the opportunity to discuss the agency that I work for.

My name is Joyce Osika, I am a staff captain with the Volunteers of America, and I am the director for senior programs.

Many of you may know that the Volunteers of America is a national organization.

We are a nonprofit, nondenominational, religious social welfare agency, and our senior center is funded by United Way.

We have all of the problems in our neighborhood that have been discussed here today. Most of our people are on fixed incomes, people who could not afford medical care. Lack of sociability and lack of mobility have been the primary problems, as well as all the human needs that elderly people require for a better life.

We have 2,000 elderly persons living in southeast Portland, that are living on fixed incomes, and dwelling in substandard housing.

Mostly they are single-family dwelling units, or apartment houses, shared bathrooms, and try to manage the best way they know how in their community.

It was brought to the attention of the Volunteers of America that many people living in our neighborhood needed help, despite the fact that in those days there were no services provided except the Multnomah County Health Department nursing services. No physician or pharmacy was available. If you are able to walk to a hospital, or ride to a hospital, the elderly would get there, and then wait several hours before being seen.

The big problem was a shortage of beds. these people were released back to the community after hospitalization, and no one was there to take care of them, so they were allowed to die with no one to help.

LIMITED HEALTH CARE PROGRAM STARTED

We discovered that malnutrition and related illnesses were evident in the area. It was decided that we would provide some kind of health care system, and started out in a target area, with a shop-front clinic in southeast Portland. where people could get help just by walking the two or three blocks, and this helped tremendously, because we found they were swamped with so many problems.

Apart from the recreational needs and the social activities, and many of the supportive programs that were developed, I think the clinic probably has been the most successful. It is free medical service with qualitative health care. We have one part-time staff physician, two full-time registered nurses, and then we are manned by two volunteer physicians, two registered nurses, and three to four clinical aides.

Presently, we have a caseload of over 1,000 people that we are dealing with on a day-to-day basis, and if a person cannot come to the

clinic, then we are out there finding out what their needs are, monitoring the elderly person's progress.

We have been able to provide the pharmaceutical services and the laboratory needs of these people through our physicians and pharmacists. Our staff has worked diligently to make sure that all of their needs are covered. If we need to go out and get a prescription, we do that, as well as providing transportation for our community.

Because of the need for this kind of a setting in target areas, we have a center where people know they can get help. We came across many people who had not quite reached the age of 60, were unemployed, not qualified for medicare or anything else.

If you are disabled, and you are receiving a veterans' penson, and you are receiving a social security disability pension, you have a wife who is also disabled and not quite 60, she does not qualify for any medical assistance.

I am speaking of a married couple who comes to the center every day. This family were volunteers and they worked with us diligently, because this man feels we have a necessary service in terms of health providers and also for supportive needs.

His name is Fred Grigsby and his wife's name is Evelyn. Evelyn is also disabled, and we have her working on a volunteer rehabilitation program, which she really enjoys, but Fred also is confronted with a very substantial hospital bill, when he found out that his wife had to go to the hospital, and he was presented with a $1,000 bill.

Now, that does not seem very much to some people, but when you have an income of $249, that is a tremendous burden. Evelyn did receive medical care, and is still under the supervision of our agency physician, but she still is not covered medically by health insurance. If it were not for some programs, I am afraid that Evelyn would receive poor health services. This kind of individual is left by the wayside, which is rather inadequate in terms of health care progress.

I would like to note that we have found it very beneficial to work in a coordinated effort with the existing health programs in Multnomah County. The Volunteers of America act as a go-between in receiving patients who are to be released from hospitals. We can follow up in the neighborhood and check on patients when they are released to their homes. We have social workers that will go out there and make needs assessments, and I believe this kind of concept will eventually work on a national level under national health services and eliminate some neighborhood problems in target areas of large populated cities.

Thank you very much.

[Applause.]

Senator CHURCH. Thank you.

Joyce, your agency is funded through the United Way?

Ms. OSIKA. Yes, sir.

Senator CHURCH. So that the money is actually donated?

Ms. OSIKA. Yes; it is.

Senator CHURCH. You seem to be doing a lot of good with it.

Ms. OSIKA. Thank you very much.

[The prepared statement of Joyce Osika follows:]

PREPARED STATEMENT OF JOYCE OSIKA

My name is Capt. Joyce Osika, director of senior adult programs for the Volunteers of America, a nondenominational religious social welfare agency funded by United Way, providing multiphase programs and services for all age groups.

Our senior adult service center is located in a target area of southeast Portland. We serve approximately 2,000 senior adults dwelling in substandard single unit rooms and apartments. Most of these residents are 60 years and older, surviving on minimal social security or veteran disability incomes, and state welfare assistance.

Many problems existed with this fixed income group. Social activities and supportive human services were restricted to individuals able to commute to available resources. It came to our attention that residents returning to their home environment after receiving medical care were not supervised, and it was noted that poor nutrition and its related illnesses were quite prevalent.

There was no easy access to pharmacies or immediate medical assistance.

The Volunteers of America have provided a drop-in center for social recreational programs and a meal site (Loaves and Fishes) 6 days a week. A free medical clinic provides qualitative, preventive, and maintenance medical care, with pharmacy and laboratory needs available at the center. The staff includes one part time physician and two registered nurses. Volunteers include two physicians, registered nurses, and three clinic aides. We provide outreach visitation for individuals not able to come to the center. A vital aspect of this program is working in a coordinated manner with existing health providing agencies (e.g. Multnomah County Health Department, Visiting Nurse Association, and private hospitals). This allows evaluation and follow-up supervision of the elderly persons returning to their homes after hospital care, on a personal basis.

Senior adult advocates of the clinic at Volunteers of America are Mr. Fred Grigsby and Evelyn Grigsby. Mr. Grigsby is a disabled veteran receiving $142.80, and receiving social security disability of $156.50. Mrs. Grigsby is 54 years old and is also disabled, but does not qualify for SSI disability or State welfare assistance because her husband receives above income allowed for a married couple. Therefore, she is not covered medically by existing medical benefits. Mrs. Grigsby has received care for the past 4 years at this center's clinic.

Senator CHURCH. Our next panelist is Dr. James S. Bennett, professor and chairman of the division of extramural programs, school of dentistry, University of Oregon Health Sciences Center.

STATEMENT OF JAMES S. BENNETT, D.M.D., PROFESSOR AND CHAIRMAN, DIVISION OF EXTRAMURAL PROGRAMS, SCHOOL OF DENTISTRY, UNIVERSITY OF OREGON HEALTH SCIENCES CENTER

Dr. BENNETT. Senator Church and staff, many of the remarks that I will make will reinforce some of the previous speaker's comments.

I have been working in community dental and health care programs for the disadvantaged for several years, and I feel the situation is extremely critical.

As the cost of living increases, the elderly individual or family existing on low, fixed incomes is forced to forego basic health maintenance practices.

In my opinion, basic health maintenance entails the identification and management of physical, emotional, and social deficits.

As deficits accumulate and dysfunction increases, the older person is forced into living patterns that many exclude important health maintenance practices.

Examples of this are: (1) Avoiding needed medical care because the person does not want to pay the medicare deductible;

(2) Avoiding essential health services that are not adequately covered by medicare or medicaid, that is, dentistry, mental health, podiatry, and so forth;

(3) Adopting poor dietary habits due to food costs;

(4) Living in substandard dwellings where rent and energy costs contribute to substandard living conditions.

These factors frequently result in mental depression, anxiety, and fear complicated by increasing dependency, increasing sensory deficits, loneliness, and isolation.

It is estimated that 60 to 70 percent of the elderly are "at risk" to develop problems which might have been prevented or reduced in scope, requiring high expenditure of personal, public or institutional funds.

Senator CHURCH. Is that a national figure, Doctor?

Dr. BENNETT. No; it is not. That is my estimation.

Senator CHURCH. And that applies to the situation in this State?

Dr. BENNETT. Using my definition of health maintenance and the need for comprehensive health care.

It is probable that recent inflation rates will result in an epidemic of increasingly disadvantaged older persons.

DENTAL CARE IMPORTANT FOR ELDERLY

The dental perspective is particularly disheartening. The majority of elderly—about 60 percent—have combinations of natural teeth and various forms of prostheses. We estimate about 70 percent have some type of prosthetic device, with complete dentures being more common with increasing age. This situation begets increasing varieties of dental problems which are complicated and costly to solve. With decreasing ability to maintain oral health, the older person often experiences disfiguring losses of tooth and bone structure with subsequent oral dysfunction and increasing risk of infection.

It is ironic that while most oral diseases and their sequelae are widespread and costly, they can be prevented and controlled through proper nutrition and careful home care.

About 70 to 80 percent of elderly need basic dental care, but the diseases are often silent until extensive damage has occurred.

Oral health is basic to an adequate quality of physical, emotional, and social health.

I have interacted with many of these elderly people who are ashamed of their appearance, of their offensive breath, who are tired of the soft foods, and present barriers to professional oral care. It is understandable why many give up and presume that oral debilitation is a consequence of aging. We need to develop concepts that oral disease control, acceptable esthetics, and good chewing function are possible regardless of age.

A reasonable health care system for elderly should include the following characteristics in my opinion:

(1) Barrier-free access to multidisciplinary health services in a manner that maintains dignity and engenders trust.

(2) Interdisciplinary health assessment of the individual resulting in identification of problems that urgently need attention, and identi-

fication of problems needing continuing monitoring and reassessment.

(3) Development of health care advocacy systems to insure health maintenance and a reasonable quality of life.

A major prerequisite for any future system will be the appropriate education of health care providers in order that they can function effectively in such a system.

[Applause.]

Senator CHURCH. Doctor, do you think dental care should be included as part of the medicare system?

Dr. BENNETT. Yes; very much so.

Senator CHURCH. So do I.

I want to thank you members of the panel very much for coming today, and we appreciate having you.

Dr. BENNETT. Thank you.

Senator CHURCH. We have one more panel, but I just wanted to mention that the hearings will continue tomorrow morning at 10 o'clock here in this room, and we will have further witnesses then, but for those of you who can stay, we have a panel on employment.

Ms. Helen Aldredge, coordinator, Older Worker Manpower System, Aging Services Division, Human Resources Bureau, Portland, Oreg.; Mr. Don Anderson, of Portland, who is 63 years old; and Ms. Nell Bayley, of Portland, who is 62 years old.

If those panelists would come forward, we could complete our hearing for this afternoon, and we have just had a final seventh inning stretch for those who have had to get to their buses to leave, and this will be the final panel for this afternoon's stretch.

First of all, Ms. Helen Aldredge.

PANEL ON EMPLOYMENT

STATEMENT OF HELEN WARBINGTON ALDREDGE, COORDINATOR, OLDER WORKER MANPOWER SYSTEM, HUMAN RESOURCES BUREAU, PORTLAND, OREG.

Ms. ALDREDGE. We are sorry so many had to leave, but we are really here to talk to you anyway.

We want to talk to you about older workers, and the need for people to continue earning money. Employment training programs can and do benefit older workers since learning does not have to stop with age.

There are, however, many barriers to placing these persons in nonsubsidized employment because of our of forced retirement age and negative stereotypes of older people.

We also have a large segment of our older population needing to work not only to supplement inadequate retirement funds but to keep active and mentally healthy by producing and feeling needed.

Employment training programs as they are now regulated do not allow for any maintenance or long-term placements.

We feel that many people would require much less assistance from health and welfare programs if they were allowed or enabled to continue earning their own way.

Testifying today are Nell Bayley, 62, and Don Anderson, 63, who represent two major categories of need.

Don is unable to work long hours or competitively, and Nell has retrained herself to a competitive level but fears job-finding problems because she is so near forced-retirement age. I would like you to hear from each one.

Don, do you want to start?

STATEMENT OF DONALD L. ANDERSON, PORTLAND, OREG.

Mr. ANDERSON. Thank you.

I worked for the senior service center, and I am a piano player. I have been a musician all of my life until just recently, when I was struck down with emphysema. Now the only sort of work I can do is just part-time work, and so it has been a godsend to me to have this opportunity to work with the senior citizens. I think everyone has been benefited by my services, I certainly am, and I am able to make ends meet, but before that I just got my SSI check, which I could not do very well with, Senator.

Senator CHURCH. Before emphysema became a problem, didn't you work for the Ink Spots?

Mr. ANDERSON. Yes, I did, sir.

Senator CHURCH. That is very good. [Applause.]

Mr. ANDERSON. Yes, I did, and as a matter of fact, I have not had any problems all my life working until just recently, and it has been so fine that I have had an opportunity to work in the capacity that I am now, but I have no complaints.

The only thing I am worried about, I just heard, is that it might come to a termination, and then I will be back to where I was before, and that is what I was hoping that would not happen, and so I just hope that this will continue.

Senator CHURCH. It has been a real definite help to you obviously.

Mr. ANDERSON. It certainly has, Senator, and I think—what do you think might happen?

Senator CHURCH. Well, we will do our best to keep it going, I will tell you that.

I think that you are certainly a very good case in point, where the program has worked the way it was intended, and as we had hoped it would work.

Mr. ANDERSON. It has worked beautifully with me, and I just hope it continues, because I cannot be in—I cannot play in smoke-filled rooms, and I want to be independent and not get handouts.

Senator CHURCH. Sure.

Mr. ANDERSON. It is just grand. I hope that all of us senior citizens can feel the same way about the future.

A VOICE FROM THE AUDIENCE. Senator Church, as long as I am there, he will stay there. [Applause.]

Senator CHURCH. Well, we thank you very much.

Now could we hear from Nell M. Bayley.

STATEMENT OF NELL M. BAYLEY, PORTLAND, OREG.

Ms. BAYLEY. Senator, you have been welcomed by the city, county, and State officials, and last but not least, I would like to welcome you in the name of the senior citizens. [Applause.]

Senator CHURCH. Thank you.

Ms. BAYLEY. In the fall of 1973, I began looking for employment because my savings were nearly gone.

For several years my mother and I had made our home together, and subsisting on her social security and her pension, and part-time work which I was able to obtain.

She passed away, and I started looking for work, but I felt so rusty, and so I was looking around for a place where I could work part time, and get my skills back.

You may have guessed that it was I who wrote the letter* that Commissioner Clark mentioned today as being a project health consumer.

It was I who had to have a replacement of my hip, a complete replacement.

That was in early 1974. In early October, my doctors told me, after having surgery in July, that I could go to work some place, if I could find light part-time work.

I began training with the city of Portland's older workers program.

WORK IS FULFILLING

Since that time, in October of 1974, I have worked 20 hours a week, and I have progressed to 40 hours per week, and I received a small increase in my hourly rate as I went along.

My first assignment** was as a clerical aide, and I am now fulfilling what they tell me is an important function as administrative aide in the accounting division payroll department in the Human Resources Bureau.

Being able to have a chance to get back my skills, and to learn the new systems through the older worker manpower system, I have had an opportunity to learn new systems. It has brought back to me things I had thought I had forgotten, and has also enabled me to be productive.

This is fine, but the best part is being healthy, not only mentally and physically, but being self-sufficient financially and building credits in my social security account. [Applause.]

Senator CHURCH. Thank you very much.

Bill Oriol of our staff, our staff director, has a comment that I think he ought to make that is appropriate to your testimony.

Mr. ORIOL. It is simply that the Older Americans Act amendments, which both houses of Congress overwhelmingly approved just last week, includes a provision for an older Americans employment program, or community service program, which will, with proper funding, and that is still the hurdle to go, might provide a more ongoing means of continuing some of the activities which you are pioneering. [Applause.]

Senator CHURCH. I just think it is elemental if you can continue as long as anyone can continue to work, and likes work, that is the healthiest thing you can do.

It will keep you healthier and keep you living longer than anything else.

Ms. BAYLEY. I have not missed a day.

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*See appendix, item 3, p. 1833.
**See appendix, item 3, p. 1834.

Senator CHURCH. That is wonderful.

Well, we have come to the end of our agenda for today.

We have hearings scheduled for tomorrow morning, and if there is someone here who would like to testify, who would like to say a word or two, or would prefer just to speak up now rather than to send in any suggestions on this form that we have provided, you are welcome to do so.

STATEMENT OF THEODORE UHRICH, SR., SECOND VICE PRESIDENT, OREGON STATE COUNCIL FOR SENIOR CITIZENS

Mr. UHRICH. Senator Church, I would like to say this, that senior citizens need more than soup or bread. What Don Anderson has been doing is to entertain the seniors, allowing the seniors to get together in little parties and groups, enjoying themselves. It is worth more than pills, and a lot of money, and it really should be a part of your program in the service to senior citizens.

Senator CHURCH. I agree with you very much.

For the record, may we have your name?

Mr. UHRICH. Mrs. Oriol has taken my name.

Mr. ORIOL. I believe Mr. Uhrich is vice president of the Oregon State Council for Senior Citizens.

Senator CHURCH. We are very happy to have you here.

The gentleman standing over there.

STATEMENT OF BOSTON E. COLLINS, PORTLAND, OREG.

Mr. COLLINS. My name is Boston E. Collins, Portland, Oreg.

I started my retirement at age 60, because I thought I saw a chance of doing some things that I had saved up for.

Well, I have come to the conclusion, and my wife will retire in a year or two, but meanwhile our income is adequate, and at the present rate we may not have any trouble, but my experience of 31 years as a tribute to dues paying to the Teamsters Union has left a very sour taste in my mouth, because if those idiots in Chicago, in this upcoming wage negotiation act as they have in their last two times, 3 and 6 years ago, my little retirement income will not be satisfactory.

Well, we ponder then some method or some means to modify the situation. We are lucky to take the route that the old people of the war of 1920, they had some good ideas, and they were operative.

They were a little bit too rough, we could not quite swallow them, but we are going to have to swallow our pride a little bit, stiffen up our backbone, and take a shot at the Eastlands and the Stennises, to name two, chairman of the board of General Motors Corp., you might even have to go as far as maybe recommending a reinstitution of the Bastille Day, maybe we can limber up the guillotine a little bit, to get their attention at the very least.

Now, I was particularly pleased in listening to Mrs. Neuberger's statement here. She is one of my most favorite people. She has always had the courage to stand up along with Wayne Morse and Frank Church, talk straight to us, recommend, scold, condone, or whatever is necessary, and try to bring us to where we will have courage enough ourselves to take some action.

I mentioned the Teamsters Union, they perhaps were a good organization in 1894. They were perhaps still a good organization in the 1930's, but by 1952, we needed them less, and now we do not need them at all.

In the 31 years I paid tribute to them, they possibly represented me on two separate occasions, as much as 20 seconds each time, other than that, I had to fend for myself.

I could manage my affairs, but we get so far out in the woods, that I discovered in 1959, that the welfare, the Pension Fund's Disclosure Act of August 28, 1958, cost us all more than we could bear to carry.

Anytime that the Congress of the United States is pushed to a point where they have to enact a law, that maybe a very small segment of the people, the Stennises, the Eastlands, and those people, that everybody else loses a great deal, so I guess I have said all I need to say, and I thank you very much.

[Applause.]

Senator CHURCH. Thank you very much.

The gentleman in the back would like to say a word.

A VOICE FROM AUDIENCE. Nobody has suggested, but I would like to ask you, why aren't you running for President of the United States in 1976?

Senator CHURCH. Who knows, maybe I will. [Applause.]

Thank you very much for coming, everybody. If you can come back tomorrow, our hearings are starting here at 10 a.m.

[Whereupon, the hearing was recessed at 4:20 p.m.]

APPENDIX

LETTERS AND ENCLOSURES SUBMITTED BY INDIVIDUALS

ITEM 1. LETTER FROM R. A. (DICK) WILSON, COORDINATOR, OREGON STATE COUNCIL FOR SENIOR CITIZENS; TO WILLIAM E. ORIOL, STAFF DIRECTOR, SENATE SPECIAL COMMITTEE ON AGING, DATED NOVEMBER 10, 1975

DEAR BILL: In response to your request for input to Senator Church's Aging Committee from the Council, I offer the following comments . . .

HOUSING

In Oregon, the State Legislature has passed legislation allowing the State to issue bonds for construction of low-income housing for seniors. Since this takes a constitutional amendment, we are working for passage of a ballot measure that will be on our May primary ballot.

2. We would like to see transportation costs and objectives included in any Federal housing projects. It is necessary to have transit facilities available when housing is provided for seniors.

3. We believe that the concept of 25 percent of income should be revived as it relates to housing construction. This should include utility and maintenance costs.

4. Income and savings levels need to be raised where this is a criteria for qualifying for low-income housing.

FOOD

1. The food stamp program is a horror. Individuals and families eligible for the program are prevented from obtaining stamps because of the maze of regulations. Seniors object to a "means test" and will not even apply for food stamps.

As the Congress reviews this program, it is our hope that it will be moved from the Department of Agriculture to Health, Education, and Welfare where it rightfully belongs. As long as State welfare agencies continue to administer the program, many eligible seniors will not apply. They simply refuse to deal with "welfare," feeling it is beneath their dignity.

2. A device needs to be established that will assure that all our seniors are receiving balanced meals. As you know, there are many programs in the field, but very little coordination. This results in duplication of effort and misses many seniors. We hesitate to recommend establishment of another bureau, but a consolidation of present programs would seem to be desirable.

TRANSPORTATION

1. The primary concern of seniors in Oregon is the lack of public transportation in our rural areas. Mass transit efforts seem to be directed to urban areas and on main arterial highways. Not much attention is given to moving people in rural areas. We need systems that will get people to medical facilities, Government agencies, and just plain shopping areas. We would like to see the Federal Government divert some interstate highway funds to this type of project.

HEALTH

1. The immediate concern in this area is expanding intermediate care facilities—that is, facilities that will allow patients to move out of expensive hospital rooms to a more inexpensive facility prior to returning home. These facilities need more medicare coverage.

2. In conjunction to this, an expanded home care program is desired. Many seniors are capable of staying in their homes if they had a supplemental home care or housekeeping service available.

3. National health insurance. This is long overdue and is a "do pass" item for this congressional session. At the present time, the Kennedy-Corman bill seems to meet the needs of seniors best. Do you suppose there is any chance that our Congressmen will forget politics long enough to agree on a much needed national health insurance bill?

In addition to the above, the Council is now working with our PUC Commissioner as well as the State Legislature to arrive at a solution to the rising utility rates. We are proposing the life-line concept, believing that this will reach the most people. We are also proposing that the State of Oregon, through legislation, assist in a home-winterizing project. The combination of lower lifeline rates and winterizing will help to solve the financial problems of many of our citizens. Perhaps the Federal Government, through the FCC, would be able to assist the lifeline concept nationally.

Finally, we believe that many of the problems encountered by our seniors would be solved with a program of income maintenance. It is painful to me to see our seniors handed meager tid-bits such as food stamps, lower bus fares, meal centers, special rates at movies, and subsidized housing, et cetera. These are piecemeal at best, and do nothing to preserve the dignity of our senior citizens.

A guaranteed income would eliminate the need for many expensive programs now offered for the well being of seniors. These programs have been shown time and again to be inadequate, expensive and not meeting the needs of many of our seniors.

After all, these citizens have spent a lifetime contributing to the well being and prosperity of this Nation. All they ask in return is an opportunity to live out their lives in peace and dignity. Due to many circumstances beyond their control, they have been left in poverty and need. They do not want to be considered as a "peculiar" group and shunted aside. They need to be included in the main stream processes of our country. Only by considering our senior population as an asset and a necessary part of our total population can we guarantee them a right to a peaceful and dignified life.

Thank you, Bill, for giving us an opportunity to tell the committee of our concerns. I hope your schedule will allow us to meet with the committee in Oregon.

Sincerely,

R. A. (DICK) WILSON.

ITEM 2. LETTER AND ENCLOSURE FROM DONALD E. CLARK*, CHAIRMAN, MULTNOMAH BOARD OF COUNTY COMMISSIONERS; TO SENATOR FRANK CHURCH, DATED FEBRUARY 6, 1976

DEAR SENATOR CHURCH: Enclosed is the additional information about Multnomah County's Project Health that you requested. I apologize for the delay in providing this material.

We received final approval from HEW for our Medicaid Demonstration Project in January, and began enrolling patients on February 1.

I deeply appreciated the opportunity to testify before the Special Committee on Aging, and am grateful for your kind comments.

If I may provide you with any further information, please do not hesitate to contact me.

Sincerely,

DONALD E. CLARK.

[Enclosure.]

MULTNOMAH COUNTY MEDICALLY NEEDY DEMONSTRATION PROJECT

The State and county medicaid pilot program involves a series of waivers of usual medicaid requirements for the purpose of performing a special health care delivery system demonstration project for the medically indigent through Multnomah County, Oregon's, project health. Medicaid funding is requested in this proposal by the State of Oregon to permit the State to gather the actuarial and health statistical information necessary to determine the viabiliy of a statewide

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*See statement, p. 1793.

medicaid program. In the process, the proposal permits project health to extend its established services to the categorically eligible, but financially ineligible population having incomes above the categorical welfare standard up to 115 percent of that ceiling. The program will integrate medicaid ineligible, but medically indigent, project health clients into a single population served by a system designed to broker the medically underserved residents of Multnomah County into the "mainstream" of medical care.

Project health is a Multnomah County program, administered by the Division of Health Services, for the pooling of Federal, State, and local funds for the purchase of health care services in the general medical marketplace for categorically ineligible, medically indigent residents (and for the purchase of hospital care for categorical cash grant recipients after in-patient benefits have been exhausted). The project commenced planning in 1972, has furnished institutional services since 1973, and will inaugurate a full range of ambulatory and hospital services by subsidizing premium payments to four prepaid health plans; (1) Cascade Health Care (a small group-practice HMO); (2) Kaiser Health Plan (a large group-practice HMO); (3) Oregon Physicians Service (Blue Shield); and (4) The Family Practice Clinic of the University of Oregon Health Sciences Center.

By 1977, the medicaid demonstration project will add to the population served by project health at least 20,000 of the estimated 41,000 medically needy county residents. The combination of interlocking programs is capable of meeting the needs of the majority of persons unable to cope with personal medical costs in the county.

Clients will be located through concerted education and referral efforts at social service agencies, for example, welfare department, food stamps, et cetera, and at traditional entry points into the health care delivery system for those accustomed to episodic care (for example, hospital emergency rooms, health department access clinics and community nursing programs, teaching clinics, selected private physician offices, et cetera).

Orientation programs will be provided for such commissioned recruiting personnel. After final eligibility certification is accomplished by the Welfare Department, trained enrollment counselors will help the client to decide on which service option is most appropriate to his needs (one of the four prepaid plans, or a card for direct provider reimbursement for precertified services). Once the client is enrolled in a plan, he will be indistinguishable from other subscribers.

A small client-paid premium contribution is required for the prepaid plans (the amount depending upon income, family size and the particular plan selected); in all cases, the comprehensive benefit package is identical, as established by contract specifications. Therefore, the plans must compete with one another in price, to attract enrollees, but the cost to the funding source is stable since it is based on a per capita rate. Utilization control is incumbent upon the prepaid provider or carrier at risk; quality control will be facilitated through contract with the federally designated PSRO, the Multnomah County Foundation for Medical Care.

An internal evaluation system, supervised by an independent, third-party evaluation firm, will seek to determine answers to a number of question incorporated in the evaluation section of the medicaid proposal.

WHAT IS CURRENTLY BEING DEMONSTRATED BY PROJECT HEALTH?

To the Federal Health Legislator and/or Administrator

Project health represents a model for national health financing. Several aspects of project health make it an especially important model. First, *pooling* of Federal categorical dollars from varying sources to purchase a single benefit package for all project health recipients (while satisfying reporting requirements of separate funding categories) permits targeted funding without fragmentation of client services. Pooling will allow the Federal Government (and other funders) to assess the extent to which a specific categorical purpose is achieved without establishing separate administrative and financing bureaucracies for their implementation. Secondly, project health is not a separate system for the poor like the county hospital system which it replaced. Rather, it absorbs the medically indigent into the same system which serves more affluent residents of Multnomah County. The emphasis of this integration is a program of comprehensive health care benefits, including preventive and health maintenance services, through

enrollment of the medically indigent individual into one of four prepaid health plans. Thirdly, project health recognizes that there will be other barriers to health care beyond mere dollars. The project couples the financial services with the "access system", an innovative redirection of the health services traditionally provided by the Multnomah County Public Health Division. This new orientation of direct government operated health services, toward overcoming barriers to access to mainstream health care, is a model for needed government services under national health financing, an area currently inadequately explored in most national health insurance legislation and of significant interest in congressional committee staff.

To the Health Systems Agency (Areawide Health Planning Organization)

Project health represents the financing, client advocacy services and systemwide quality maintenance approach which will be necessary if implementation of areawide health plans is to be achieved. The project also represents the model for an agency which could be joined into a single regionalized health authority (or health care corporation) to assure the Federal mandate of integrity of federally financed health and health care programs.

To the Local Health Policymaker (Board of County Commissioners)

Project health represents an opportunity to achieve the mandate to assure, promote and protect the health of all people by directing necessary expenditures for the medically disenfranchised in such a way that the entire health care delivery system is favorably influenced. By purchasing rather than providing, and by pooling rather than fragmenting, local government reduces separate parallel bureaucracies and can realize the administrative economies of scale. By coupling financing with the services of the locally operated public health department, the effectiveness of the latter can be enhanced, meeting increased demand for services with increased effectiveness rather than with increased staff.

To the Client

Project health provides the dignity of access to a single system, not a "poor folks" system; except to the computer (management information system), the client is indistinguishable from other prepaid plan enrollees. More important, it represents the opportunity for the medically indigent to promote and maintain the health, rather than chasing after it in an illness-based direct services indemnification system.

WHAT IS PROPOSED TO BE DEMONSTRATED BY INTEGRATION OF MEDICAID FUNDS INTO PROJECT HEALTH?

To Federal Health Legislators and Administrators

Integration of medicaid funding into a single system of health care funding and brokerage addresses the as yet unanswered question of the efficacy of centralization of medicaid and its potential incorporation into a national health financing package. Special concerns about assuring the rights of the indigent and disenfranchised while assuring cost-effective and accountable expenditure of Federal funds are central to the proposal.

To the State Legislator and Health Administrator

The project permits collection of adequate data for proper evaluation of the issues which attend the legislative decision to implement a statewide medically needy program in the State of Oregon. Of special interest is the possibility that a medically needy program could maintain persons in health adequate to prevent their further spend-down into welfare.

To the Local Health Policymaker

Addition of medicaid dollars to match local hard county general fund dollars enables local government to come still closer to achieving its mandate. Good will, good design, good administration and even a good share of the County's property tax are inadequate to meet the need for health services for the medically indigent. Federal assistance, through medicaid match (and through funding from the other Federal health dollar categories which will also be contributing to the "pooling" approach) will be necessary.

To the Client

The medicaid demonstration project represents access to health services which can keep that person healthy, employed, productive and hopeful.

HOW WILL THE MEDICAID DEMONSTRATION BE CARRIED OUT?

The document which follows is a technical and literative description of a highly complex, already operating medical care delivery project. Integrating the medicaid client into services already purchased for other medically indigent persons in the mainstream can be achieved by finding him, determining his eligibility, and counseling him within the same system which provides care for other project health clients. Thus, once the State Welfare Division has referred the person eligible for medicaid financing into the project health system, that client, except for an identifying code which allows the person's services to be documented, becomes indistinguishable from other project health clients.

The project health client is educated concerning his or her options for prepayment among the various prepaid systems available. The thrust of project health is to encourage, to the extent possible and appropriate, enrollment in a prepaid and health maintaining system, rather than episodic use of the traditional fee-for-service system. Once enrolled, the medicaid client receives the same services of other project health clients * * * most especially, the assistance of the "access system", the ongoing consumer advocacy, health education, and client tracking systems of the local health department. Moreover, he enjoys a range of services equal to, or greater than, those benefiting subscribers of the health plan which he elects, without stigmatization as a "charity patient", since he will be indistinguishable to providers from other plan members.

HOW WILL WE KNOW IT WORKS?

First of all, it works already! That is, already thousands of Portlanders are receiving services in the mainstream. However, funding under medicaid will result in further implementation of project health's system evaluation program. The specific evaluation questions to be addressed in the medicaid demonstration project are also contained in this document. However, the overall thrust of the evaluation addresses the following goal: To determine whether application of medicaid funds, by a local brokering organization, toward purchase of four prepaid health insurance programs for indigent persons will result in: (1) increased utilization of "mainstream" health care resources; (2) improved access to medical services; (3) more comprehensive coverage; (4) comparable or more favorable cost benefit indicators; and (5) increased satisfaction of both providers and consumers.

The ultimate goal of project health is to assure, promote, and protect the health of all people by assuring access to a single, preventively oriented health care delivery system for all of the residents of Multnomah County. Medicaid demonstration funding will permit Multnomah County to come one step closer to achieving this goal. Therefore, this request is made.

ITEM 3. LETTER FROM NELL M. BAYLEY*; TO DONALD E. CLARK, CHAIRMAN, BOARD OF COMMISSIONERS, PORTLAND, OREG., DATED NOVEMBER 14, 1975

DEAR COMMISSIONER CLARK: Please accept my apology for the delay in answering your letter of October 18, 1975, postmarked October 27, 1975, and received November 5, 1975. I am as slow as the post office, if that is possible.

As a "Project Health Consumer" you asked for my "thoughts on this program." I don't think, I *know*, it was a miracle for me, for which I will always be grateful. If it were not for Project Health Care Delivery System, I would be a hopeless invalid and on welfare today instead of being able to work 40 hours a week and be self-sustaining.

In January of 1974 I went to my personal physician because of the excruciating pain in my left hip. He ordered X-rays and they showed disintegration of the hip joint and referred me to Dr. Roderick Begg, orthopedic physician, who confirmed the radiologist's reading of the X-rays and recommended surgery to replace the hip joint and part of the thigh with plastic and stainless steel.

Early in 1973 I received a flyer from the Royal Order of Masons informing me of the trust fund set up by Louis G. Clarke for treatment of "worthy members of Masonic Lodges." Benefits were also available for members of their families, including daughters, at Good Samaritan Hospital. Dr. Begg does not operate at

*See statement, p. 1824.

that hospital so he referred me to Dr. Faulkner Short, who is on Good Samaritan staff. Dr. Short concurred with Dr. Begg, saying that surgery should be performed as soon as possible.

I gathered the necessary documents to prove my father was a member in good standing at the time of his death and proof that I am a member of the Order of the Eastern Star. I presented these to Mr. W. W. Youngston, Jr., Secretary of the Administrative Committee. He informed me I should have the surgery and then petition for consideration of acceptance of my case.

During this time I was in contact with Mr. Shumack, business office manager, at Good Samaritan Hospital. Neither he nor I felt I should enter the hospital under these conditions. He knew my financial condition, that is, no income, no insurance, and my savings used up to less than $400, so he contacted Florence Bowles of Project Health for me.

Mrs. Bowles was just great! She was kind, considerate, and most helpful. She worked with the hospital, doctor, and me and in less than 2 weeks I had surgery.

Lab tests showed I had sustained a small fracture of the hip, probably when I fell and fractured my left shoulder in December of 1970. Osteoarthritis had set in and disintegrated my hip socket and upper portion of the thigh bone.

Before my hip got so bad, I had applied for work with Operation Mainstream and, because their program applied only to people living in the county, they sent my application to Helen Aldredge, coordinator of the senior community service project. She called me and we became very well acquainted via the phone. On October 24, 1974, while still using one crutch, I was placed with the Human Resources Bureau as clerical aide/receptionist in the Area Agency on Aging, working 4 hours a day.

On January 15, 1975, I was transitioned to the Older Worker Manpower System as Secretary to the coordinator and worked 32 hours a week. On September 16, 1975, I was appointed administrative aide in the accounting department of the Human Resources Bureau and am now working 40 hours a week.

I hope you won't feel my account of events is too lengthy or that it sounds as if I were bragging. In a way, it's *my* "success story" made possible by *your* program.

I was desperate when I contacted your office and didn't know which way to turn. I had very little social security to my credit, no income, no job, and the terrible pain. It was a pretty poor picture at the age of 61. Next month I will be 63; I have a job; the pain is gone and I can keep up with the youngsters in HRB youth manpower, and without even the use of a cane. Life is beautiful, thanks to Project Health!

Many people should know about your program. I had no idea there was anything like it in existence and, I might add, neither did the doctors.

Sincerely,

NELL M. BAYLEY.

FIRST ASSIGNMENT INFORMATION BY NELL M. BAYLEY, PORTLAND, OREG.

AREA AGENCY ON AGING DIVISION

(Caroline Sullivan, Supervisor)

Hire—October 24, 1974, Clerical Aide/Receptionist.

Responsibilities:

1. Receive and direct incoming calls to Area Agency on Aging.
2. Type letters and documents as requested by AAA Director, planner, service coordinators, and Senior Community Service Project Director.
3. Keep time for AAA and central staff.
4. Filing and other general office activities as requested.

$2.10 per hour—20 hours week.

Transitioned to Older Worker Manpower System, HRB, January 15, 1975. Helen Warbington Aldredge, Coordinator

SECRETARY TO COORDINATOR

Responsibilities:

1. Act as receptionist and provide information to both walk-in and telephone contacts in coordinator's office.
2. File materials in central file system; type letters and reports as required.
3. Be responsible for payroll control for all OWMS participants.

4. Maintain the master roster and make changes as they are relayed to the central office; report changes periodically to area managers.

$2.50 per hour—32 hours week.

April 1, 1975—$3.00—40 hours.

ACCOUNTING DEPARTMENT

(Gary Holiday, Administrative Services Officer)

September 16, 1975—Administrative Aide.

Responsibilities:

1. Work with the Accounting Division on all the time and attendance reports (TAR), personnel action notices (PAN), mileage reimbursements for the older worker manpower system (CETA I and SOSP).

a. Process TARs twice each month, including preparing for transmittal to the subcontractor.

b. Process PANs and prepare TARs for each one.

c. Send out authorization for reimbursement forms to all those driving personal cars on business.

d. Keep accurate files and documentations for all the above.

2. Compose and type brief memos and letters to worksite supervisors and related staff in relation to questions or instructions for the above task areas.

3. Do research in these and related personnel records as required by Accounting Division.

4. Answer telephone and explain to worksite personnel and/or participants in OWMS how the payroll system is planned, when required.

5. Complete other tasks as designated by the Accounting Division and as time permits.

$3.30 per hour—40 hours week.