S. HRG. 102-508

# A HEALTH CARE CHALLENGE: REACHING AND SERVING THE RURAL BLACK ELDERLY

## WORKSHOP

BEFORE THE

## SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

HELENA, ARKANSAS

AUGUST 28, 1991

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# A HEALTH CARE CHALLENGE: REACHING AND SERVING THE RURAL BLACK ELDERLY

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WEDNESDAY, AUGUST 28, 1991

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Helena, AR.*

The Committee met, pursuant to notice, in the Fine Arts Center, Phillips County Community College, Helena, AR.

Staff present: Portia Porter Mittelman, staff director; Mia Masten, professional staff; Kris Phillips, communications director; Sherbert Harvey, intern; and Carter Thomas, intern.

## OPENING STATEMENT BY PORTIA PORTER MITTELMAN, STAFF DIRECTOR, SPECIAL COMMITTEE ON AGING

Ms. MITTELMAN. Good morning, everyone. First of all, I think we should start out by giving special appreciation to the Lee County Chorus. The Chorus is under the direction of Mrs. Gleola Bursey; and our soloist this morning was Mrs. Alma Clemmer, so another round of applause for the Chorus.

Before we start I do have one announcement. Apparently, one of our participants this morning lost a diamond ring in the bathroom, so if anyone finds a ring if you could give it to one of us running around here or Mia over there, please. Thanks.

My name is Portia Mittelman. I'm the staff director for the Senate's Special Committee on Aging, and we really are delighted that you've come out in this terrible weather to be with us this morning.

Our workshop today is on serving the rural black elderly, and I bring you greetings this morning from my boss, Senator David Pryor, who serves as Chairman of the Senate Special Committee on Aging. Many of you are aware that the mission of the Senate Aging Committee is to explore all aspects of life that impact older Americans. In keeping with this mandate, Senator Pryor has directed us to develop policy recommendations for a host of issues, including housing, transportation, health care, and legal services. The list goes on and on.

Senator Pryor has a particular concern for the special problems of rural areas, and today's workshop is but another step in his plan to study every component of rural life. We have come to the Delta Region of our State, home to a concentrated population of elderly blacks, to devote our attentions to a discussion of the problems and rewards of serving the black elderly. Although we'll be hearing about the challenges of promoting and delivering health care to this population, we won't stop there. We'll also hear about unique

and effective programs that are meeting this challenge. Senator Pryor often tells us, "We all know about the problems. Now let's concentrate on the solutions."

I'd like to share with you a letter Senator Pryor wrote to welcome you to the workshop today. There are copies of the letter available for everyone outside on the table in case you didn't pick it up. The letter reads:

Dear Friends, I am delighted that you are attending the workshop on A Health Care Challenge: Reaching and Serving the Rural Black Elderly. This is the first session of a very special workshop series on preventive health care for the minority elderly. As many of you are aware, this series is a follow-up to the historic hearing the Special Committee on Aging held in conjunction with the Congressional Black Caucus Health Brain Trust last September.

Last year's hearing helped shed some light on the health status of the black elderly. The purpose of this workshop series is to promote ongoing discussion and to raise consciousness about the disparity and health status among the minority elderly. We are also highlighting programs that are doing something to eliminate this inconsistency.

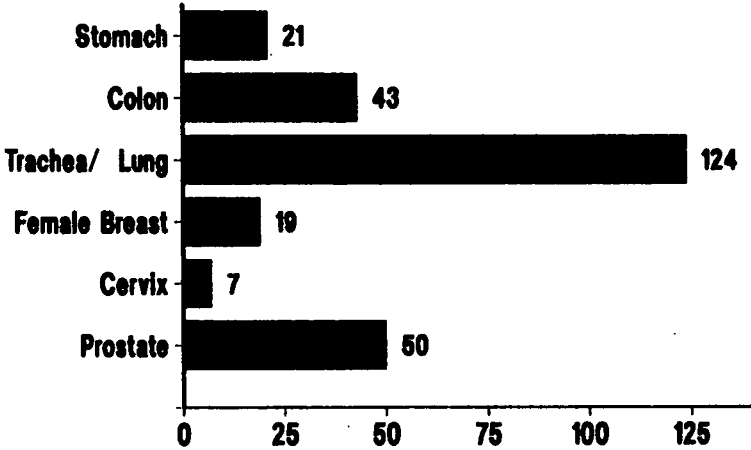
Since my recent heart attack, I now take preventive health care much more seriously than I have in the past. It is disturbing to see that although there has been a decrease in deaths from heart disease within the general population, the death rate from this disease in the Afro-American community has remained the same.

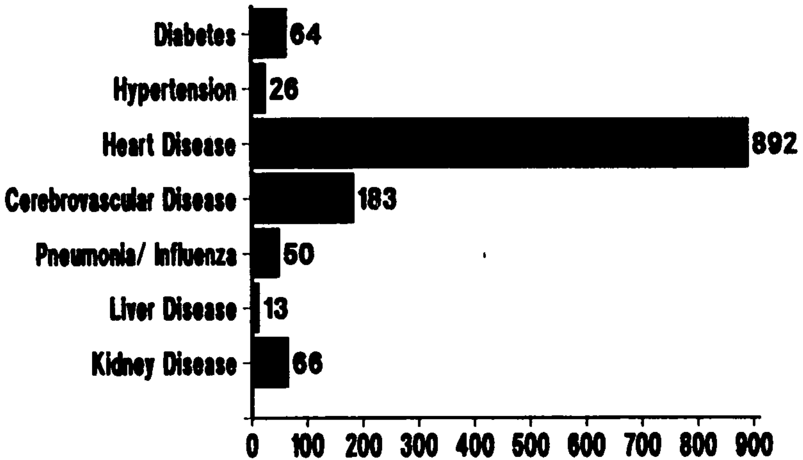
We have some charts that are showing some of the statistics that Senator Pryor is referring to.

We have also learned from testimony during last year's hearing that blacks have a 25-percent higher incidence of cancer. Cancer of the lungs, prostate, and pancreas are more frequent than other types of cancer. At the front of the room you will notice the chart of cancer deaths among blacks age 55 and over who died in Lee and Phillips Counties in the last 10 years. You will see for yourself how much higher the numbers are for these cancers compared to other forms of this disease. Many of these lives could possibly have been saved through effective health promotion strategies.

We have assembled a distinguished group of experts to share with us the importance of health promotion and to discuss current programs that are reaching and meeting the needs of the rural black elderly. Please feel free to ask questions and make comments as we welcome your thoughts and insights on this important issues.

And he signs it sincerely, David Pryor.


1980–90 Deaths Among Blacks Age 55 and Over
Lee and Phillips County Arkansas
Stomach
21
Colon
43
Trachea/ Lung
124
Female Breast
19
Cervix
7
Prostate
50
0
25
50
75
100
125
Source: Ar


1980–90 Deaths Among Blacks Age 55 and Over
Lee and Phillips County Arkansas
Diabetes
64
Hypertension
26
Heart Disease
892
Cerebrovascular Disease
183
Pneumonia/ Influenza
50
Liver Disease
13
Kidney Disease
66
0
100
200
300
400
500
600
700
800
900
Source: Arkansas Center for Health Statistics

Ms. MITTELMAN. Now let me just underscore a little of what the Senator has said in his correspondence. For today's session to be a success, all of you should feel free to participate. Ask questions, challenge the speakers, share your experiences. We need the benefits of your collective insight; and before you even make comments, there is a microphone in the center of the room here.

The moderator for today's forum is Dr. Bailus Walker, Dean of the College of Public Health for the University of Oklahoma Health Sciences Center. Dr. Walker will be introducing our panel in just a moment, but first we will be viewing an excerpt of the documentary on the Arkansas Delta prepared by the Arkansas Educational Television Network. Following the film clip, the panel will come forward with their presentations.

Now, before we see the film, there are a number of people we need to thank for really making this happen today.

First of all, we have to thank Dr. Steve Jones who is the President of Phillips County Community College; also Paula Hickey and Derrick Thompson who are also on the college staff. They're responsible for the room this morning and setting it up to our liking; also Dr. Charles Cranford and Jim Wohlleb of the Arkansas Department of Health; Sam Simmons and Larry Crecy of the National Caucus and Center for the Black Aged in Washington, DC; Jim Galliher of the Center for Rural Elderly; John Eason and everyone at the Lee County Cooperative Clinic; the Minority Affairs Division of AARP and, of course, AETN for providing us with the film.

And last but not least, I'd just like to thank several of my Aging Committee colleagues. There are some of them against the wall. First, Kris Phillips. Kris is our communications director for the Aging Committee in Washington. And we have two interns who came to share with us this morning. Sherbert Harvey, who's over by the wall. Sherbert is a graduate student at the University of Oklahoma; and he completed a fellowship with our committee this summer, also Carter Thomas who's over there by the door. Carter's a student at Hendrix, and he also did an internship with us this summer.

And last but not least, Mia Masten, who is in the peach jacket. Mia's really the driving force behind today's workshop, and I'd like for you to give her a special round of applause.

I again welcome everyone and let's begin.

[Video of documentary of Arkansas Delta played.]

## STATEMENT OF DR. BAILUS WALKER, DEAN, COLLEGE OF PUBLIC HEALTH, UNIVERSITY OF OKLAHOMA

Dr. WALKER. I'm going to step to the podium because I have an old football injury that gives me problems, and I need to stand periodically.

I'm Dr. Bailus Walker, Dean of the College of Public Health, University of Oklahoma; and it's certainly a pleasure for me to convene this forum on "A Health Care Challenge: Reaching and Serving the Rural Black Elderly." As you well know, this forum is under the direction of the U.S. Senate's Special Committee on Aging, and that committee is chaired by Senator David Pryor.

We should commend Senator Pryor for his effective leadership in addressing the national problems of the elderly—the health, social, and economic problems of our senior citizens. And the Committee ought to be commended, the committee that Senator Pryor chairs. It should be commended for the extraordinary work that it has done and continues to do on behalf of the elderly citizens in this country.

Senator Pryor has directed that this discussion today focus on health promotion for black elderly in nonurban areas. It is very clear from the video that we saw that this is, indeed, an appropriate focus because involvement for providing health services to elderly blacks is rapidly changing due to the significant social and economic changes, many of which we saw identified in the video.

It is also clear that rural society and rural infrastructure both have undergone major transformations in the 20th century. It's very clear that the rate of poverty in rural communities now exceeds that in major cities. But this focus on health promotion strategies is also appropriate because we have an increasing body of knowledge that makes very clear that aging, getting older, can proceed without—and I underscore "without"—disease and dysfunction and related problems.

In reality, I think it's very clear that many of the changes that take place during the aging process is due to diet, to smoking, drug use, to environmental exposure, and to some extent some of the psychological or social influences. As this knowledge about risk factors as we call it in public health—as this knowledge increases, I think it has brought into very sharp focus the importance of health promotion and disease prevention which is our topic today.

This discussion here today is taking place against a background of knowledge that suggests that black elderly are in need of health promotion services; that black elderly in rural communities are interested in receiving health promotion services; and that there are health and social services, providers, who are, indeed, interested in working with black elderly to help them change behavior, change practices that will prevent disease and dysfunction.

There is emerging a very strong emphasis on health promotion and disease prevention—early detection, early treatment. It's not only emerging in the academic community, but we're beginning to see more physicians practice health promotion and disease prevention in their offices.

And we're also seeing significant policy development. Tobacco use is declining throughout the United States. We are seeing a whole new group of codes and ordinances that are restricting the places where you can now smoke.

The food industry is changing its processing and related methods of producing foods, so that we now have in the market a large number of products that are low in fat, low in cholesterol, low in salt. All of these are designed to help people make choices conducive to health.

Food labeling has become a matter of national policy. This also is helping consumers make choices about proper nutrition.

Many insurance companies now are reducing their premiums on people who are carrying out healthful behavior, and so we're

seeing a great national movement toward health promotion and disease prevention.

Against that background, let me talk about some of the general approaches to health promotion among the elderly. And I will not talk about any specific model because there are a number of them, and you will hear from the rest of the speakers about various approaches that they have pursued in their own activities. I'd like to talk about some fundamental principles that I have distilled from a number of programs that are being carried out across the country.

First, I think it's very clear that the church in both urban and rural communities is a very, very important institution and plays an important role in building self-respect and in teaching people to take an active role in leading healthier lives, and there is a church in every community. There's probably no church that could not coordinate and carry out a health promotion program designed to reach elderly persons.

In several southern communities we find local churches providing—providing space, providing personnel, all focus on health promotion activities. Several churches have established health centers located in their facilities, and these churches are emphasizing prevention and health promotion. There are a number of churches that have engaged in very, very effective high blood pressure screening and control programs. A number of churches have trained lay members to go out into the community and teach others about health promotion and disease prevention activities.

So the lesson from these couples of examples is very clear. We need to use existing institutions to carry out health promotion activities, and the church is a well-established institution in most communities and certainly can be used as one avenue to reach the black elderly.

The second thing that we have learned from these models is that collaboration is a very, very important thing because in order to reach the rural black elderly we need multiple channels. We need many avenues to reach this population; and, therefore, no single agency in State or local government and no single community organization can reach this population. And, therefore, it becomes important for many agencies to collaborate.

Later on you will hear about historical black colleges and universities that have developed integrated approaches, bringing in agencies on aging, bringing in the American Cancer Society, bringing in the local cooperative extension program; all of these groups collaborating to reach the elderly with health promotion and disease prevention activities.

A related consideration is taking the programs directly to the elderly, and this is one of the reasons why I think we need to commend Senator Pryor and his committee for bringing these programs, these hearings, and these discussions right to this community. All too often these types of discussions take place in Washington far from the target population or from the community where the problems exist. And I think that same principle has to apply in health promotion and disease prevention activity. We've got to take these programs directly into the community. In many cases, we may need to invest dollars into mobile units to reach people who may be living at some distance from the center of town.

The third consideration is the tailor-making of the program. The program developed for the Delta Region or for this community may be different from health promotion programs that are developed in Tennessee or Kentucky or other States. We must tailor-make these programs to meet the fundamental needs of the target of population in our specific communities. All too often we have designed programs in one State or one community, and think that we can move that program to another State or another community without considering the special needs of the receiving community. And all too often, programs are failed because we have not tailor-made those programs to meet the specific needs of the community.

And, finally, I would suggest that we need, certainly, a national health program that has a very strong emphasis on health promotion and disease prevention, a program that integrates promotion and prevention into curative medicine. Many physicians focus much attention on treatment. What we are suggesting here is that we need a national program that focuses more attention on prevention, that physicians in the private practice of medicine think first about how to prevent disease and disability before they consider how curing or treatment may take place.

Finally, there can be very little doubt that the opportunities—the unlimited opportunities to provide services to black elderly in the rural community exist. And while our attention here today is focused on older adults, the elderly, we would all agree that health promotion should not be arbitrarily started at any specific age. Ideally, health promotion for the elderly should begin at childhood. We would pay particular attention to the needs of the elderly. Indeed, we ought to be working with children, so that once they reach that older age, health promotion practices would have already been in place.

What we will accomplish here today is a discussion of some of these strategies. We will leave here with some suggestions or recommendations as to how we reach this population, how we can take programs that may have been effective elsewhere and implement them with some modification in this region. The individuals that you will hear today are experienced in this area, and they will bring to us some new insight as to how best to approach this very important problem that Senator Pryor and his committee are focusing on.

Let me introduce to you the first speaker who will be Ms. Carol Crecy who is the Deputy Associate Commissioner for State and Community Programs with the U.S. Administration on Aging. Ms. Crecy will outline some of the activities of the Administration on Aging, Ms. Crecy.

[The prepared statement of Dr. Walker follows:]

### Opening Statement of Dr. Bailus Walker, Dean of Public Health, University of Oklahoma, Health Sciences Center

It is a pleasure and honor to convene this forum on A Health Care Challenge: Reaching and Serving the Rural Black Elderly under the direction of the United States Senate Special Committee on Aging.

The committee is chaired by Senator David Pryor of Arkansas who is an effective leader in a national effort to address the health, social and economic needs of the elderly. Senator Pryor and the committee are to be commended for their extraordinary work on behalf of our elderly citizens and for convening this forum.

Senator Pryor directed that today's discussion focus on health promotion for black elders in non-urban areas. This is indeed an appropriate focus because the environment for providing health services to non-urban elderly is rapidly changing due to significant social and economic changes that are taking place.

Rural society and rural infrastructure have undergone major transformations in the twentieth century. To be sure the rate of poverty in rural America now exceeds that in major cities of our country. But this focus on health promotion strategies is also appropriate because an expansive body of scientific data now make clear that aging can proceed without disease and dysfunction. In reality, many of the changes during the aging process are the results of such preventable risk factors as diet, smoking, inactivity, drug use, environmental exposure and psychosocial influences.

As this knowledge about risk factors has been gained, so has the growth in the potential contribution of health promotion activities and related services to improve the functional status of senior citizens. This expanding knowledge has also brought into stark relief the importance of integrating quality of life considerations into optimal health promotion programs and services.

Finally, these discussions here today take place against a background of data which show that (1) the black elderly are in need of health promotion services, (2) the black elderly are interested in receiving health promotion and disease prevention services and (3) there are health and social services professionals avidly interested in working with black elderly to help them sustain behaviors and practices that prevent disease and that promote health.

Indeed, there is emerging a stronger emphasis on the practice of prevention and promotion through early detection of diseases and through counseling by physicians and other health professionals.

Running parallel to these developments are secular changes in society. Tobacco use is declining and throughout the United States new codes and ordinances are restricting tobacco use in public places. The food industry is changing its methods of food processing and of preparation to reduce fat, cholesterol and salt content of food. Health foods are increasingly available in supermarkets and in restaurants. New food labeling requirements will help consumers to make dietary choices most conducive to health. Further, there are financial incentives for individuals with healthy life-styles in the form of lower insurance costs and higher taxes on users of tobacco and alcohol. In the environmental health area, economic incentives are also being put forward to encourage industry to do more to prevent pollution of air, water, and soil at its source.

The sum vector of the preceding list of developments is an environment in which health promotion strategies can be brought to older adults in rural settings.

In this context then there are a number of models for reaching elderly blacks in sparsely populated areas. Rather than cite specific models or attempt to evaluate their effectiveness or even suggest a preference for one over the other it is more productive to outline a number of fundamental principles or themes which emerge from these several approaches.

First, the church in both urban and rural communities is a valued institution and plays an important role in building self-respect and in teaching people to take an active role in leading a healthier life. There is probably no church in non-urban communities that could not coordinate and carry out a health promotion program designed to reach elderly persons. In several southern communities, local churches are providing space for outpatient clinics in which health promotion activities have been integrated with curative medicine with emphasis on nutrition, exercise and related health promotion counseling and guidance.

Another church in this southern region established in 1987 a health center which works with several other churches and focuses on the "whole person" approach to health care. This church sponsored health center provides all services offered by a family physician: preventive, therapeutic, health promotion and education. In addition, the church health center sponsors a health education program which centers around lay advisors who receive eight weeks of training to teach church members about hypertension, diabetes, depression and other health problems. In another community, a state university has developed a church-based health promotion program that serves approximately 5,000 black elders. This program provides various health services such as health education and physical fitness initiatives.

The lesson from these experiences is clear: Existing institutions that already serve the elderly should be encouraged to provide, expand and improve coordination of health promotion services.

Second, "collaborative effort" is a common theme of many of the community-based health promotion strategies because reaching older adults in non-urban areas often requires multiple channels or avenues.

Several programs developed by historically Black Colleges and Universities have integrated the efforts of Cooperative Extension Services, agencies on aging, agricultural groups, public health and social services agencies, as well as voluntary agencies such as the American Cancer Society which, for example, has several projects underway to provide comprehensive cancer prevention-related services to underserved communities.

Clearly there are legions of resources that can provide avenues of approach to older adults in rural communities: Medicare services, the numerous outreach programs of the Administration on Aging (U.S. Department of Health and Human Services), food and nutrition programs, farm extension services, publicly assisted housing programs and related social services programs supported by both private and public sector agencies and organizations.

The active participation of diverse segments of the community in health promotion strategies should blur the importance of involving the elders themselves and their families in the actual planning, designing and implementation of health promotion projects. In summary, meeting the health promotion needs of older adults is a shared responsibility.

Related to this collaborative scheme is another consideration; taking health promotion information and strategies directly to the target populations. This means reaching the elderly in their homes, in places where meals are served to them or in other places where they may spend a considerable amount of time. Linking health promotion activities with home health and social services can be highly beneficial to the target population. This may require mobile units to ensure that the maximum number of persons can be reached even in the most remote areas.

Recognizing the importance of taking health promotion strategies to the target population and of the value of home-based services, a number of foundations have funded programs to encourage the expansion of non-traditional services such as home maintenance and repair to prevent falls and other types of injuries, housekeeping services and transportation which enhances efforts of older adults to pursue sound health promotion practices while at the same time function as independently as possible in the community.

A third consideration is to tailor-make health promotion programs to meet demonstrated needs. Assessing the health promotion needs is an important first step. This assessment should identify and prioritize health risk factors among the target population as well as the identification of perceptions, health beliefs and self-care practice. Such information will aid in the development of programs and services that are culturally sensitive and meaningful to the older adult population and provided in an environment that is concerned about the needs of that population.

All too many programs designed for older adults have failed because it was assumed that services provided in one community could be replicated in another without an assessment of local needs and interests. Demographic social and economic constraints mitigate against such an approach.

Fourth, there is an urgent need for a national health program with a strong emphasis on health promotion and clear incentives for the integration of public health/preventive medicine into every element of the health service system. This subject has been discussed extensively over the past several decades and all available evidence points to a growing level of support for comprehensive reform of the health care system. How soon such reforms will be brought to fruition cannot be predicted with any degree of accuracy.

What is clear, however, is that incremental strategies—the development of a series of policies designed to "fill in the gaps"—may not be sufficient to offset the current and expected future rise in health care costs unless there is a robust national investment into prevention services.

## CONCLUSION

There can be very little doubt that the opportunities for applying our rapidly expanding base of knowledge are imposing to contemplate.

While our attention today is focused on older adults, we would all agree that health promotion should not be arbitrarily started at a specific age. Ideally health promotion for the elderly would not begin in the latest stages of development but would be a part of an ongoing program begun in childhood.

Thus, the health care system, the social services agencies, the education community and many others should encourage individuals of all ages to increased responsibility for their own wellness and health promotion. But individuals will need all forms of assistance in undertaking this responsibility—an issue which will be explored in presentations and discussions heard here today.

## STATEMENT OF CAROL CRECY, DEPUTY ASSOCIATE COMMISSIONER FOR STATE AND COMMUNITY PROGRAMS, U.S. ADMINISTRATION ON AGING

Ms. CRECY. Good morning. Thank you for inviting me to participate in this workshop on the health status of the rural black elderly. I am pleased to be able to represent the U.S. Administration on Aging on this very important occasion.

Dr. Joyce T. Berry, the U.S. Commissioner on Aging, is charged with the responsibility of providing for a comprehensive, coordinated system of services which enable older persons to maintain their independence for as long as possible. But she is also personally concerned about the well-being of every older American and committed to taking action to enhance the quality of life of the elderly.

Workshops such as this are important, if we are to conquer today's concerns and face the challenges of the future. The aging of the population of America is expected to have a significant impact on the Nation's health care system, as well as the social and economic components of our society.

Federal, State, and local governments, health care providers, and health researchers must work in concert if appropriate public policy decisions are to be made and implemented. And individuals must take personal responsibility for adopting good physical and mental health practices.

Before I talk about the initiatives undertaken at the Administration on Aging, I'd like to share with you some demographic information about the elderly, especially the black elderly.

According to the most current census data available, the older population—60 plus—of all races is projected to grow by 99 percent between 1989 and 2030, compared to 183 percent for the black elderly.

The older black population numbered about 3.6 million or 9 percent of the older—60 plus—U.S. population in 1989, but are projected to be 12 percent of this population in 2030. In fact, elderly blacks are the fastest growing segment of the black population.

The percentage of older—65 plus—black persons with incomes below the poverty level in 1988 (32 percent) was more than two and one-half times the poverty rate for older people in general (12 percent).

Older (65 percent) black persons are more likely to report their health status as fair or poor than other people in general (41 percent versus 29 percent in 1989). Likewise, the percentage reporting health-related limitations and activities was higher for older black persons (48 percent versus 37 percent in 1988).

The level of education attainment by older (65 percent) black persons is below that of other people as a whole, whether this is measured by median years of schooling (8.4 versus 12.1 years in 1988) or percent completing high school.

Now, I have just given you a lot of statistical data, but what does it really mean? It means that the factors which largely determine the quality of life for an elderly person—education, employment, income, and health have a disparate impact on older black Americans. And it's not likely to improve greatly in the near future.

For many years, the Administration on Aging has supported numerous research and demonstration projects to test innovative ways of providing health education, health promotion, and health care services to all older Americans, particularly as it relates to minority older persons.

The initiative, "Health Promotion for the Minority Elderly," utilized historically by colleges and universities (HBCUs) to foster collaboration and cooperation among those who serve older people. The initiative was designed to address the health promotion needs of older minority people by accessing the wealth of human resources harnessed by the HBCUs.

The 10 schools awarded grants under this initiative are involved in developing and demonstrating strategies that will ultimately promote better self-care habits among America's diverse population of elderly people.

Because there is a dearth of information on self-care strategies for minority elderly, there is an urgent need for this kind of information which we will receive from these grants. Most of them will be coming to a close within the next couple of months, and we hope to have the results of their studies probably within the next 90 days.

Other efforts mounted by the Administration on Aging which impact on the health status of older minorities include a project at the University of Alabama in Birmingham, which will train nutrition project staff to identify older persons with hearing problems and refer them for care. The project will target rural, low income, and minority older persons.

Another project coordinated by Lincoln University of Missouri, which will engage 10 historically black colleges and universities in a diabetic screening, referral, and counseling program and a nationwide diabetic public education campaign.

Grants awarded to five national minority organizations and to two local organizations to increase the awareness of entitlement programs among minority older persons, and to enable them to gain greater access to supportive services and entitlement programs.

The National Resource Center for Rural Elderly was established in 1989 at the University of Missouri at Kansas City. This center serves as a focal point for information, technical assistance, and training concerning issues affecting the rural elderly in three focus areas—transportation, health care, and housing and assisted living alternatives.

In order to address the eldercare needs relating to the income security of older black persons at risk, particularly older minorities, women, and people who live alone or with nonrelatives, the Administration on Aging established the National Eldercare Institute for Income Security at the Families USA Foundation. One of the activities of this institute will be to convene selected aging and nonaging organizations to facilitate their development of outreach strategies by providing information, technical assistance, and training on the issue of entitlement programs, particularly the qualified Medicare beneficiary program.

Although the majority of today's older Americans are healthier, better educated, and more financially secure than previous genera-

tions, the statistical information I gave to you earlier clearly indicates that there is a large number of elderly, especially the black elderly, who cannot look forward to a healthy and secure old age. It is this group of elders at risk of losing their independence who the U.S. Commissioner on Aging was determined to reach and assist when she launched the National Eldercare Campaign.

For these and other older Americans, the crucial consideration is to function independently, at home, and in the community as long as possible. Their greatest fear is that if and when they begin to lose that independence, there will be no one or no place to turn to for help.

What is the National Eldercare Campaign? It is a nationwide, multiyear effort to mobilize resources for home and community-based care for older persons at risk of losing their self-sufficiency.

The Eldercare Campaign is aimed at expanding the involvement of a variety of agencies and organizations representing government, business, labor, the voluntary, religious, and civic communities.

Because the National Eldercare Campaign is focused on how older persons at risk are served in their homes and in their communities, action at the local level is critical to its success. Community Eldercare Coalitions which we refer to as "Project Care—Community Action to Reach the At-Risk Elderly," will be called upon to demonstrate that public, private, and voluntary sectors can be mobilized around an Eldercare agenda and cooperate effectively in providing home and community-based services for older persons at risk.

We also plan to undertake a National Media Campaign to focus the public's attention on the unmet needs of older Americans and the changes in society that the demographic revolution will bring.

The basic premise of the National Eldercare Campaign is that "Aging Is a Community Affair." There's a general assumption that the community and the family are responsible for the welfare of children, but not a similar one at the other end of the age spectrum where care-giving is often left to families alone. An Eldercare system that works will always be one that involves the family and the community.

Older Black Americans are judged to have poorer health status than aged white Americans by numerous standards of measurement. In addition, many of the health conditions experienced by black older persons may be lifestyle-related. High blood pressure, lung cancer, and diabetes are of special concern.

Clearly, this is a situation that can be influenced by facilitating the acceptance of personal responsibility for one's own health care. By changing certain risk behaviors into healthy ones, older persons can improve health and reduce the likelihood of disability. Improvements in diet, nutrition, increased physical activity, reduction in tobacco use and weight control can eliminate and enhance the health of older people.

Although it's commonly believed that problems in old age are inevitable, many are, in fact, preventable or can be controlled.

Providing information about and encouraging and motivating older minority people to adopt good physical and mental health practices is a priority of immense importance.

There are many factors which impact on the disparity of health status and health care of most minority populations in the United States. We are making some progress in identifying and understanding their significance.

We recognize that progress toward a healthier America means a substantial improvement for certain populations that are especially at risk.

The U.S. Administration on Aging is committed to correcting the disparities between services provided to minority and nonminority older persons. Today's workshop is evidence of Congressional support for our Nation's most vulnerable citizens.

Our goal is to ensure that all Americans have the opportunity to enjoy a healthy old age. By working together we can make that goal a reality. Thank you.

[The prepared statement of Carol Crecy follows:]

REMARKS BY CAROL CRECY, U.S. ADMINISTRATION ON AGING

INTRODUCTION

Good morning. Thank you for inviting me to participate in this workshop on the health status of the rural black elderly. I am pleased to be able to represent the U.S. Administration on Aging on this important occasion.

Dr. Joyce T. Berry, the U.S. Commissioner on Aging, is charged with the responsibility of providing for a comprehensive, coordinated system of services which enable older persons to maintain their independence for as long as possible. But she is also personally concerned about the well-being of every older American and committed to taking action to enhance the quality of life of the elderly.

Workshops such as this are vitally important, if we are to conquer today's concerns and face the challenges of the future.

The aging of the population of America is expected to have significant impact on the Nation's health care system, as well as the social and economic components of our society. Federal, State and local governments, health care providers, and health researchers must work in concert if appropriate public policy decisions are to be made and implemented. And individuals must take personal responsibility for adopting good physical and mental health practices.

Before I talk about the initiatives the Administration on Aging has undertaken to address the unique needs of older minorities, I would like to share with you some demographic information about the elderly, especially the black elderly.

DEMOGRAPHIC HIGHLIGHTS

According to the most current census data available, the older population (60 plus) of all races is projected to grow by 99% between 1989 and 2030, compared to 183% for the black elderly.

The older black population numbered about 3.6 million or 9% of the older (60 plus) U.S. population in 1989, but are projected to be 12% of this population in 2030. In fact, elderly blacks are the fastest growing segment of the total black population.

Nearly three out of every five aged black individuals are women.

Black persons have a life expectancy of 69.6 years compared to 75.2 years for nonminorities—a gap of over 5 years. However, the survival rate for black persons who reach age 70 is higher than for white persons.

Major causes of death among elderly black persons are cancer, heart disease, stroke, diabetes, and cirrhosis of the liver. In nearly all of these diseases, the death rate for black individuals far exceeds that of nonblack individuals.

In 1988, the median income for older (65 plus) black families ($13,500) was 38% lower than the median income for all older families ($21,800).

Older (65 plus) black couples and individuals are about as likely as older people in general to receive income from Social Security (86% versus 91% in 1990) or earnings (14% versus 17%), but are much less likely to receive income from private pensions (22% versus 32%) or assets (26% versus 68%).

However, they are three times as likely to receive income from SSI or public assistance programs (22% versus 7% in 1986).

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The percentage of older (65 plus) black persons with incomes below the poverty level in 1988 (32%) was more than 2½ times the poverty rate for older people in general (12%).

Economic factors have been shown to play a major role in the health and well-being of the black elderly. It increases the risk of functional impairment and the need for long-term care. It limits access to quality professional health care for those in need of long-term care. Chronic diseases especially in the black elderly impose large demands on the personal financial resources and thus result in severely diminished quality of life in this population.

Older (65 plus) black persons are more likely to report their health status as fair or poor than older people in general (41% versus 29% in 1989). Likewise, the percentage reporting health related limitations in their activities was higher for older black persons (48% versus 37% in 1988).

Currently, the insurance coverage most readily available to the elderly is Medicare, which is designed primarily to cover hospital care for the acute illness, and is of limited use to the elderly who suffer from chronic health conditions. It is even less helpful for the low-income black elderly because of rising coinsurance and out-of-pocket costs.

The level of educational attainment by older (65 plus) black persons is below that of older people as a whole, whether this is measured by median years of schooling (8.4 versus 12.1 years in 1988) or percent completing high school (24% versus 54%).

I have just given you a lot of statistical data, but what does it really mean. It means that the factors which largely determine the quality of life for an elderly person—education, employment, income and health—have a disparate impact on older black Americans. And it is not likely to improve greatly in the immediate future.

## ADMINISTRATION ON AGING INITIATIVES

For many years, the Administration on Aging has supported numerous research and demonstration projects to test innovative ways of providing health education, health promotion, and health care services to all older Americans, particularly as it relates to minority older persons.

The initiative, "Health Promotion for the Minority Elderly," utilized historically black colleges and universities (HBCUs) to foster collaboration and cooperation among those who serve minority older people. The initiative was designed to address the health promotion needs of older minority people by accessing the wealth of human resources harnessed by the HBCUs.

The 10 schools awarded grants under this initiative are involved in developing and demonstrating strategies that will ultimately promote better self-care habits among America's diverse population of elderly people.

The HBCUs participating in this initiative are: Alcorn State University, Natchez, MS; Florida A&M University, Tallahassee, FL; Hampton University, Hampton, VA; Lincoln University, Jefferson City, MO; Morehouse School of Medicine, Atlanta, GA; Morgan State University, Baltimore, MD; Prairie View A&M University, Prairie View, TX; Tougaloo College, Tougaloo, MS; Virginia State University, Petersburg, VA; and Voorhees College, Denmark, SC.

Because there is a dearth of information on self-care strategies for minority elderly, there is an urgent need for the kind of information which we will receive from these grants.

Other efforts mounted by the Administration on Aging which impact on the health status of older minorities include:

A project at the University of Alabama at Birmingham which will train nutrition project staff to identify older persons with hearing problems and refer them for care. The project will target rural, low income, minority older persons.

A project at Boston University which will develop a statewide diabetes education initiative aimed at service providers and minority elderly to focus on etiology, symptoms, treatment and life style modifications.

A project coordinated by Lincoln University of Missouri which will engage 10 historically black colleges and universities in a diabetic screening, referral and counseling program and a nationwide diabetes public education campaign.

Grants awarded to five national minority and two local organizations to increase awareness of entitlement programs among minority older persons and to enable them to gain greater access to supportive services and entitlement programs.

The National Resource Center for Rural Elderly established in fiscal year 1989 at the University of Missouri at Kansas City. This center serves as a focal point for information, technical assistance and training concerning issues affecting the rural

elderly in three focus areas: Transportation, health care and housing/assisted living alternatives.

In order to address the eldercare needs relating to the income security of older persons at risk, particularly older minorities, women, and people who live alone or with nonrelatives, the Administration on aging established the National Eldercare Institute on Income Security at the Families USA Foundation. One of the activities of this institute will be to convene selected aging and nonaging organizations to facilitate their development of outreach strategies by providing information, technical assistance and training on the issue of entitlement programs, particularly the qualified Medicare beneficiary program.

THE NATIONAL ELDERCARE CAMPAIGN

Although the majority of today's older Americans are healthier, better educated, and more financially secure than any previous generation of older Americans, the statistical information I provided earlier clearly indicates that there is a large number of elderly, especially the black elderly, who cannot look forward to a healthy and secure old age.

It is this group of elders, at risk of losing their independence who the U.S. Commissioner on Aging was determined to reach and assist when she launched the national eldercare campaign.

For these and other older Americans, the critical consideration is to function independently at home and in the community as long as possible. Their greatest fear is that, if and when they begin to lose that independence, there will be no one and no place to turn to for help.

What is the national eldercare campaign? It is a nationwide multiyear effort to mobilize resources for home and community-based care for older persons at risk of losing their self-sufficiency.

The eldercare campaign is aimed at expanding the involvement of a wide variety of agencies and organizations representing government, business, labor, the voluntary, religious, and civic communities.

Because the national eldercare campaign is focused on how older persons at risk are served in their homes and in their communities; action at the State and local levels is critical to the success of the campaign. Community eldercare coalitions, which we refer to as Project Care—Community Action to Reach the At-Risk Elderly, will be called on to demonstrate that the public, private, and voluntary sectors can be mobilized around an eldercare agenda and cooperate effectively in providing home and community-based services for older persons at risk.

We also plan to undertake a national media campaign to focus the public's attention on the unmet needs of older persons and the changes in society that the demographic revolution will bring.

The basic premise of the national eldercare campaign is that "aging is a community affair." There is a general assumption that the community and the family are responsible for the welfare of children, but not a similar one at the other end of the age spectrum where caregiving is often left to families alone. An eldercare system that works will always be one that involves family and community care.

NEED FOR PERSONAL RESPONSIBILITY

Older black Americans are judged to have poorer health status than aged white Americans by numerous standards of measurement. In addition, many of the health conditions experienced by black older persons may be lifestyle-related. High blood pressure, lung cancer and diabetes are of special concern.

The longer a person lives, the greater his or her chances are of incurring at least one or more chronic conditions.

Clearly, this is a situation that can be influenced by facilitating the acceptance of personal responsibility for one's own health care.

One of Secretary Sullivan's themes for the 1990's promotes the concept of personal responsibility. This concept seems to best exemplify the mission of the Administration on Aging in the area of health promotion.

By changing certain risk behaviors into healthy ones, older persons can improve health and reduce the likelihood of disability. Improvements in diet, nutrition, increased physical activity, reductions in tobacco use and weight control can enhance the health of older people.

Although it is commonly believed that health problems in old age are inevitable, many are in fact preventable or can be controlled.

Providing information about and encouraging and motivating older minority people to adopt good physical and mental health practices is a priority of immense importance.

CONCLUSION

There are many factors which impact on the disparity of health status and health care of most minority populations in the Untied States. And we are making some progress in identifying and understanding their significance.

We recognize that progress toward a healthier America means a substantial improvement for certain populations that are at especially high risk.

The U.S. Administration on Aging is committed to correcting the disparities between services provided to minority and nonminority older persons.

Today's workshop is evidence of congressional support for our Nation's most vulnerable citizens.

Our goal is to ensure that all Americans have the opportunity to enjoy a healthy old age. By working together we can help make that goal a reality.

Dr. WALKER. Thank you very much.

Let's see. Mr. Ed Doman is your counterpart at the local level. He is director of the East Arkansas Area Agency on Aging. We welcome your perspective.

## STATEMENT OF ED DOMAN, DIRECTOR, EAST ARKANSAS AREA AGENCY ON AGING

Mr. DOMAN. Thank you, Dr. Walker.

Ladies and gentleman, every Agency on Aging is involved in the provision of several services to the black rural elderly community. These services include congregate and home-delivered meals, transportation, case management, and personal care. The meals and transportation are subcontracted, while case management and personal care are provided directly.

Some of the barriers we perceive include the following:

Transportation.—Black elderly individuals are much less likely to own dependable automobiles. Even if they own automobiles, many are physically unable to operate them. This creates a situation where independent living is virtually directly tied to the availability of affordable transportation. Getting to town to see the doctor can be an expensive proposition when a person's income is below the poverty level, and referral to a regional specialist is even more problematic. The existence of a service or resource means very little if the person in need cannot access that resource. We have an elderly transportation network, but it needs to be expanded. We plan to upgrade our transportation services when funds become available from the additional 1 cent cigarette tax that was passed by the State legislature this past session.

Another barrier we see is substandard housing. Much of the housing, both urban and rural, do not constitute a good living environment. It's difficult to maintain acceptable personal hygiene without hot water and adequate toilet facilities. A person is much more susceptible to health problems in both summer and winter when the house is virtually open to the elements.

We also identify emergency medical transportation. Truly rural elderly have a tremendous problem if they have a medical emergency. When an ambulance has to respond from 40 miles away to a site without street numbers, one would just have to hope that the emergency was not too critical. Obviously, this is a problem for the

entire rural population, but the frail elderly person is much more likely to need ambulance service.

We also feel there are inadequate community alternatives. I list this because our agency tries to work with individuals to maintain as much independence as possible for as long as possible. Our experience is that people desire to remain in their own home and receive what services they do get from local sources, if possible. Presently, such services as adult day care and respite care are not readily available in most communities. In the absence of appropriate home and community-based programs, individuals are pushed toward institutional care.

In summary, I would say our activity is trying to reach and serve the black rural elderly individuals in a manner that they desire. The process starts with a case manager who goes to their home and makes them aware of what services are available, which services they are eligible for, and gives assistance in accessing the appropriate services.

Problems exist because of the extensive need for transportation to medical services and other resources that help maintain independence. The living environment resulting from extended poverty is a complicated factor. Unfortunately, part of the solution is money. It will take more funding to develop new community programs and a mechanism to get to them. However, I can honestly say I believe that the prolonged independence and improved quality of life for the elderly is worth the price. Thank you.

Dr. WALKER. Thank you. Let me now introduce to some of you and present to others Mr. John Eason, who is the administrator for Lee County Cooperative Clinic. This clinic provides a number of services for the elderly, and he will share with us his experience.

## STATEMENT OF JOHN EASON, ADMINISTRATOR, LEE COUNTY COOPERATIVE CLINIC

Mr. EASON. Thank you, Dr. Walker. We at the Lee County Cooperative Clinic have been in business for 22 years; and we're constantly on the firing line. Dr. Walker talked about collaboration. We started collaborating with the health department, and we have an Elderly Program in which to serve the elderly in our area.

We know that the plight of the indigent elderly is one which causes nightmares for all of us. This is especially true of those of us who witnessed their problems with economics, socialization, and health care. As we see the diseases which affect the already weakened bodies of these people, as we witness the problems of not enough money for medication or utility bills, we are more determined than ever to make the quality of life better for the elderly.

Many of these elderly have spent their lives in the fields or doing their odd and menial jobs which were honest but hard. The endcare benefits, they deserve to have decent homes, clothes, and food. We must accept this challenge and not pass it on to someone else.

Now, we know that medical care and economics are interdependent on how one—how well one lives. Now, economically, some of the people that come to our senior citizen programs receive Social Security. Social Security ranges about $425 per month. That's high. We have a lot of people living on less than $425 per month. Their

SSI check on that $425 is $2 so their total income is $427 per month. Now, there's one person their Social Security's $87. Their SSI is $140. Now, the spouse's Social Security is $200 and SSI and $140—$340 with two people in the family—$567. Those two individuals live on $567, Dr. Walker, per month.

Now, they have to try to pay utility bills out of this $547 a month and eat; and if they have to go to the doctor, you know that they would not have very much medical care. And we know some people in Lee County who live on less than this amount of money. We have some who get a little retirement, but very little.

Now, medically, in the Lee County Cooperative Clinic we have dental facilities, we have medical facilities, and we have pharmacy. We have people coming from Cross County, St. Francis County, Phillips County, because we can fill a prescription, Dr. Walker, for $4 regardless of what it costs us. A person that's on Medicare and below the poverty line can get their prescriptions filled for $4.

Now, a lot of times if they have to go out in the community it will cost $40 or $50, and you know a person getting $300 to $400 per month does not have very much money to spend on drugs. All right.

Now, what are some of the most common diagnosed diseases? Now, I'm not going to get too much into this because we have Dr. Payne who worked at the Lee County Cooperative Clinic. He knows more about the medical side than I do, but I was intelligent enough to go have a meeting with one of my physicians yesterday so I wouldn't be stupid. I didn't want to be like one of our former Presidents. He would go to sleep when things would be happening.

Now, the number one problem that we have is hypertension. Now, who wouldn't have hypertension if he were trying to live on $400 a month. See, we're talking about economics, folks. If you were going out trying to live on $400 a month, you'd be hypertensive.

All right. We'll talk about diabetes. Now, what do we do about diabetes. Now, we have a dietitian who will give the diet—who will tell you, what foods to eat and those foods not to eat. So we try to be preventive, but, people, when you are in poverty, you don't think about prevention. You think about getting well now; you don't worry about what's going to come in the future. You think about immediacy which is now.

Socially, now we said that we have the Aging Program. When I first started with the clinic in 1977—Mr. Doman, you weren't with the Aging Program at that particular time, we were serving 5 meals per day; now we're serving 200. We have 100 home-delivered meals. We have people that take 100 meals to people in their homes so that they will have one good meal per day. And we have one lady that calls us—every Monday she will call us three times, "Are you going to serve meals today?" Yes, ma'am. We're going to serve meals today. And she'll call back in another 10 minutes, "Are you going to serve meals today?" Yes, ma'am. We're going to serve meals today. Because this lady knows that if she does not get this good meal, this is the only good meal that she will get during the daytime.

Then we have what we call congregate meals. That's where you go to the center. We have a center where we bring them, most of

them we transport, Mr. Doman had told you that we got some new vans because of the 1 cent sales tax that was passed. So we use the vans—we have five areas in the county, and bring in 15 or 20 elderly from each area of the county once per week, and they are like children, folks. They are glad when Monday comes; they know that we're going to Monroe. The people in Monroe are glad when Monday comes because they come by the center, they get their meal, and they do their shopping.

And it's—it's very funny. We had one young lady that when I first started working driving the van. In a rural society you have people with hogs, they have chickens, and they have to buy their chops and things to keep their chickens; so they were buying 100 pound bags and this young lady had to carry 100 pound bags because they couldn't. So these are some of the things that you have to look at. When you are employing people, you have to know what they're going to be doing because you don't want a young lady lifting 100 pounds. So you say that the civil rights people are going—say, well, you've been discriminatory. But you don't want a young lady carrying 100 pounds, do you? At least, I'm from the older school; I wouldn't.

So, the people are very, very glad to come. Now, people you know a lot of times the elderly are exploited. They are exploited by their own kin—their daughters, aunt, or nieces or nephews. What I mean by this, Dr. Walker, is this. You will see the elderly on the third. They will be on their sticks, their walkers, taking their checks to cash. Why? If their friends—if their relatives cash them, sometimes they don't get their money. They will fleece them out of their money.

You may think that I'm lying, but you go to the First National Bank on the third in Marianna. You will see those people there because they want their money because they have to pay their bills. And if they don't go and do it themselves, what will happen? They don't have it. People will take their money. So, these are some of the things you don't know. When you're running an operation in a rural area, you have to be pretty shrewd.

These are some of the things; and as I have stated before, we work with the health department. We also have a housing project. We have housing because, you know, housing, water, sanitation, all of this is important to health—how well you live; how long you live. And exercise—we also have calisthenics for the elderly. They have a big time. You saw Steve Barnes out of Little Rock there on Channel 7 where you have exercise. They make quilts, and they sell quilts. They raffle off the quilts; they sold me one. I think I had to pay about $75 which is cheap; because you go in the North, you can give a lot more for a quilt.

These are some of the things that we're trying to do in the community to help the elderly. And the only thing that we can say—we know that we need more money, but instead of the more money, we're trying to do better management. I'm 56 years old. I was born and reared in Lee County, and I can remember when you didn't have very much meat, Ms. Crecy. You take and make a lot of gravy; so that's what we do now. We take a small amount of meat and make a lot of gravy where everybody can get a little of the pie, all the people.

So, that's what we're doing at the Lee County Cooperative Clinic, and we have a great group of board of directors, and you saw our choir. We had to let them go back because some of those were nurses. We try to give people what they need. Thank you very much.

[The prepared statement of John Eason follows:]

LEE COUNTY COOPERATIVE CLINIC
530 West Atkins Blvd., Marianna, Arkansas 72360
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EASON's PRESENTATION

The plight of the indigent elderly is one which causes nightmares for all of us. This is especially true of those of us who witness their problems with economics, socialization and health care.

As we see the diseases which attack the already weakened bodies of these people, as we witness the problem of not enough money for medication or utility bills, we are more determined than ever to make the quality of life better for the elderly.

Today you have the opportunity to make a difference. We urge you to make policies and pass bills which will increase the quality of life for the indigent elderly. Many of these elderly have spent their lives in the fields or doing other odd and menial jobs which were honest, but hard. The end result was small reward. They deserve to have quality health care benefits, they deserve to have decent homes, clothes and food.

We must accept this challenge and not pass it on to someone else. These elderly have already paid the price. We owe it to them to help them to enjoy the American dream. Don't you think that it is time that bill is paid?

Think about the elderly who are victims of stroke, heart disease, diabites and arthritic pain. Think of the many hypertensive patients who are sick and some dying from lack of adequate care.

I urge you to make the difference in the lives of our elderly.

LCCC CARES

AN EQUAL OPPORTUNITY EMPLOYER

Dr. WALKER. Thank you. Dr. Payne has certainly been on the front line of these issues, and he's a physician from Memphis and practiced in the Delta Region. He has had some firsthand experience on dealing with the issues and problems that the elderly face. Dr. Payne, would you share those experiences with us?

STATEMENT OF ERNEST B. PAYNE, JR., M.D.

Dr. PAYNE. Yes, thank you. Good morning and thank you for inviting me to this debate and workshop.

I've listened very carefully to some of the comments so far, and I have some comments about some of those things. I think one of the most important things in terms of my experience at the Lee County Clinic in Marianna is the impact that poverty plays—as a risk factor, for disease. I think one of the panelists mentioned earlier that something could be done on the part of individuals who are sick to prevent disease, and this is true but disease marches on. Disease has been with mankind and will continue to be with mankind. And it is, in many cases, something none of us can do anything about.

I think poverty, in particular, very often is a risk factor for disease. I know in my own private practice in Memphis and patients that I did see, elderly patients, in the clinic in Marianna, the overwhelming majority of them were poor people. I think when individuals are termed or defined as being poor, many times we will often use income levels.

At Lee County Clinic I've noticed that the word "poverty" very often meant "absolute poverty" and that individuals were so poor that there was no income. One of the things that distressed me most, I think, was the cost of medication. It didn't mean very much for a patient to come to the clinic and have the medications prescribed for them and the cost of that medication would very often on average be $170 to $300 a month, particularly if the patient was on more than one medication a month. If it were not for that pharmacy in that clinic, many of the patients would not have seen medicine at all.

Mr. Eason mentioned that in the clinic they were able to provide some medications at $4 a prescription on a monthly basis. This is true, but many times the medications that the patient required were not available. These are some of the more expensive medications that would literally outstrip the budget of the clinic if the clinic were forced to provide those medications. So, it was not unusual to see patients return to the clinic sicker than they did the month before, but simply because they could not afford the medications. So, one of the things I want to stress at this workshop—this is something we're really going to need to do something about.

Another thing I would like to impress upon everybody's mind—and this is something that I think the community, doctors, nurses, clinics, the politicians, everybody must be aware—must be made aware and must be involved with a commitment that begins with the realization that health care is going to cost money. It's not going to cost less money in the future; it is going to cost more. As the population ages, as the number of people reaching the age of 65 increases, as the number of people who live to the age of 85 and 90

increases, they are going to be—there's literally going to be more people who are elderly and poor who will require health care. The aging process continues, but generally we're seeing a trend in which people are living longer, and they are going to require health care. They are going to require health care that is accessible to them, that is affordable, and that is quality care. It doesn't mean very much if you are sick, you live in Lee County, and you have chest pain, and you come to the clinic and the doctor there decides or diagnoses that you have coronary artery disease and you can't get the bypass surgery or you can't get the cardiac catheterization because there is no local hospital to provide that service. If you need to be referred to a major center, such as Little Rock University or Memphis and you have no money, then you are not going to get the bypass surgery that you may need. You're not going to get angioplasty or some of the things that have recently been realized in the medical profession as advances. So, this is something we need to do.

We need to realize that rural elderly people need the same quality and level of care that everybody else receives in other parts of the country. There is a disparity truly in the type of health care that is given people in rural communities as opposed to urban communities. There is a difference between the type of care that is given to people who are poor than those who have private health insurance. This is unfortunate, but it is a fact.

I agree there should be emphasis on preventive health care. This is extremely important. Again, one must look at that particular problem in the view of who you are talking to. If you say to a poor, elderly individual that a low cholesterol diet or low-fat diet is important for their health, this is a good thing to tell them; but if they cannot afford fruits and vegetables, then you have not accomplished anything.

Many of the individuals that I saw in the clinic could only afford beans and cornbread because these were the cheapest items that they could afford. This is not very good if you have high blood pressure or if you're a diabetic or if you have coronary artery disease. This is something that's not very good; but if this is all you can afford, then this is where you must work from. So again it is not always the individual's fault that they are unable to cooperate with the doctor in preventive health care.

Again, we need to remove poverty as a risk factor for disease, and I want really to emphasize that. The things that the clinic, such as Lee County Clinic, are doing in terms of the elderly health care centers—exercise programs and diet programs, meals, transportation, and so forth, are all very good; but the clinic is only able to do that on a limited basis with a limited number of people. So these are things that we know are working well. These are the things that the money should be spent for. We don't need any B–2 bombers at $800 million apiece.

It was very shocking for me to find out that there are approximately 350 to 400 community health centers across America and that total U.S. funding for these clinics is approximately $400 million, a little less than that, I think, this year. And the cost of one B–2 bomber being $800 million is—was something that was incredi-

ble to find out. So I think the priorities that we have in this country should be changed.

If we realize that health care costs and the alternative is to have a Nation of sick people receiving substandard or poor quality care or inadequate care or not enough care, then eventually society pays for that in other ways. So if we can do something on the front end, that is, starting with the very youngest and all the way through and beyond age 65, is something very meaningful and I think we can make a dent in this and do something.

But again the commitment must be made. The decisions must be made in Washington, that this is the direction that we're going to go, that no longer are we going to have a pluralistic society that we have in America where we have all of these problems, and we can't solve them because they cost too much. Yes, they do cost, but we are intelligent, educated individuals. Many of us are Christians. We believe that the right thing must be done; so we should get on with doing just that.

Again, thank you for inviting me.

Dr. WALKER. Thank you very much. Thank you very much, Dr. Payne. I think we will all agree that, certainly, poverty is one of the leading causes of death and may never appear on the death certificate, but I think it's very, very clear now—we're very clear about the fact that poverty is a factor.

Let me, oh, raise several questions, I think, that all of your presentations have generated. One of the concerns the Committee—the U.S. Senate Special Committee on Aging has reaching this population. How do we reach the rural population of elderly people? Some of them probably live in remote areas where transportation may not be the best. Some of them may be unaware of the kinds of programs that we've identified here this morning. How do we reach these—how do we reach this population? If we address that issue, I believe there are some other things that follow. Let me ask you, Mr. Eason. How do you get your services out to people who may not be aware—may not be able to come into your clinic? How do you reach the people?

Mr. EASON. Well, Dr. Walker, we've been there so long; we don't have to advertise. They know we're there. But the problems that we have—we don't have enough finances to reach those people that could avail themselves. We have a waiting list. We're serving 100 now, (home delivered) but we could do 40 or 50 more.

Dr. WALKER. So are you reaching 50 percent, 60 percent, 70 percent? What percentage of the population that need your services are you reaching?

Mr. EASON. I'd say about 70 percent. Fifty to seventy percent.

Dr. WALKER. Mr. Doman, you've got case workers, case managers?

Mr. DOMAN. Right.

Dr. WALKER. How are they operating?

Mr. DOMAN. The case worker is the initial access point to all the services that we provide. The case worker is knowledgeable of what services and programs are available in the community, whether we provide them, whether it's a hospital service, whether it's the health department, department of human services, or whatever else. In order to serve that person whose territory is rural, the way

we do it is you take the service to the person and see if they need then to access other services in more populated towns but our in-home service aids from our personal care program.

In Phillips County we serve a little over 400 individuals in their homes with personal care assistance and activities of daily living. We consider that as preventive practice or preventive medicine because it's heavy hygiene oriented, and we try to keep the immediate living area in a state that's acceptable in a living environment. And they will also assist in the preparation of food many times. And all of this is done by prescription from their attending physician; so we take that service to the individual. The case worker goes to the home. Our personal care aides and nurses go to the home. We subcontract for home-delivered meals with Mr. Eason—that meal goes to the home because many of these people are homebound. They can't get out to go to the service. It's a real task to ride that bus that far to go see the doctor when you've got arthritis so bad that you can't get out of the bed in the morning without somebody helping you out of bed.

And I think, too, to emphasize the extent of poverty that exists, and it's prolonged poverty that's happening is the thing. I think someone mentioned earlier in a presentation that there were about 2,200 elderly individuals who are 65-plus in Phillips County alone. The figures that we look at indicate that 1,700 of those folks live at poverty or below as far as income goes. And that is terribly pervasive; but not only that but the poverty that's being talked about is SSI level. It's the $427 a month. It's not the Federal poverty figure, because most people are below because they're on SSI, and it brings them up to two-thirds of the Federal poverty level. And when you're talking about 1,700 people out of 2,200 who are at that level, it gives you an idea of just how pervasive poverty is for these rural folks.

We see it as you're going to have to take a lot of the service to the home, and you're going to have to develop other services in the community that they can access. There's a dire need for more day care, for more adult day health care that's more medical affordable. We, you know—we try to preserve independence and improve the quality of life is basically what we try to do, and it involves a lot of programs. And sometimes you have to do like Mr. Eason says. You have to make a gravy and give as much of it as you can to as many as you can, even though you're not giving as much as you want to to anybody.

Dr. WALKER. How do these people come to your attention? Is there some referral system? How does that work?

Mr. DOMAN. We have a referral system. Some are referred by physicians, some by neighbors, some by family. Our case management program is throughout the county, so they're out in the rural areas anyway. The nurses are making visits in the home; so a lot of times someone will share, Have you seen Ms. Jones three houses down the road here? She's been having a lot of trouble too. Word of mouth is probably the primary means that we get referrals.

Dr. WALKER. Does your agency fund any outreach efforts?

Ms. CRECY. Let me say a couple of things. First of all, we are trying to work with our sister agency within the Department of Health and Human Services and the Social Security Administra-

tion to make information more readily available at that place. For a lot of older people, the Social Security District Office or local office is one place that they may go; and we feel that if information about the Area Agency on Aging is available there or about the programs that are available in the community can also be picked up at the Social Security District Office, this person can find out and get more information than they would at a one-stop shop so to speak.

We are also under the Older Americans Act—have been funding national organizations to do outreach to find these very people that we're talking about. I agree that poverty is a factor, a risk factor, and I mentioned earlier about the qualified Medicare beneficiary. That's a program—it was a study that was—came out this past summer that over half of the people who are eligible, who are receiving this benefit of covering some of their out-of-pocket and medical expenses were not, in fact, receiving this benefit because they didn't know about it. And so there's a major effort to try and reach out and identify where these individuals are; so that we can get them to the proper places, and they can, in fact, get the dollar benefits, the coverage for medical costs, that would be picked up by Medicare, if, in fact, they did know about it.

So we are working to help and to identify and to do outreach, and as I said earlier, it's a community affair. We're trying to get everybody involved. We're trying to get the churches involved; so that you know who's in your church and who's in your community better than we do and give you the kind of information you need to help those people that you know about.

Dr. WALKER. We'll take some questions from the audience. But go ahead, Mr. Eason, sure, please.

Mr. EASON. I have one comment.

Usually, there's a difference between urban life and rural life. Within the rural community everybody attends to everybody's business; so everybody knows what's going on so the word gets around if there's something good; eveybody knows about it, and if there's something bad, everybody knows about it.

Dr. WALKER. Even when they don't want to know about it.

Mr. EASON. That's for sure. Yes, sir.

So most of us know those particular things, so if you have something good going the word gets around. Because I know up at Wynne, which is over in Cross County. They found out somewhere you can go down to Lee County Cooperative Clinic, you can see a doctor—for "x" number of dollars you can get your prescription; so that friend can bring a friend; so we have people enrolling.

Dr. WALKER. Mr. Eason, let me ask you.

Mr. EASON. Yes, sir.

Dr. WALKER. Is there somebody in your clinic who can, for example, work with a person who may only have $25 to spend on food but through proper advice and guidance can spend that $25 on foods that may not increase high blood pressure. Is there such a counselor?

Mr. EASON. Yes. We have a nutritionist that can work with them, but, Dr. Walker, the problem is this. They aren't going to follow that advice, Dr. Payne can tell you, a lot of times people are set in their ways. They come and see you but they are just about

going to do what they want. Dr. Payne, would you comment on that, please?

Dr. PAYNE. Sure. That is a very serious problem. If your eating habits, for example, have been a certain way for 30 years, it is very difficult to get a person to change and many times we would literally have to read the riot act to them to get them to change. Where you are successful with that is if that patient has a support system, a family who would also listen to the diet, a friend or a neighbor who would listen to the diet, and if the service is available to help, home health that would come to the home and give the patient further reinforcement and instruction. That would always help, but that is not always available.

Dr. WALKER. Gentleman, do you have people who could do that—help people spend—get the most out of their money for meals?

Mr. DOMAN. We will advise people on how to best utilize the money that they have. But we also get involved actually through, like Mr. Eason, because there are nutrition education requirements that come along with serving the meal, whether it's a home-delivered meal or a congregate meal. There will be speakers who come to the center and talk to people about a healthy diet, and we make literature available.

Along the same line, right now we're trying to start an anti-smoking campaign, "It's Never Too Late to Quit." But there is nutrition education that comes along with the meals and our case managers, you know, they can't really serve as financial advisors, but they will try to give the advice needed or to link this person up to someone who is nearby, a relative or a neighbor, that can advise or maybe could read the diet. You know, if you give a diet to someone who's illiterate and they live alone, it's not a terrible value to them. So you try to link them up with someone who can help them utilize what service is available.

Dr. WALKER. Questions from the audience please.

## MS. PAT HAWKINS

Ms. HAWKINS. I don't have a question.

Dr. WALKER. Could you come to the mike please, ma'am, and please identify yourself? It doesn't have to be a question. We've got comments; we're open for this workshop, and we want the input of everybody.

Ms. HAWKINS. Okay. Well, this is a comment in relationship with some of the things that have been said. I'm Pat Hawkins. I work for the Oklahoma State Department of Health, and I would like to just address several things that were said and answer one question as to how are we doing outreach to the black elderly? We're not doing effective outreach to the black elderly.

In Region 6 over the last 7 years we have seen a decline in utilization of Older Americans Act programs among all minorities, so outreach is not being effective. I think what has happened, just as in Mr. Eason's case and in what we see in Mary Mahoney in Oklahoma City, is that people are pushing all of the minority older blacks into the community health centers. And they don't have the capacity to serve all of these people.

Another comment that I'd like to kind of relate to is that you talked about the commit—the interest of providers and service providers and agencies in addressing problems of the rural black elderly, but I think you should send the message to Senator Pryor that if you review this audience you will not see providers. Here, those people who will be making decisions doing the outreach, you see us preaching to the choir again. We see older blacks here who are trying to get information, but most of the information that's come out of here is information that providers and agencies need to use.

You talked about the rural church. I think we need to take a look at the rural church. My parents live in El Dorado, AR—still attend the same church that I was raised in, and that church is now 80 percent older blacks. They don't have the capacity, they don't know the resources, they don't even know what Triple A is; so the Triple A's are going to have to make the initiative. The initiative cannot be on the part of older blacks. It must come from providers. It must come from agencies.

You think in terms of nutritional requirements, and you mentioned some of the things. But I wonder if the Triple A's of the Administration on Aging isn't making the nutritional status of older blacks worse. I looked at an area in Spencer where the Triple A has gotten together the churches and had these churches prepare meals. And I said to her, "What is the menu?" "I don't know." So they've just given it to the churches. The churches don't have the facilities to do that anymore.

When you have a circuit minister that comes once or twice a month but a church is open 1 day a week, and then they open up to those meals. There must be much more collaboration, and I think that collaboration is the responsibility that rests upon formal agencies.

You talk about all the different things, and you talk about the nutritional counseling, and you talk about collaboration, but you haven't mentioned the health department. Those are the people who should be responsible for getting out and doing diabetes testing, diabetes management training, and so forth. So there's a lot that's left to be done. But, as I say, take a look at that rural area, and especially go and take a look at those rural churches; and I'll bet you they don't have the resources to set up and do what you think they can to help promotion.

Dr. WALKER. Since you're on TV you may clarify what you mean by Triple A, not the American Automobile Association?

Ms. HAWKINS. The Area Agencies on Aging which are the local units for the Administration on Aging. But, as I say, Federal Region 6 has seen a decline over the last 7 years and it's getting worse. Fewer and fewer of our people are using economy sizes. Fewer and fewer of them are getting home-delivered meals. Fewer and fewer are getting home health care services. So actually, you know, you've given a very nice presentation, but you've talked about the ideal. But the ideal is not there with the rural elderly, especially the blacks.

Dr. WALKER. Let me ask the panel. I think she makes a very important point. How does the referral system work? We often hear we've got all of these agencies working on various aspects of the problems, but agency A doesn't talk to agency B, and agency C

doesn't talk to agency D. Mr. Eason or Mr. Doman; can we have better cooperation among agencies and referral?

Mr. EASON. In Lee County we work with the health department. We get along—we work with the health department. I was in a lady's house and she had a worker in from the health department. She was doing chores, and the lady was needing home-delivered meals, and I told her to call the agency down there. I said we've got a waiting list; I said now you're going to have to wait awhile. But she said, "Do you have food?"

If the lady from Oklahoma—you may be having—our people avail themselves to what's happening, and I have witnesses here from Lee County, the people that come from this center. And we're talking about the poor. We've been talking about poor blacks, but we have whites coming to the center and some may not be poor and some might like the camaraderie of people of their own age, and they play bingo, and they have a good time. But we do take referrals from other agencies. We do the X-rays for the health department. We have a lady from the area—our district manager's here, Ms. Dennis. She can tell you—because, see, a lot of people get hung up on turf, Dr. Walker.

But, see, the point is this—when you're working with poor people, you try to get the services to the people. See, if you're in this bag and you want your name on the paper to get the headlines, you're in the wrong profession. When you're working with poor folks—see, you want to get the services to them. We don't care who gets the credit. A lot of times when you get your name on the paper too much and a lot of times you don't want them to know.

Dr. WALKER. But gentlemen, what about referrals to other agencies? I've got somebody who needs housing, how do you deal with that problem?

Mr. DOMAN. We refer or we make referrals to all of the agencies that have resources. We make housing referrals to child care, to home health. We make referrals to Social Security. Anybody that we think can help that individual; we work with. We have a 1-800 number for referrals that's no cost, and it goes through the Jonesboro office, and so that's logged in and those referrals take place locally, insofar as the outreach goes and who's being served, like Phillips County and Lee County. I think 75 percent or more of the people who are going to the centers are at or below poverty level, and I would say that 90 percent of the people going to the centers are probably minority. Of the average elderly in the Delta is a black female who's over 70 years old who lives alone and is unable—that's average. Look at all of the profiles of all of the people who we're serving. So I feel your outreach program is working here. I'm not familiar——

Ms. HAWKINS. I know Mr. Eason's probably running a very good clinic. I've read about it and heard about it, but that's an isolated example. But if you're doing that, as I say, the rates are down all over the region for the last 7 years.

Mr. DOMAN. They are not down in Region 3 in Arkansas.

Ms. HAWKINS. Well, now see Arkansas is in Federal Region 6.

Mr. DOMAN. Right.

Ms. HAWKINS. In Federal Region 6 the rates are down.

Dr. WALKER. Let's get another point of view here. Come right ahead, please, sir.

LARRY CRECY

Mr. CRECY. Thank you very much Dr. Walker. My name is Larry Crecy. I'm with the National Caucus Center of Black Aged in Washington, D.C. Before I proceed with my statement here, I'd like to debunk all rumors—the vicious rumors that Carol Crecy is my daughter or my mother. Actually, she's my twin sister. First of all——

Dr. WALKER. She didn't plant you in the audience?

Mr. CRECY. First of all, I'd like to thank Senator Pryor for having the insight and real feel for the issues, such as health that affect rural black elderly. I think Senator Pryor since his tenure as Chairman of the Senate Special Committee started off last year with the landmark joint hearings last year with the House of Representatives Congressional Black Caucus Health Brain Trust which he and Congressman Stokes co-chaired the hearing that pertained to black health—black elderly health, also to his hard-fought battles last year on trying to contain prescription drugs costs. I know there were a lot of institutions that perhaps were a little dismayed by his boldness, but his intention and the results of his action in that area certainly has helped on the issue of prescription drugs dilemma that often black elderly are faced with, the choice between taking prescription drugs and/or paying for housing, shelter, food, and preventing them from further sliding into ill health as Dr. Payne and Mr. Eason have indicated earlier.

However, all of these major issues addressed so well by the panel which focus on the need, I think there's something that fundamentally needs their curve here in this country—and hopefully we're moving you toward that direction—is that we need to bring about systemic change in the way health is brokered in this country, not only from the standpoint of the issue of, as Ed Doman had touched on in his eloquent presentation of the relationship between pocket book and health, SSI to poverty levels.

I think right now and hope most of the folks in this audience are aware of the fact that in the Commission of Gwen King, who is the Social Security Commissioner, just recently published in the Federal Register, July 31 Federal Register, issues related to the modernization committee of modernizing SSI, some of the issues are bringing SSI above—the payment of SSI above the poverty level. As you know right now SSI—in other words, the Federal Government subsidizes poverty for SSI recipients. We need to get the payments of SSI—the monthly payments above poverty. Four hundred and seventy dollars a month is not a lot of money for anyone to live off of; so I hope that everyone in here—and if you're not aware of it, if you could see our Reverend O'Neal or Joe Woods, we're—we have an effort out here that starts next week. It's simple tear-along-dotted line, check off the appropriate blocks, sign it, put your stamp on it, and send it back to the Social Security Administration for ones—those issues that we feel are pertinent to the changes and proposed changes to the Supplemental Security Income Program.

Also, that it is important for you to read that July 31st Federal Register, particularly all of you professional individuals here and the community-base folks that are active in the aging network. You need to get that information and those comments in from your constituents and your client groups, because many of you, Ed and Mr. Eason here, have access to these folks that don't normally read the Federal Register. I'm sure there are not too many in this room that read the Federal Register on a daily basis. Okay. And it's not been well publicized that Commissioner King has solicited comments to the improvements on SSI from the population of the United States.

I think also that it's very important that the issue of qualified Medicare beneficiaries—this whole effort at a grass—needs to come down to a grass roots level. Many of you may not be aware of that there are—there is an opportunity for those folks that are below poverty at this point in time; and it will rise over the next 3 years to 120 percent of poverty, that those individuals who are below poverty that are receiving Medicare can have the State Medicaid Association pay for their Part B and deductibles through the State Medicaid Program, and NCBA is working very hard with HCFA. We finally have an audience now with HCFA.

I think all of that is important that you get that information now because there are a lot of folks that don't qualify for Medicaid but are really—who are living on Old Age Survivor's Dependent Insurance or on private pensions that could qualify to have their deductibles. You know $29.95 a month out of your pocket if you're only getting $400 a month is a substantial part of your outlay; so I think it's important for your community and the folks in your families to know about this opportunity to get the State Medicaid Association to pay into it.

But I think most importantly that this panel and in what needs to be said is that we need to do a better education job beyond the traditional Aging Network. I think Dr. Berry's initiative on Eldercare is important that—to recognize that the plight of our elderly here, whether they be black elderly or white elderly, needs to be a joint community effort. And there is—there seems to be a big knowledge gap about eligibility criteria, even amongst whom of our entrenched purveyors of aging service.

A lot of folks don't know the eligibility criteria for SSI or Old Age Survivor's Dependent Insurance or the Veteran's Department Indemnity Compensation Program that many of the elderly, particularly black elderly in our communities, may qualify for because of either their husband or their children's services of time in the service that they can qualify through DIC. And DIC is much higher a beneficiary—of monthly benefit than the Social Security or SSI.

But I think we need to do a better job of educating our own network and the providers and advocates in our network about the entitlement program. The NCBA has been involved in trying to expand on that activity.

I think it's important as mentioned by Dr. Payne, the whole idea of preventive health. We as a race eat too much fat, consume too much alcohol, and smoke too much tobacco, but health promotions in—on preventive health issues must be tailored to the black community if they are to be successful. They cannot be the mainstream

type of education and outreach in media kinds of campaigns. They have to be tailormade. Most black elderly will look at eating bean sprouts as some type of Yuppie foolishness; whereas, there needs to be some kind of manner communicating the kinds of nutritional values of certain foods stocked by our elderly, trying to change the habit that they have formed over 50, 60 years in eating process. Just the food eating process is hard to turn around, and you need to have a hands-on war type of approach, not the traditional "eat healthy" type of media campaigns but something that is relevant to them as a population.

And then, finally, I think most importantly—and I had to laugh last week when I got my monthly edition of the National Medical Association Magazine. There was a comment by a doctor who is in public health service, serving over here in Belzoni, MS, that was just absolutely pleading and making a statement about the availability of health care in rural America, particularly to rural blacks.

I think the access to health is the most important issue, and I think that this country is finally coming to terms with the fact that when we're spending 12.2 percent of our gross national product—gross national product of the United States, folks. We're not talking about gross national product of some Third World country. This is a tremendous amount of money that we spend on health care, but yet still we have so many people in this country, over 40 million, that don't have adequate access to adequate health care, even on an emergency basis. We have—there's been a lot of patchwork activity going on toward trying to deal with the symptom of—the symptomatic issues that come out the inadequacies of our health care system.

We need to establish and make a commitment as a Nation to have and access, to help from womb to the tomb. Preventive health is great, media approaches to preventive health, raising SSI payments will help, educating our Aging Network and our community-base organization as to the dilemma and plight of the black elderly and elderly in general is going to help; but the bottom line is this Nation has go to make—when we have a system that takes up 12 percent and it's forecast by the year 2000 that better than 16 percent of our gross national product will be expended on health care, which doesn't serve everybody, than it tells me that the system is broke. If the Medicare—if the recipients of services are not happy, if the providers of services are not happy, if the brokers of services are not happy, then it tells me that we have a failed system here in this United States of America. We need to look at it from the systemic change. Thank you very much.

Dr. WALKER. Thank you.

Mr. WILLIAMS. I come from the lower Delta, Chicot County, AR, and as I——

Dr. WALKER. Would you, please, just state your name for the record.

## YORK WILLIAMS

Mr. WILLIAMS. I'm York Williams from Dermott, AR.

Dr. WALKER. All right.

Mr. WILLIAMS. As I read the letter announcing the conference going to promote ongoing discussion that will be highlighting the programs that are effectively reaching the minority elderly. While I think highlighting the programs are successful for the few who can get to it—the services that get to them is good—I think we really need to take a look also at what happens to those 15 people that John Eason brings in on Monday. See, they won't get back until another 7 days. Then what happens to them the other 6 days, you know? There is not only a decline in participation; there's decline in availability of programs. Now, we can talk about barriers all we want to, but the barriers finally wind up being absent of funds.

I think it's commendable that the Lee County Cooperative Clinic has designed a program which gets some services to people 1 day a week, you know. That's fine and gives them a chance to come in and do their shopping, this sort of thing, but if strategies are going to be debunked, you know, to increase health care to the minority elderly, then it's going to cost. And as health care costs are escalating, it means that fewer people are going to get fewer services on the funds that are available here.

You talk about—and I was in a conference or a meeting—a hearing last night where there was a turf battle between the community health center people and the local hospital people. The local hospital people say we got the answer; we've got everything you need. And what you need to do is to don't bother with those people from the community health centers and let us solve the problem. Another lady from the community health center says, Oh no—said, ya'll can't handle it; we've got to handle it. It's got to be this or that, to which I responded, I don't think it's got to be either this or that. It seems to me that what needs to happen is we need to take off our gloves and sit down and let's talk about a cooperative venture, some kind of interagency agreement whereby the services can get to more people rather than the turf battle.

As I see some of the things that will contribute to health, there is, as I understand it, almost no money at all for dental services. And all—you do pretty good when you can eat the vegetables that somebody, the doctor talked about here earlier, you know, that will help promote better health. But when you get a certain age, your teeth start falling out; and when you finally get enough money to get them all pulled, then you can't eat. You know you can't eat your carrots. You know carrots don't dissolve very well. You know, raw vegetables just don't dissolve very well, and there's no money, as I understand it, available through a Federal funding of any kind that will provide dental services. And, certainly, if people get funds to provide dental—dental care, certainly, you know—if you've ever had a toothache, you know what it's all about. But bad teeth ruin health, I am told. Is that right? Bad teeth ruin health. When you finally get them all out and the body has wasted away, you can't get any form of dentures or any kind of dental services. So increased funds for dental services, as I see it, is an absolute necessity for increased health services.

Increased funds for medication—it's traumatic as a minister to hear members of the congregation talking about the amount of their income they're having to spend for medication that they've

just about got to have. If there's any one poor agency, it's the black church. The black church can do very little in terms of assisting people; yet we try to help out as much as we can, so increased funds for medication for the elderly, access to the funds that are available, I'm talking about increased funds for transportation, and the vans that the Area Agency on Aging use in Southeast Arkansas. You know, those fellows should have been retired years ago. They kind of ramble on, and you see them on the side of the road a lot. So increased funding is an absolute necessity.

Housing, you know, if you think I'm joking, those of you—if you people will take a drive around some of the low-income areas of Marianna, and maybe they've got problems solved here but if not come to the Dermott with me, and I can show you where people live in abject poverty. They lived better when they were on the plantation in some instances than they do now in these less-than-ghetto kinds of conditions. And we can talk about all the strategies we want to, but unless increased funding can come to provide services to people, services are not going to be created.

And I don't know what the purpose of this workshop is, but I hope it's certainly more than an ongoing discussion. I would hope certainly that some of this will wind up before the committee, and that they will be able to do something about some of the problems which the elderly face in terms of health care, as well as other problems.

Dr. WALKER. I can assure you that Senator Pryor's committee will be taking their recommendations that we generate here and building them into national policy.

Go right ahead, ma'am.

## LOUISE DENNIS

Ms. DENNIS. I'm Louise Dennis with the Health Department, and I'd like to make a few comments about some of the issues that you all have brought up.

First of all, I've been in the Delta for 30 years and have worked very closely with the Lee County Co-op and the Office on Aging. There's not enough of us to do the job that needs to be done. We have gotten away from turf battling to trying to work together.

In the Health Department we cover I—we cover eight counties, two of these are Phillips and Lee County. This past year, in 1990, we talk about home health, in-home health services, we served 1,255 clients from these two counties. This goes from skilled home care through personal care to hospice care. We in Phillips County employ over 100 personal care aides; so with the Office on Aging we are serving a large portion of the 1,500 clients that he spoke of for personal care.

How do we get these people? Many of our personal care aides are from the community. We go out, we recruit people who want to be personal care aides, and then we have them do a survey of their community. Do you know someone that needs personal care? Of the clients that we served in these two counties this past year, 66 percent of them are minority. What do we need in in-home health services? To restate what the Office on Aging said, we need respite care. One of our main things is respite care. We need more funding

for elderly abuse detection. When we find someone who has been abused, the system does not—there's not a good system to do follow-up.

We need Medicare funding for personal care chore services. There is no funding through Medicare; it's all Medicaid, so only—only through Medicaid do we have a source of funding, although like the Office on Aging and the Health Department do limited personal care on a sliding fee basis for other people.

Transportation is an acute need for the Delta. We need specially equipped vans. We need help with buying prescription medicine. We need to increase the number of clients through Meals on Wheels. We need special diets provided by Meals on Wheels. We need to recruit and retain physicians in the rural area. In this area we have less and less physicians, and the average age of physicians here in Phillips County is approaching retirement age.

The other issue is chronic disease. We have done a poor job in chronic disease and in prevention in the Delta. As we know the two leading causes of death is heart disease and cancer in Arkansas and in the Delta.

We need screening programs. Since I—in the last 20 years, I have been involved in four hypertension screening programs in the Delta. We have failed through all of these.We have worked with different programs in doing this. We go out and screen the masses. We can do follow-up but there's no treatment. There has been limited treatment with the Lee County Co-op and the other community health center in West Memphis. But the majority of people, if you're going to have a hypertension program, then you need to involve treatment.

We need services—pap smears, mammograms, diabetes screening, colon cancer screening, and then available treatment. We need to establish more indigent medical clinics for chronic disease. The private medical community is unable to care for the large indigent case load in the Delta. The community health centers have been instrumental in providing primary care; yet many indigents are left unserved. Lack of money is a barrier to health care.

The Arkansas Medical Society should be commended for implementing the Arkansas Health Care Foundation; yet, with the doctors they have enrolled to serve the indigent, they cannot meet the needs. We need to establish extensive community health education programs on preventive measures for chronic disease.

School health clinics an school health education activities should be expanded and focused on preventive behavior contributing to chronic disease. We should try to duplicate models such as in Memphis, the Binghampton Project, the Patch Project, which has been used nationally.

In Greenwood, MI, the Freedom From Hunger Foundation has funded Partners for Improved Nutrition and Health. They have empowered the local community using volunteers to provide for their health needs. We in the Health Department—we're a part of the larger State Health Department, and we want to be a part of the future in East Arkansas.

So any way that we can help—like the lady from Oklahoma from the Health Department, we are very involved in East Arkansas,

and we work very closely with the private providers and the other people. Thank you.

Dr. WALKER. Thank you very much, Ms. Dennis. I know your State health director, Joycelyn Elders, and I was wondering how I was going to get out of here without allowing her to have equal time; so you've saved my life, and you've saved my friendship with your State health director. Thank you very much for that very, very insightful presentation.

GEORGE DAVIS

Mr. DAVIS. My name is Dr. George Davis and I'm from Oakland, CA. I'm the National Executive Director of the National Black Aging Network, and I would like to preface my comments by saying that I saw something today that I haven't seen in years which was rain. It has not rained much in California, so it was, indeed, a pleasure to be in a storm, other than I have felt it was a hindrance but a bit of a blessing.

Second, I felt very good being here because listening to the gospel music—I've worked with singers, and I don't feel comfortable unless they feel that something about God is happening around them. So I feel very good about that.

I wanted to make a couple of comments because as I look poverty in Arkansas is equal to the poverty in San Francisco. If you're poor and black in Arkansas and you're poor and black in San Francisco, then something ought to be done about it. It's just a high class form of poverty. That's all it is.

Our organization is a grass roots organization. We take a grass roots approach to solving problems. Part of what we look at is the family. We recognize that the black family has changed and needs to be reconstructed. We can talk about a lot of things, but unless we go back to the basics where the family is involved, you know we're not going to solve a lot of problems.

Our organization is developing Afro-centered nursing homes as one of our solutions. We recognize that sometimes that Afro-Americans will have to go into a nursing home; so what we're trying to do is make the nursing homes meet their needs. For example, the one that we're getting ready to develop in San Francisco is going to have a chapel. We know our seniors go to church, and they ought to have a chapel in their nursing home, and ministers ought to be able to come there and be there for service on Sunday in a denominational way. Because I don't care how much medicine you give a person, if they don't feel right about something they are not going to take it. The same thing about the food. You can talk about nutrition all you want, but if the food does not look good, we're not going to eat it. That's just our culture. It has to look good and say something about ourself, and that's what NBAN does.

NBAN says that everybody who's in a community has a role to help the black elderly. The prostitute on the corner may be a prostitute, but she's still black when it's all done. She has a role to help on the corner. Whoever's involved in that community ought to be doing something to help their population. We're talking about poverty and how it relates to health. Something has to be wrong if we have athletes making millions of dollars a year, and we're talking

about people who are black and poor. We've got all these athletes who make millions of dollars, and we've got poor people who are Afro-American in this country. Something's wrong with that—some kind of imbalance. We as Afro-Americans have to take the responsibility ourselves and call them to task. We always talk about not airing out our dirty laundry in public. If laundry is dirty, it needs to be cleaned in public so it'll be clean forever. And that's our responsibility, and we cannot sit there and wait for people to do all these things for us.

We as a people somehow survived very successfully before we depended upon the government. In the South we owned things. I don't know too much about the South, but in California we used to own bowling alleys, we owned hotels, we owned restaurants. We don't own them anymore. Something went wrong somewhere. People have changed. Our priorities have changed. Our older population has paid their debts. It is the younger populations' time now to get into the trenches and do some real work. We can no longer try to rationalize our problems and talk very sophisticated terminology. That's not going to get it. If we are having more poor people, then we're doing less work. We have to go out there and do more work.

I'd like to thank Senator Pryor because he is one of the few persons that I've met—heard about in my lifetime who is actually going out there and committed to doing a good job. I think Dr. Joyce Berry is a blessing for us, not just because she's an Afro-American and she's very visible, but I think she's a person concerned about all people in the United States who are old and who are poor.

But I would like to see a more concerted effort on our parts to get down, as you say, to the real roots of something. You know, we have a lot of conferences a year. We talk a lot of philosophy, but it has been going on now for some point that we walk out of the conference that there's a commitment made in black and whites that we will do "a," "b," "c," and "d"; so that we have another conference in another year; that those people who are poor, we can see a reduction in the number who are poor next year, in 1992. If not, we're just marking time.

But, I think, again our organization, NBAN, is committed to networking all kinds of community-based organizations. You know we feel that on a community basis—that's what's going to happen. Mr. John Eason, you have a good word—your "trenches" are still there. You do not make money serving people. It's the poorest paid profession in the world. You can take all your expertise and go anywhere and do something, but when we work in the trenches, we're dealing with human lives. But I feel good when somebody gets a house. I feel good when somebody gets their check. I feel good when somebody can pay their bills. That's how I feel good. And I know I'm not going to be paid for what I'm doing, but as the end of what I'm doing, I can say that a life was enriched. And If we go about the task of enriching lives and networking with the Senate, networking with the Administration on Aging, and getting out there and doing something positive from a grass root level door to door—we got in to this situation by relying on technology and

technocracy. We've got to get out of it by relying on ourselves, which is very important.

Dr. WALKER. Thank you very much.

BETTY COLE

Ms. COLE. Good morning. My name is Betty Cole, and I operate a nonprofit organization called Eldercare that's in Arkansas.

We are a provider agency and we received funding from the Area Office on Aging. I would like to say that our organization is a grass root organization, and we are a self-help organization. We exist now with approximately four people on our staff and community volunteers through the R.S.V.P. program. Every day to me is a daily task to provide the kinds of services that we are providing.

Our primary mission is to prevent early nursing home placement for the frail and disabled elderly within our community. I think that we have a great coordination program with the county health department. We used to have monthly activities—that we coordinated activities, but when you're short in staff a lot of things always go lacking. And that's one of the things that's very difficult all the time for an administrator to coordinate the program, plus try to run the program also.

I would like to say that my program could not exist without support from the senior employment program which is the—I always forget the acronym—the NBAC——

Dr. WALKER. NCBA.

Ms. COLE. NCBA—well, I guess I should know, but they serve—they are a vital bloodline to us. And we wouldn't be able to provide the meaningful jobs that we provide for our people. I have—at one time I had four people on my staff that was provided to that program, and I would like to say that the forum today was contacted about this through Reverend O'Neal. And I really considered not coming because I had been to an Elderly Choices Program in Little Rock, and I thought it centered around basically the same thing. But I'm glad that I came, and I'm glad to know, you know, as a community worker and have been since 1968 since leaving college, that there are people that are very seriously interested in the plight of the elderly. Thank you very much.

Dr. WALKER. Can you describe what services you're providing?

Ms. COLE. Our basic primary service that we provide is day care services. And with the—out of that day care program we provide socialization, we provide a meal and snack, and we provide a counselor, and we provide in-home—just in-home based socialization with people that cannot come into our program.

And, hopefully, this fall, maybe October 1, those people who are now not licensed to provide services, hopefully those people will become a part of our program. But they are physically unable to come in, and they are unable to come in because we are not licensed to provide medicine. And, hopefully, this fall we will be, hopefully—I'm looking for a word. We will be capable of providing those kinds of services for those people that are unable to come in—to provide services. I'm talking about people that may be a stroke patient, someone that may have to have medicine maybe from three to four times a day. We are not licensed to provide med-

icine at our center, and eventually—I know of several people within the target area that we are targeting right now. There are several—there are lots of people within our county area that we could provide services for. And we are in great need of a handicap van, and, hopefully, this fall we will have a handicap van. And I would like to say, just to emphasize very strong, that I consider myself a self-help organization because there is no one on our salary that's making $18,000—on our staff that's even making $20,000. So——

Dr. WALKER. Do you have a lot of volunteers?

Ms. COLE. Yes, we have a lot of volunteers. I would like to say that 80 percent of my time is volunteer, so, yes, we do have.

SADIE BARNES

Ms. BARNES. I'm Sadie Barnes, and I'm case manager for the Area Agency of Aging. And I'd like to address the latest viewpoints about the Area Agency. In Phillips County we do have a case load of personal care of 400 clients. Along with personal care there is case management, and on my load I do have 125 people that I do serve that do not receive personal care services; that need food stamps assistance; that may need their home represented by Mid-Delta and also different forms of papers that they may get from the Department of Human Services or Social Security that they do not understand.

And the majority of people that live in Phillips County cannot read—that we have to realize this. And by our accessibility to get out and show the people that we are there to help them. Along with a $9 bill worker that I have in my area, we are able to get out and meet a lot more people. We serve people maybe on a one time basis that we do not even put on our case load. They may just need us to come out and read a letter for them to understand. And not to say—to discredit other agencies in your area, but our case management in Eastern Arkansas is one of the best in the State. Because the people do know that we are out there; we are accessible to them. And the majority of the agencies that are in Eastern Arkansas know to call us and know when we can be there to help them with whatever problems may come up.

We also assist with the additional business for Adult Protective Services, and if it's something that we feel that we cannot handle, we have consultants that we talk to with Adult Protective Services to get the needs met for people that are being abused in the different areas in Eastern Arkansas.

And might I add to you if the program in your area is not working, I'm sure a lot of the directors would be more than willing to come and help and show them how the case management program is to be run. Thank you very much.

STATEMENT OF MIA MASTEN, PROFESSIONAL STAFF, SPECIAL COMMITTEE ON AGING

Ms. MASTEN. My name is Mia Masten. I'm with the Special Committee on Aging, and I'd just like to make two comments. Mainly, they both have to deal with the purpose of this workshop. As you noticed, we passed out some evaluation forms and one of the things

we'd like to get out of this evaluation form is not only how this particular workshop held and what you feel about this workshop, but we also want your recommendations. Mrs. Hawkins mentioned the outreach programs are declining. If you can make some recommendations on what needs to be done to help or to remedy that.

Also the purpose of this workshop—this workshop series is not only to promote ongoing discussions but also these workshops have been the starting of a lot of recommendations that are now policy. For instance, some of the recommendations in terms of plans and transportation are now either amendments or additions to the reauthorization of the Older Americans Act, that's going to be put in placement, of course, in September. So that's part of the purpose of this workshop, and, please, we do recommend and we welcome your recommendations on the evaluation form—recommendations that you see as necessary and just any input that you have on this workshop and for any future workshops. Thank you.

Dr. WALKER. Mr. Doman, you mentioned a tax that has helped your agency. Can you explain?

Mr. DOMAN. This last legislative session—a 1 cent increase in tax per pack of cigarettes was passed and actually and the cost of stamps that go on the cigarette as opposed to a sales tax. We were projecting that that would generate $2.3 to $2.7 million over a 12-month period of time. The July revenue—we found out the other day—was $209,000; so that was very encouraging because the wholesaler would use up his inventory in July without buying new stamps. So we feel like that the money generated will be greater than that in the upcoming months, and then maybe we'll see $2½ million. And the way the funds—and the funds are specifically designated by statute to go to elderly transportation and home-delivered meals.

All funds generated in the first 6 months will be used to upgrade the existing fleet of—as the gentleman from Vermont said a lot of these vans have 150,000, 160,000, 170,000 miles on them, and there's just so much you can ask out of these vehicles. So those funds generated the first 6 months will be spent to upgrade quality of the fleet. And after that point most of the funds will be split about 50/50. Fifty percent will go to expanding or continuing to upgrade the fleet, and 50 percent will go to expanding home-delivered meals. We find—our agency contracts and pays for over ½ million meals annually in our 12 county area. But we have waiting lists in each county for additional home-delivered meals; so we're targeting those funds from that 1 cent cigarette tax into upgrading and expanding the transportation fleet and into expanding the home-delivered meal program. Ms. Cole, for instance, is one of those individuals that, I think, would like to see a handicap-accessible van for her individuals to have transportation to and from her day care.

Dr. WALKER. Do you have other comments?

Mr. EASON. No. The only comment that I had—in a small community where we live—at the clinic we even fill out homestead tax forms for people—food stamp forms. You know, those food stamp forms, they try to trick you. They ask you the same questions about 5 or 10 times to see if you're going to answer them the same way. Also we have the disability form. When you've been in the

community a long time, they think that you—Dr. Walker, they think you're a lawyer, a doctor, and everything else. Now, I don't know. Some people think you know how to go to the lawyer. I say, now, I'm not a lawyer. Some of this I can read and understand; some of it I can't. Some of those wherewith's and therefore's I don't understand either; so when you live in a small community, as I state, and everybody knows you they kind of trust you; so you have to do a lot of things. And like I told the board if you don't charge people, they don't give you a dollar. They may bring some peas or something, you know, but you don't take any money. And if they got some cucumbers or even brought some "chow chow"—if you don't know what "chow chow" is—cabbage chopped up. It makes peas taste good. You know, in Tennessee——

Dr. WALKER. I know what that is.

Mr. EASON. They brought some yesterday, and, you know, people—people appreciate what you do. Poor people will try to pay you in some form of offering, so we do a lot of things. Because as I told the board of directors for which I work, all the time people don't necessarily need to see the M.D. They need other things, so we try to be a full service community center. I'm predicting this for—we were talking about national health insurance, I'm thinking that they're going to fund that money through community health centers in order to give people quality care. We are taking, as Dr. Payne told you a few minutes ago—we are taking—we're getting this year $500 million—yes, $500 million, which is one-half billion dollars. But we're serving over 6 million people with quality care; so if we can do it, there has to be some vehicle, that you were talking about Dr. York Williams, that—some vehicle by which to get into the system. It boils down to one thing—funds.

If you have one agency or agencies that have proved—that have track records they can do quality care without going down the drain with a lot of money, as they did in S&L and we have to pay it back, this is a vehicle by which to do it. And we think that the community health centers, possibly, will be one of those agencies. But even, you know, Senator Kennedy's an advocate of community health centers, also Tom Harkin and those people on those committees. So that's what we're trying to do, but it's like the lady says, We don't do everything for everybody because we do not have the money. Thank you.

Mr. WILLIAMS. I'd like to make one other comment, and that is we use the term, you know, of what ought to be done through the black church—of—it seems to me that they're in two different worlds. If, somehow, a strategy could be developed that would bring together the leadership, you know of—the structure starts—that little church down at Chittom's Switch and go from there to the district association, from the district association to the State convention, from the State to the national. And then there are several auxiliaries associated with it. I would suspect that there have been 50,000 young people and their leaders meeting this summer—young people, I'm sorry. Fifty thousand young people and their leaders meeting this summer, and the leadership of these auxiliary bodies of these district associations and of these State conventions are completely devoid of any information regarding what is available.

Structure is—the structure is there, and I would suspect that the structure of the black church is here to stay. You know, it's been attacked in many different ways, so if, somehow, an effort could be made to inform the leadership to involve the leadership in some training, then that information would be getting down to the local areas.

An example of this situation over in another area—Arkansas is getting $9.4 million in early childhood money this year. Next year that $9.4 million is going to become $10.5 million, and next year it's going to become at a 3-year authorization. And the Early Childhood Commission is having difficulty trying to figure out how they're going to be able to get providers. And I would suspect there are 500 black churches in Arkansas with facilities. I'm talking facilities that would meet licensure standards, and these people don't know anything at all about what's going on.

I went to a whole bunch of meetings and on the way to one of the hearings and got over a little bit of information, and people don't believe that this is really true. But here the Early Childhood Commission is sitting here trying to figure out, oh, how are we going to be able to find our providers? You know, sure you spend $9.4 million, and there are probably a minimum of 500 churches that would pass licensure standards just like that. But the leadership of the local churches, faculty of local churches, and ladies that you have in the local churches don't even know that this exists. The same thing is true in other services. The services might be available, but there's a gap between the leadership and in the service organizations, leadership in Congressional committees and groups of it were, and of the lay public where this—where the two become together and utilize existing resources.

One of the most underutilized of pieces of property of this country is the black church. There are millions and millions of dollars in property that's standing idle that's used, either the sanctuary used it once a week. Did I say once a week? Maybe once a month or twice a month, and then they have, you know, the quarterly activities of some kind—it's a great big fellowship hall, you know, and classrooms and restrooms and this sort of thing. And there are many others, many churches and groups, that's building facilities that could easily build to meet licensure standards that programs could be used for the benefit, not only of young children but the elderly and other people as well.

Dr. WALKER. How do you suggest we bring together the church? And that's why I said in my opening statement I think the church is a very, very important vehicle for the delivery of a whole range of services, and I'm glad you underscored that. How do we bring the churches and the governmental agencies together so that the church groups know that an agency is looking for some place to allocate resources and provide certain—how do you do that?

Mr. WILLIAMS. For instance, in Arkansas there are about four Baptist conventions statewide. There are about four or five groups of the Church of God in Christ and that leads—it seems to me that the conferences just such as this group here today—if the leadership of these church bodies could be brought together and somebody would sit down and share with them what is available in a whole array of services. They have follows-up—see, we just came

out of the district association out of Deshay and Drew Counties. Well, several things we're gradually beginning to change. Some of these things, while preaching is important, and Bible study, some of these things have to be put into action. If on a State level the State leadership cuts across denominational lines and they were informed then that association groups—well, that structure is there—government, you know, it's there and it's firmly entered, and if the State Leaders Association Agency group leaders are brought together and informed about what is available, then I think you might be able to mobilize that particular reservoir of resources that could be used to pipeline services to people.

The big problem is finding the space that would meet standards. There are hundreds and hundreds of churches over the State which would meet standards and have space and have playgrounds and area, you know, it wouldn't take much because I think this would be a very important step in that direction.

Ms. Crecy. I would like to share with you the fact that we recognize getting out to people at the community level is very important. That's is part of what the National Eldercare Campaign is about and bringing information so that you can be more knowledgeable about what is available and empowering the community to be responsible for its own actions and its own people.

The Administration on Aging feels that too long we have as aging advocates talked to each other as opposed to talking with other people in the community that need to have this information. We have a major effort of trying to reach churches of significant youth and other ranks. In September the National Black Baptist Conference will be having a major conference in their board of directors; so I want to let you know we're moving in that direction that you talked about.

Unidentified Speaker. Let me follow-up quickly here and the sad thing is political leaders know all these things, for example, but every 2 years, every 4 years, every 6 years we bring them together, you know, for a specific activity known as election year. Now inbetween, you know, the 2-year term, the 4-year term, or the 6-year term which ought to be about the business and sometimes life's very unpopular with some of my fellow—you fellows because I say to them, "I don't want no election year." I've got election—got leads every year.

So what I'm saying is the leadership knows these people. They know where they are and rather than inconvenience them on a 2-year or a 4-year or 6-year basis—that's convenient to them in an interim in terms of developing. I'm—well, because from West Memphis we have a great church out there and I'm happy and I'm proud of their bringing the people to the church. I wish—one of the greatest things that ever was to get this around to the churches—we have some great personalities, like there we have many people out there to come, but the most important thing about our church—we believe in doing what you said, you know, the people walk up to me—and I'll tell them you said so—they'll—because they don't want their people to be a liar, so this is the most important thing it is. If you tell them this is what we want and this is what the Senator said, this is what the government said we are looking for, and we can get much support. I have plenty of proper-

ty over there, plenty of friends. I have churches. I can get this word out and they would be glad to get moving, them peoples, and, you know, spread this out. And I know it would be a great help to each of us—be a great help to them, and we have there at Proctor and out there around Hughes, AR—it's a lot of people's in need out there. A lot of people just don't know, and I believe they would do but they don't know.

But we need somebody to come out and explain along with the pastor, and then we can get the word over to many peoples. A lot of the peoples just really actually don't know. And I thank you for opening this way for us because we really need it because I think I've got about a 5 acre facility out there if we need more building to get them over this and any time that I set up a meeting and set a time that ya'll come out, we're going to have this meeting. We're going to talk about something to help you. They would show up, but I don't want to be telling them that for nothing, and they would call me a liar, and so ya'll I thank—thank God for this opportunity. Pray for us.

Dr. WALKER. Let me just pose one—maybe a final question for the panel. I think we have heard a lot about needing more money and I think, certainly, we'd all agree that that would be the case—do we need more money or do we need to do things in different ways? You went silent on me—there. Do you need more dollars, or do you need to change the way you do things? Do you make the maximum use of the dollars that are available?

Mr. EASON. Sir, let me give you an example. Our budget was $1,150,000 and now our budget is $1,900,000. I think that's over a 4-year period and the cost of living has just about doubled, in some instances both, but say there is some time you've reached your maximum in management and with the Lee County Clinic we've reached—in a primary agency we have reached our capacity there that it has to be more funds. We have more people coming to the clinic than we did in 1977. Our caseload is much greater because people are poorer around the surrounding counties—because I've had in Forrest City a lot of our people—a lot of those places have closed down where the people used to work and the people that used to be affluent are in poverty now.

Dr. PAYNE. I would say a little of both. Basically, one of the things that I think that can be done is that all your areas can use the existing facilities for a little more—for example, I think maybe 280 to 300. You will wait to the next day and physicians look at the weight of the problem that would help, never mind if there's a problem of transportation. The fact that if there's a problem with transportation, many times the patients would wait until they were so ill that the community health center could not help them. In that case, emergent care is needed, and when the patients show up at the Lee County Clinic in need of emergency care, then we have a problem. So appropriate use of what health care facilities that we have is very important.

Dr. WALKER. Mr. Doman, what can we do better in the Area Agency on Aging?

Mr. DOMAN. Well, I think we should always have an open mind, for one thing, about improvement in both efficiency and innovations. I would agree with Mr. Eason, though, that the group of

folks that we're trying to serve is increasing in size and they're increasing in need, and it may be that the population as a whole is decreasing in total numbers, but the group that we're targeting our services for is increasing. And if the Federal funding continues to stay level, and it appears that it is going to continue to stay level, at least for a while longer, then it behooves us to try to arrange the services the best we can.

We've been talking about the church involvement. One of the things that we've found has been very successful is church summer camps for youth, coming up to our area. They go in and they do renovations in elderly homes if needed. We have weatherization programs around, but they're never funded or staffed to the point that they need to be. So this was a way to get people's houses weatherized or to get chores and tasks done, and they're doing it for free. And the youth of the church are benefiting, and the elderly individual is benefiting as well.

But, realistically, you can only rely on volunteer help to a certain point and meet a schedule and stand responsible for a program operated. Many members of the community volunteer, both in Mr. Eason's program and our agency, but there's a point where you've cut all the fat you can cut. And if the people you're trying to serve are increasing in numbers, even though you're becoming more efficient, you're going to need some more funds to expand the program.

Mr. CRECY. I'm curious, Dr. Walker. I think that was an interesting question. I think that I agree with Dr. Payne and Ed Doman and Mr. Eason. A couple of things, I think as far as preventive health care—and Dr. Payne addressed it very, very succinctly—what happens with rural elderly is that they are going to wait until the last moment, and it's always an emergency and chronic care that they end up, in most instances, going to.

If we had more money for preventive health services, then we would have less utilization of emergency services or waiting until the moment where it's just—they've become critically ill. I think the other thing is—is that I commend the volunteer efforts of this program in this country, all across country, but there is only so much that volunteerism can do. I think someone had mentioned something about a thousand points of lights with no batteries. Well, we're slowly running out of batteries for the thousand points of lights across this country.

We—it seems to me that we have a fundamental question that we have to look at. We have given expansively to the world at large in our foreign aid or propping up of governments to assist in and overcoming their dilemmas. But the infrastructure here in the United States of America has really suffered, our social service infrastructure in particular. We have reached a peak—a point where all of the good management, coordination, the utilization of volunteers and human resources and community resources is probably reaching—reaching its upper limit right now. We do need a change to the system.

We've accommodated a lot of things with patchwork attempts to cover shortfalls in revenues to address services that are needed in the community. We can't continue to patch the system. We need to have a fundamental change in the commitment on the part of the

Federal Government toward the people who fund it. We have a larger growing elderly population. By the year 2000, it's almost going to be another third larger and on the front end of the baby boomers that are coming along. That means that the area agency system is going to be strained more; the health care system is going to be strained more, unless we come around to one basic issue. With 12 percent of our gross national product, soon to be 16 percent, is being utilized for health services, and we still have a disproportionate amount of the American population that does not have access to health care.

And remember, now, you have children out there that are suffering also, and the elements, the neglect, and the preventive health that they're not getting at this point in time will be big-buck items for us later on down the line when they get to be 45 and 50 and 60 and 70 years of age. It's a ticking time bomb. This country needs to start re-allocating its resources. Fine, I understand it's a troubled world out there, but if we don't take care of our own infrastructure, our own health, and our own citizens here in this country, we're not going to have a country very long. Thank you very much.

Dr. WALKER. Reverend, you had a point you wanted to make. Please go ahead.

Mr. WILLIAMS. I think the basic point—the basic issue that I wanted to mention is that escalating medical care costs and inflation—inflation and escalating costs and a declining interest in domestic programs, which includes health and human service programs means that the situation is becoming more and more acute. So, basically, more dollars are needed to provide the same services because of escalating costs and inflation, even if the population were not increasing. So you've got an increasing population and the older they get; the more acute the health problems become. You have declining cost which means that—declining funds, that is, to meet these services means that the situation is growing more desperate as times goes on. So more money is needed just to maintain—well, not—yes, maintain the same level of services, not to mention the increased number that's coming into that category.

Dr. WALKER. Any other comments? Yes. Let me just emphasize that it's important that we hear from all of you, not just from the panel. Senator Pryor wanted to hear from everybody here on this issue because it's so critical and it's certainly important to him and his committee. Go right ahead, please make your statement.

## HELEN SIMPSON

Ms. SIMPSON. I'd like to say my name is Helen Simpson. I'm the Secretary-Treasurer for the City of Lakeview. We have enrollees with the NCBA program, and I feel that it's a good program because it enables our elderlies to remain active; whereas, a lot of other adult markets have put the elderly people on the shelves. It enables them to enhance and motivate their feelings as to being dependent. They advance their skills in what they have, and most of them were usually from share cropping or farming or whatever.

The Title V income which is from the NCBA program also still enables them to receive different services as food stamps, different Medicare/Medicaid—it depends on their income level. We need more programs like this. I feel that if we start cutting the funds in a lot of areas that's really needed as far as health care and that—

we can get more out or it; whereas, NCBA also works on getting information out to, not only the enrollees; but they are also trying to get information to the communities by getting information to the elderly and bringing to the different worksites, filling out the forms, asking the different questions that they need to know, and finding out if they're eligible for something that they did not know. So we really need to get information to our elderly people, which also means that we need to increase funds in these areas instead of cutting it back.

Dr. WALKER. Dr. Payne, let me ask you. I think we all agree that, certainly, it's more than just medicine as we've heard from this panel. But is there a problem in attracting physicians to working the rural areas?

Dr. PAYNE. Is there—there is. There's—right now we are facing a crisis in recruitment of physicians in rural areas. I think the projected need for physicians in rural areas nationwide is somewhere between approximately 10,000 and 12,000 physicians as a minimum, and we're—for example, the Human Public Health Service has provided physicians from there. However, when the scholarship program was discontinued—I think it's been reissued. But when the scholarship program was discontinued, we're looking at a situation this fall with only 293 physicians being available for the nationwide need for almost 10,000 to 12,000.

The issue of getting physicians in the rural area is a very difficult thing. I did make some recommendations in the past. Some of those recommendations would include recruitment of individuals, young men and women, from the rural areas who would more actively—more easily return to these areas to work. But it's difficult to get someone to work in a Spanish community or a Mexican-American community or the rural community, and they were not born there; they were not raised there; they don't have an appreciation for the culture. I think—so that is important, and some of those issues are being addressed but it is a very difficult thing.

Dr. WALKER. Mr. Eason, if you had the money, could you hire the people that you need to provide all these services that you provide?

Mr. EASON. No, sir. We have very difficult problems coming—people coming to the rural—we have four physicians. I've been in the clinic about 14 years. This is the first time I haven't been recruiting physicians. We have all of the physicians that we need as of now.

Dr. WALKER. What about other type personnel other than physicians?

Mr. EASON. No, we don't. See, for instance, mostly in small town areas and Marianna, a lot of our people were born and reared there, and they have stayed there. And once in a small community, you get a job and you make a pretty decent living; you don't move. You're not very mobile. What we try to do just like Dr. Payne said, what we try to do, we try to utilize the people in the area. And I am employed by what we call a grass roots organization. We have a local board, 501C-3, and my people, my bosses are not lawyers, attorneys, and what have you, they're just common people.

Dr. WALKER. Yes, ma'am. Go right ahead, please.

## ALICE HESTER

Ms. HESTER. Thank you very much. I'm Alice Hester, and I came to the front to express appreciation to Senator Pryor for the letter that I received in order to come to this meeting—workshop this morning.

I represent Delta Sigma Theta Sorority. I represent Area Agency as a director. I represent the Regional—Helena Regional Medical Center as a board member. I am a senior citizen. I am a retired home economics teacher. I have much information, and I think on my evaluation slip you'll find some suggestions that I feel you as a committee can perform that will help our senior citizens.

One of my main objectives in standing in confidence for senior citizens is about the best thing you could offer. And that means going in with them, talking with them, and showing them the things that they really need because we understand that all of them are not able to comprehend the things that they really should. Thank your very much for your presence.

Dr. WALKER. Thank you. I don't want to close off discussions. Are there any comments or suggestions, recommendations, questions any of you would like to offer?

Well, let me say that this has certainly been a very, very productive meeting, and I think we all should commend Senator Pryor and his staff represented here today. They brought this forum out to the people—they could have easily sat in Washington and tried to decide what was going on, but to bring this out to the community, is certainly a mark of statesmanship on Senator Pryor's part and certainly is commendable. His staff deserves commendations of the highest order.

I will not attempt to summarize what has been said here today, other than to say I think we've heard some very, very constructive recommendations and comments. I think the presentations by each of the members of the panel have certainly been very, very to the point: and I believe that the recording of this hearing will reflect that this was a very, very productive day in terms of what the committee charged us to do.

I want to recognize some people who are members of the committee that made a very outstanding contribution to the success of this meeting today—Ms. Louise Dennis, who we heard earlier today and who is from the Arkansas Department of Health; Lewis Leslie, who is the assistant—Mr. Lewis Leslie who is the assistant director of the Bureau of Public Programs of the Arkansas Department of Health; and Ms. Barbara Hagar, who is director of the health education and health promotion program of the Department of Health. Let me in her absence commend Dr. Joycelyn Elders who is the State health director for Arkansas for her input into this forum.

Before we close I think we ought to have a minute of silent prayer for Senator Pryor's full recovery. We all know that he has experienced a cardiac heart problem. He is on the way to recovery, and I'd like for us to engage in and participate in a few minutes of silent prayer for his full recovery.

[Moment of silent prayer.]

Dr. WALKER. Thank you, Mr. Eason. Thank you, Ms. Crecy. Thank you, Mr. Doman. Thank you, Dr. Payne. Thank you, ladies and gentlemen for your participation today.

[Whereupon the workshop was concluded.]

# APPENDIX

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### HEALTH PROFESSIONS EDUCATION NEEDS FOR RURAL, BLACK, ELDERLY PERSONS


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We wish to express our gratitude to Senator Pryor and his staff for organizing this workshop in Helena. The aging, black, rural population has many needs. One of the most urgent is health care. Today's attendance testifies to its importance. Thus, we appreciate the Senate Committee staff coming to Helena to focus on our concerns. This is much more convenient than our traveling to Washington, DC!

The Delta Health Education Center is an outreach program of the Area Health Education Centers (AHEC) Program, which was started in the 1970s and operates six AHEC programs in small cities throughout Arkansas. With a central office on the campus of the University of Arkansas for Medical Sciences (UAMS), the AHEC Programs foster training of health professionals in rural areas of our state. We sponsor rurally oriented training for physicians, nurses, pharmacists, social workers and others while they are studying for these professions. We also hold continuing education classes for professionals who practice in rural areas.

In November of last year, with money from a federal grant, the Delta Health Education Center was established in Helena. The Helena Regional Medical Center has generously provided us with space for offices and a large meeting area. We have been busy during the past year getting acquainted and collaborating with local agencies that will help us bring more awareness about health to school children, their parents, workers as well as the unemployed, and the elderly. Our central mission is to increase the number and the professional knowledge of health workers in the counties of the Arkansas Delta area. We have supported instruction of teachers in health education in the Helena-West Helena Schools, training of nursing assistants and building a medical reference collection here at Phillips County Community College, summer preceptorships for two medical students in Helena and two others in Lake Village, and a two-week educational summer program for acquainting high school students with health professions. We anticipate many, many more opportunities during the coming years and invite all who are interested to contact us.

This workshop is appropriately held in Phillips County, one of three majority black counties in Arkansas. Its neighbor, Lee County, which also has a black majority, is one of the poorest in the U.S. While other rural areas in the U.S. have grown more slowly than urban areas, the population size here has decreased during the last sixty years. From 1930 to 1990, Lee County's population decreased by 51%, Phillips County's by 29%. Health care resources are a fraction of what the state as a whole has available. Only one hospital operates in these two counties. A federally supported Community Health Center, the Lee County Cooperative Clinic, offers primary health care and other services to low-income persons, while Department of Health units in each county provide primary care mainly to mothers and children. Stringent budgets permit these public agencies to reach only a fraction of those who need their services (although the size of the fraction is not known exactly).

Home health services, on the other hand, are meeting much of the apparent need. From the Department of Health skilled nursing services, physical and speech therapy, home health and personal care aides, and hospice services are available without regard to ability to pay. In addition, one non-profit agency offers personal care and another home health services. In Phillips County both the hospital and a non-profit agency have home health care programs, and the Area Agency on Aging runs a personal care program.

One 90-bed nursing home in Lee County and three in Phillips County with 318 beds provide for those who can not stay in their homes.

The numbers of trained health professionals are far below state averages. The following table shows the numbers of various health professionals in Lee and Phillips Counties and the State of Arkansas in 1989.[1,2] To the right of the number of each professional is the ratio of the general population to that group of professionals. These ratios make clear the much greater needs for health professionals in these two counties, where the majorities are black.

| Professionals | Lee County | | Phillips County | | Arkansas | |
|---|---|---|---|---|---|---|
| All physicians | 6 | 2,417:1 | 22 | 1,445:1 | 3,438 | 697:1 |
| Primary care Physicians | 5 | 2,900:1 | 12 | 2,650:1 | 1,562 | 1,533:1 |
| All nurses | 64 | 227:1 | 285 | 112:1 | 28,213 | 85:1 |
| Registered Nurses | 39 | 372:1 | 155 | 205:1 | 13,476 | 178:1 |
| Dentists | 2 | 7,250:1 | 7 | 4,543:1 | 1,009 | 2,374:1 |
| Optometrists | 1 | 14,500:1 | 5 | 6,360:1 | 255 | 9,392:1 |
| Podiatrists | 0 | | 0 | | 32 | 74,844:1 |
| Psychologists | 0 | | 1 | 31,800:1 | 48 | 11,037:1 |
| Audiologists | 0 | | 1 | 31,800:1 | 48 | 49,896:1 |
| Registered Dieticians | 0 | | 0 | | 308 | 7,776:1 |
| Pharmacists | 6 | 2,417:1 | 22 | 1,445:1 | 2,007 | 1,193:1 |
| Occupational Therapists | 0 | | 0 | | 178 | 13,455:1 |
| Physical Therapists | 1 | 14,500:1 | 2 | 15,900:1 | 386 | 6,205:1 |
| Respiratory Therapists | 0 | | 4 | 7,950:1 | 137 | 17,482:1 |

Recruiting health professionals of appropriate disciplines is a national problem. Although the greatest physician needs are in primary care, less than half of residents training in the U.S. are in the primary specialties of family medicine, internal medicine, obstetrics and gynecology, and pediatrics. In addition, only 439 or 0.5% of all medical residents in the U.S. were training in Arkansas last year. Since the state has approximately 1% of the U.S. population, our state is training medical residents at about half the rate of the U.S. average.[3]

In addition, some allied health professionals are difficult to retain. Laboratory technicians and respiratory therapists, for example, are two that have the highest attrition rates.[4] Their expertise is critical to comprehensive primary care, but few are needed on a small staff such as in a community hospital. Thus, such losses from professional staffs are often disabling to rural facilities, which have limited access to labor markets of trained professionals and are distant from other facilities that might provide temporary help.

National health survey results show that rural persons suffer more chronic conditions than urban persons.[5] Greater rates of deaths due to strokes, liver disease, diabetes and homicide are suffered by black persons, according to national health statistics.[6,7] Dr. Frank Farmer of the University of Arkansas has looked at mortality rates of U.S. counties and their rates of poverty and rural populations. While higher mortality rates of counties are consistently associated with percent rural, the statistically significant association that explains this is between *poverty* and mortality.[8] In Lee and Phillips Counties, death rates of persons above 65 years of age are more than 25% greater than statewide death rates for the same ages. It should be no surprise that the combination of fewer personal resources and scarcer health care services in rural areas would result in greater rates of disease and death. However, few data are available for rural, black health status, particularly for these counties.

Our experience in eastern Arkansas convinces us that greater availability of health care services and health professionals can be permanently improved only through a broad, community-based effort. Training of health professions students in rural areas depends on enough professionals in rural areas to supervise and instruct them. Where health professionals either are simply not present or are overwhelmed by demands, there is no opportunity for supervision by local professionals. Thus, the local "infrastructure" of health professionals must first be enhanced. A partial solution to this is possible through resources of distant medical centers. Planning is underway for primary care physicians along with their medical residents to travel regularly from UAMS in Little Rock and the University of Tennessee in Memphis to sites in east Arkansas. Other health professional training can also be arranged.

There are numerous challenges to building up local health facilities. One that is generally appreciated is the relatively weak and volatile economic base that threatens stability of hospitals and other health care facilities. Another that may not be so well recognized is the choice by local residents to look elsewhere than to local clinics, hospitals and physicians for health care. Many procedures could be handled as well or better in high-quality local facilities than in distant medical centers. Recently cancer screening was proposed as part of our program. Instead of utilizing the local hospital for the services, the first two choices were importing a mobile device from Memphis and sending local residents to another city for screening. Local allegiance and confidence are necessary aspects of viable local health care systems.

Transportation is another commonly recognized difficulty of rural life. This problem is shared by training programs, too. Arrangements must be found to decrease the time and fatigue of frequent travel by commuting health professionals. Since travel is a common need of many service providers, there are opportunities for sharing transportation resources.

Communication, cooperation and coordination are cardinal traits that can prevent wasteful expenditures and yield healthier citizens. We have been very encouraged by the extent to which these traits characterize the many projects now underway in east Arkansas. As present programs grow and new ones start, it will be critical to expand networks of organizations and individuals.

We offer four recommendations for further action:

1. More information is necessary for dealing with problems of rural, black elderly persons. The variety and extent of needs have not been well enough measured. Data are needed that can monitor their health and welfare as well as tell how well programs are succeeding. Information is necessary about this population as well as about present resources that are in place and could be tapped further.

2. Networks of individuals and organizations are critically important. Workshops, conferences, publications and other means will continue to be important to fostering effectiveness and efficiency.

3. Improved transportation is important not only for clients to visit service sites but also for service providers to reach sites and residents.

4. Training programs should be devised for the particular environments where more personnel are needed. Working from the perspective of local needs and resources will enable successful programs to be designed and implemented by persons closest to those needs.

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