

OREGON PUBLIC HEALTH ASSOCIATION

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AFFILIATE OF AMERICAN PUBLIC HEALTH ASSOCIATION

# THE *Probe*

Quarterly Newsletter of the Oregon Public Health Association

Spring 2003

## Stories of the Uninsured

# Who's the fool in Oregon?

## April 1: The fall of Oregon's progressive community-based care system

by Kathleen JB Bonn

The state of Oregon has long been a leader in the provision of services to seniors. Oregon was the first state to approach the Center for Medicare and Medicaid Services (CMS) for a federal waiver to provide necessary assistance to the elderly outside of nursing homes.

Services to the elderly meet needs created by "deficits in activities of daily living." With federal support, Oregon Project Independence (OPI) provides a variety of care-service modalities: in-home care, assisted living, residential care, and adult foster care – in addition to traditional nursing home care.

Oregon is now struggling with budgetary limitations that threaten provision of necessary services to thousands of elderly and disabled Oregonians. The progressive policies implemented in Oregon beginning in the 1980s are in danger of extinction. Budget deficits forcing regressive policies threaten to return Oregon's long-term care system to pre-1980 standards, leaving many seniors without home care or life-saving medical assistance.

Effective February 1 this year, a number of changes have been put into place to Oregon's service provision system. The changes revert personal care back to pre-OPI standards.

At incomes over 100 percent of the

federal poverty level (FPL), those previously receiving services based on Activities of Daily Living (ADL) survivability levels 15-17, as determined by the state assessment tool, are no longer eligible for any kind of assistance.

Further reductions in services are scheduled to take effect on April 1. During the first draft of this article, the cuts were alarming and unacceptable. Services were being reduced from a survivability level of 14 to 9.

An example of a person at level 9 would be having cognitive problems along with an inability to bathe, unsafe ambulation, difficulty making it to the toilet alone, and require someone to bring

*(continued on page 4)*

### OPHA Mission

- *Protect and promote the health of all Oregon residents*
- *Educate and support public health workers*
- *Advocate for just and equitable health policies*

## Who pays for uninsured health care?

Sure, we still hear of cost shifting from the insured to help pay for the health care of the uninsured, but nothing like the emphatic rhetoric in the campaigning days of state healthcare reform in the early 1990s, when cost shifting was John Kitzhaber's primary plank for the Oregon Health Plan.

Is cost shifting still a problem? How much shifting are we talking about? And getting to the point, if we should miraculously agree to consolidate the system and pay for everyone fairly – 100 percent access – then how much money could we expect to free up from current sources

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# NATIONAL PUBLIC HEALTH WEEK: April 7-13

## New website features overweight/obesity theme

American Public Health Association just launched a website for National Public Health Week, coming soon – April 7-13th. The theme this year is overweight and obesity. The tagline: Getting in Shape for the Future: Healthy Eating and Active Living.

All of the information for National Public Health Week can be accessed at <<http://www.apha.org/nphw>>

The following ideas may be helpful for local event planners:

1. A "What's Happening in Your State" page on the website. To post

events, e-mail: <[lakitia.mayo@apha.org](mailto:lakitia.mayo@apha.org)>

2. Under the toolkit, find an event logo that can be downloaded as a link to the National Public Health Week site: <[www.apha.org/NPHW/images/](http://www.apha.org/NPHW/images/)>

3. Add to the resources page, highlighting information on overweight and obesity. E-mail ideas to address above.

4. Send news of local events to the APHA newspaper, no later than May 5: <[nations.health@apha.org](mailto:nations.health@apha.org)>

5. Sign up as a regional partner for National Public Health Week.

## APHA Annual Meeting soliciting abstracts

American Public Health Association's 31st Annual Meeting and Exposition is scheduled this year for November 15-19, in San Francisco. A call for abstracts is currently open.

Abstracts are welcome in any area of public health, including those that incorporate the meeting theme related to "Behavior, Lifestyle and Social Determinants of Health." Abstracts will only be accepted through the APHA Web site, <<http://www.apha.org/meetings>>

A complete list of deadlines is now available at the APHA Web site. Participants will be notified of selections about May 30.

## Dr. Stephen Bezruchka takes population online

Oregon Public Health Association joined PSU's School of Community Health, and Clark and Multnomah county health departments to bring Dr. Stephen Bezruchka to Portland on March 24, to talk on "What makes a population healthy?" Dr. Bezruchka teaches population health at the University of Washington., and works as an emergency physician in Seattle.

Dr. Bezruchka maintains a web site: <<http://depts.washington.edu/eqhlth/>> Also: <<http://depts.washington.edu/eqhlth/>>

**F**or relevant information about local services and resources use Oregon Helps = [www.oregonhelps.org](http://www.oregonhelps.org)

The site is designed to assist families throughout the state find whether they are eligible for a variety of benefits, including food stamps, Oregon Health Plan, Temporary Assistance for Needy Families (TANF), and several other services.

## Planning is underway for the 2003 OPHA Annual Conference & Meeting

**OREGON IN ACTION, PART II  
0 HEALTH DISPARITIES, 100% ACCESS**

**November 3-4, 2003  
Columbia River DoubleTree  
Portland Oregon**

Speakers include Dr. Marilyn Gaston, former assistant surgeon general, with Mary Lou Anderson, John Scanlon, Karen Minyard . . . and others.

<[www.oregonpublichealth.org](http://www.oregonpublichealth.org)>

## Fresh web links on public health

- Information about the uninsured = <http://coveringtheuninsured.org/>
- Lobby state for health = <http://oregoniansforhealthsecurity.org/>
- Health resources, links to every state's public health and mental health agencies, plus links to almost 1,000 city, county and regional health departments across the USA = [www.healthguideusa.com](http://www.healthguideusa.com)
- Portland Community College/ Institute for Health Professionals = <http://www.healthprofessionals.pcc.edu>

### PUBLIC HEALTH SYSTEMS PERFORMANCE

- National Public Health Performance Standards Program = <http://www.phppo.cdc.gov/nphps/>
- Resources for public health systems performance = <http://www.phf.org/PerformanceTools/NPHPSptools-EPHS.pdf>
- Survey on Performance Management in States = [http://www.turningpointprogram.org/Pages/pmc\\_state\\_survey.pdf](http://www.turningpointprogram.org/Pages/pmc_state_survey.pdf)
- Council on Linkages Between Academia and Public Health Practice = <http://www.phf.org/Link.htm>
- Core competencies for public health professionals = <http://www.trainingfinder.org/competencies/list.htm>



Money won't fix it:

## Healthy Start program fails to impact abuse

by Tom Engle

[tengle@teleport.com](mailto:tengle@teleport.com)

Rates of child abuse in Oregon over seven years in Healthy Start counties compared to non-Healthy Start counties show no appreciable difference in trends.

- Twelve counties began the Commission on Children and Families (CCF) Healthy Start program in 1994. Seven state-supported Healthy Start counties were added to the roster with the passage of SB 555 in 2000.

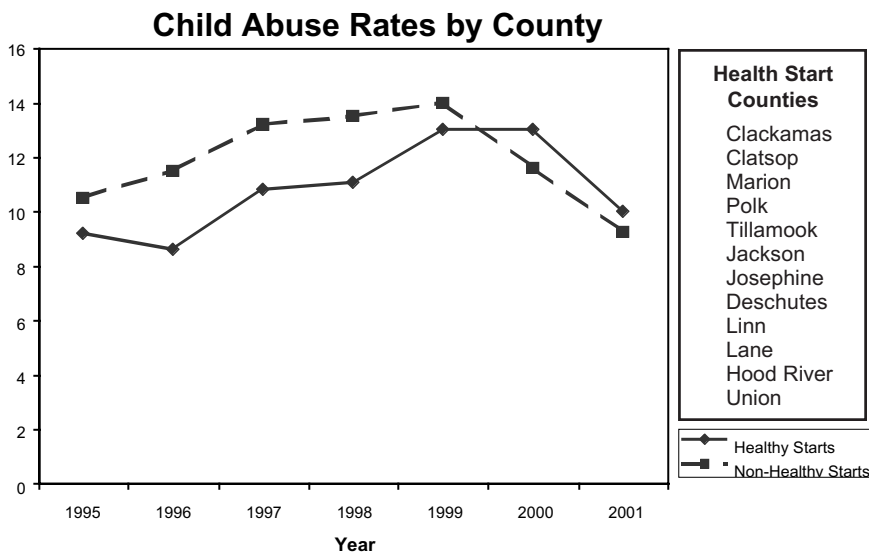
- Both CCF-supported evaluations – “Monetary Benefits and Costs of Oregon Healthy Start,” and “Healthy Start 2000-2001 Status Report” – heavily emphasize the opinion that the Healthy Start program reduces rates of child maltreatment. Those reports use DHS-supplied victimization data.

- The chart here uses data from DHS annually published victim rates per 1000 children by county (<http://www.dhs.state.or.us/abuse/publications/childabusereports.htm>). The chart separates the initial 12 Healthy Start (HS) counties from the remainder.

- This data suggests the Healthy Start program has had no impact on the child victimization rate. The trend lines for both Healthy Start and non-Healthy Start counties have the same shape and trend, and the only observable trend is regression to the mean.

- If one assumes CCF is correct that Healthy Start reduces child maltreatment rates for served children versus non-served children, one way to explain no overall change in county rates is to hypothesize that somehow the program increases child maltreatment rates in nonserved children. Clearly this is not true.

- Since the Healthy Start program through OCCF (the state commission)



has spent well over \$50 million on this project without reducing child-abuse rates, it might consider shifting resources to a program with demonstrated efficacy, such as the Prenatal and Early Childhood Home Visitation Program, a model studied and proven by the Kempe Prevention Research Center for Family

and Child Health, or other similar best-practice programs. Since the county CCF planning process is ultimately responsible for deciding programs to implement, and this program has little impact, the child maltreatment prevention effort should be reconfigured directly under a state agency such as OCCF or DHS.

## Whatever happened to cost shifting?

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already devoted to uncompensated care?

If any of these questions have occurred to you, then you will welcome a report released in February by the Kaiser Family Foundation and Urban Institute: *Who Pays and How Much? The Cost of Caring for the Uninsured*, by Jack Hadley & John Holahan (also a *Health Affairs* web exclusive, 12 Feb. 2003). The report makes a fresh and welcome contribution to the literature on the uninsured, which often only keeps us updated on standard data and arguments.

The central accomplishment of *Who Pays?* is summarized in a few easy tables. The study makes two estimates of uncompensated care, one using Medical Expenditure Panel Survey (MEPS) data, and the other using budget data from providers. Both methods arrive at a figure near \$35 billion for uncompensated care.

Add to this amount an additional \$30 billion in care for the uninsured provided by community health centers and direct government services. For the uncompensated care, the public purse covers most of that as well by special sharing considerations in Medicare, Medicaid, and from state sources.

The hospital share of uncompensated costs are estimated at about \$24 billion, about the same as the public subsidies received by hospitals, though not necessarily distributed to the right places. The mismatch of costs and reimbursement leads the authors to estimate a cost shift from the insured to the uninsured of \$1.5 to 3 billion in 2001.

The study manages to illustrate the substantial contribution of public funding to health care for the uninsured, and argues for rationalizing the system with this money as a good head start. A gem.

## Stories of the Uninsured

# Who's the fool in Oregon?

(from Page 1)

meals. For the moment, this deep cut has been rescinded, restoring services to a level 12. Proposed cuts in provider reimbursement, which threatened a cascade of disastrous consequences, have also been momentarily rescinded.

The original battery of cuts would have contributed to a domino effect that multiplied negative consequences for those in need. For many remaining in range of the cuts, the results may be indistinguishable as they face reduced options, deterioration, misery, health problems, and in some cases certainly death. Even in the present revision, there is a likelihood that subsequent events will cost the state more dollars than it saves, apart from the significant human costs – which it will not save.

People began receiving closure notices in February and continue to

receive notices of possible further cuts.

An estimated one-third of Aging and Disability Services (ADS) staff is expected to be laid off due to April 1 cuts, according to County Commissioner Dianne Linn. Medicaid enrollment will be reduced significantly, but the remaining staff will maintain the responsibility to assist with the changes in status for all the affected elderly: obtaining alternative services, seeking adjunct means to obtain medications, meet nutritional needs, and find safe housing opportunities. Case managers will be responsible for monitoring the care needs of seniors remaining in the system, as well as for those at risk who have lost benefits.

An example of the needs required by a person at a level 12 would include assistance in medication management, ambulating outdoors, memory, adaptation and judgment, (including need for

money management), redirection for wandering, reassurance with mood and encouragement to eat.

Assessment of functional abilities in Oregon is done with a computerized tool called the *Client Assessment and Planning System*, or CAPS tool. With this program, an individual's abilities to perform specific functions are evaluated

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## The story of Mrs. C: A disposable case on the border of decency, verging on disaster

Mrs. C. is a 78-year-old widow who lives alone with her Persian cat in a subsidized apartment complex in NW Portland. Her husband died 20 years ago. They had no children. Mrs. C. tries to keep her house fairly tidy. She is as independent as possible, but has impairments due to environmental exposure to toxins. She worked in a dry cleaners most of her life and the chemicals have caused some problems with her lungs. She is unable to exercise due to poor respiratory function, which has resulted in subsequent weakness in her upper legs.

Most days, Mrs. C. walks the hallways of her apartment complex to get exercise. A grocery store is only 6 blocks away, but she cannot go there without a ride. She loses her breath and must sit for long periods. Once in the store, she uses one of the motorized carts. Although Mrs. C. is safe walking in her home, it takes her all day to vacuum her small one-bedroom apartment. She must stop and rest after 10 minutes or so. It takes her several hours to recuperate from the exertion.

Mrs. C. also is afraid to bathe. The steam from the bath makes her dizzy and she is afraid she will fall. For the last two years she has relied on sponge baths. Due to her medical conditions, Mrs. C. is on 12 medications. Her medicine expenses are on average \$40 per prescription.

Her income is \$682 per month. One-third goes to her subsidized housing costs, after medical bills are discounted.

Mrs. C.'s CAPS assessment places her at a level 15. On February 1, she lost all her benefits. Her housekeeper services

can no longer be paid. She also lost her Medicaid prescription-drug benefits. Her rent will still be adjusted based on the prescriptions she actually buys, and she will have an increase in her foodstamp benefit if she can show monthly that she is purchasing her medications.

She must also pay her phone, heat and cable bills. Cable is her only entertainment. This leaves her \$13 per month and \$139 in foodstamps to live.

Having just enough money will not be enough. Mrs. C. is in a quandary how to pay for visits to her doctor. The only medical benefit she continues to receive is the payment of her Medicare premium. The Medicare co-pays and deductibles are supposed to be waived, but she has always been billed and has paid them. She is afraid her doctor will no longer see her if she does not pay the bills, and she does not want to change doctors.

To manage with her \$139 in foodstamps, she will start getting meals-on-wheels and not pay the suggested donation. She intends to cut out coffee and no longer buy ready-prepared food. Mrs. C. is uncertain how she will be able to prepare her meals. She is not able to stand for long periods of time to cook.

Finally, Mrs. C. is very concerned she will fail the Housing Authority inspection of her home and she will be evicted. She is unable to clean on her own and she knows the carpet, stove, refrigerator and bathroom will become unacceptable in time. Mrs. C. is seriously considering cutting out or reducing her medications against her doctors advice.

## Social services lose survivability

(from Page 4)

with a logarithm that arrives at a survivability level: how likely it is a person will survive without services given their current functional abilities. A level 1 is very unlikely to survive. A level 99 has no functional impairments. A level 17, the pre-February 1 service benefit cap, has some impairment, but it is considered to be minimal. Through the CAPS tool, the case manager accounts for the senior's medical conditions, medications, and medical treatments required as well as how these health aspects impact their care needs.

Mrs. C., a level 15, was denied services on February 1 (see sidebar on Page 4). Mrs. C. has clearly considered all of her options. She is clear headed and has good judgment. She simply has no options left. She is not alone. The state of Oregon projects the elimination of levels 15-17 will impact 3,231 people. Now reduced, the April 1 cuts originally impacted an addition 6,368 people.

### A cascade of obstacles

Mrs. C. has fairly typical limitations for a senior assessed at levels 15-17. As an outsider looking in, Mrs. C. looks pretty independent. She is seen walking the halls daily. Her apartment has always been clean. She seems fairly healthy for a woman her age. Yet the specifics clearly point out the problems Mrs. C. will encounter when she no longer has services. Without her medications, she will decline rapidly. She will become eligible for Medicaid again, but at a much higher cost to the state for medical care.

Low-income housing is in short supply in the Tri-county area. People who are losing their benefits, like Mrs. C., are expected to clog the hospital systems with emergency room visits and extended-stay hospitalizations until they are able to meet the criteria for a level 14, or soon, a level 12.

Meanwhile, all care providers are having reimbursement rates cut, when they are already paid below their own daily costs. Hospitals must develop

strategic plans on how to manage an increase in charity nonpaying admissions. Health care plans such as Kaiser, Providence, Care Oregon and many others are re-evaluating their ability to provide care to Medicaid patients.

Managed care plans have been hard hit by the limited reimbursement allowed under the Oregon Health Plan (OHP). As a result, many refuse to accept any further Medicaid beneficiaries. Carriers like Kaiser, ODS and Providence have backed out of the Oregon Health Plan. Care Oregon, a nonprofit, came into existence specifically to meet the needs of the low-income Medicaid population. With budget reductions eliminating drug coverage, Care Oregon has decided to discontinue coverage of 12,000 OHP standard patients. Managed care plans are undergoing a transformation in response to the steady decline in capitation rates. As a result of the February cuts to OHP, all "Standard OHP" Medicaid clients have been dropped by health plans in the Portland area. Since doctors often will only accept a patient if insured, many are going to be left without medical access.

For hospitals, the solution heard most often is stricter criteria for emergency department admissions. Legacy's Good Samaritan Hospital, for example, has hired a new utilization control case manager to insure appropriate emergency room admissions. Patients who are not critical are being sent back home.

Patients are already screened for ability to pay. With the new cuts, screenings have become more stringent. Fewer patients are being admitted in order to reduce unreimbursed expenses.

Another burden presents itself when a hospital provides care for homeless persons, especially with disabilities. Once admitted to the hospital, patients cannot be discharged to an unsafe situation.

Oregon Health & Science University (OHSU) and Good Samaritan Hospital expect to see an increase in the number of patients who have their OHP premiums paid by the hospital. In many cases, it is simply cheaper to pay to keep patients

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insured, so they are able to maintain reasonable health and stability more independently. Likewise, hospitals will pay transportation costs, when needed, for those who have lost transportation benefits.

Cuts in mental health services will also impact hospitals. According to Christie Williams of Gresham Cascadia Mental Health, the hospital emergency rooms will be used as a safety-net for individuals in crisis as intensive case management and drug benefits erode. Cascadia Mental Health was forced to lay off 181 mental health workers as a result of the budget reductions. These are serious restrictions.

These changes are already seriously impacting the ability of agency staff to be available for clientele. Along with heavier loads in fewer hands, case managers are also obliged to learn a cadre of new services due to changes in OHP. Trying to locate alternative, and mostly nonexistent, resources to substitute for former services is a frustrating occupation. Case managers have deep concerns about individuals as well as the population of seniors as a whole. The emotional strain of chasing too few resources for too many needs impacts the effectiveness of the staff and the overall morale of the agency.

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## History of the uninsured

# Oregon pioneers long-term care options

In 1981, Oregon approached the federal government with the idea of providing services to a larger portion of the aging population with a variety of care options. With a budget neutral proposal, the state intended to use the same amount of money to serve more seniors, while insuring choices to maintain a better quality of life. By providing seniors with care options in their homes or homelike settings, instead of institutions, costs per senior would be reduced and quality of life enhanced. The philosophical underpinnings were life, dignity and individual choice.

The initial waiver for long-term care services, in 1981, allowed services to Oregon seniors in a wide range of home and community-based settings. The waiver helped consolidate different programs. Medicaid, OPI, and other services to seniors were provided through Oregon's Area Agencies on Aging network. By 1983, adult foster-care homes were being licensed and regulated by some of the counties.

Committees focused on developing standards for residential care, assisted-living facilities and adult-care homes. Standards for nursing homes were reviewed anew. Senior services began to look seriously at the services provided to the elderly in Oregon. The goal was to provide settings that would address psychosocial as well as physical needs.

This paved the way for Oregon to establish the progressive concepts of client choice regarding care options that would establish the state as a leader in the care of seniors. Foreseeing the need for an expansion of health care and options for Oregonians, in 1987 a consortium of concerned Oregon businessmen, healthcare providers and legislators combined forces to obtain another waiver for "keeping Oregonians healthy." The ensuing process resulted in a number of new bills in the Oregon legislature that eventually created the Oregon Health Plan.

By 1989, HB5530 acknowledged the complaints of younger people with disabilities, demanding equal assistance and care options as elders. The younger population had been underserved. The Senior and Disability Services Division was formed to recognize younger adults, who were served through Disability Services Offices modeled after the Area Agencies on Aging.

While these changes were occurring, new care options prompted providers to become more sophisticated and innovative in meeting the needs of the

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*Seniors looked favorably on these more independent options and began "coming out of the woodwork"*

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population. Seniors looked favorably on these more independent options and began "coming out of the woodwork," as Rosalie Kane put it. The "woodworking effect" resulted in an industry boom. Providers scrambled to meet the growing demand. As a result, Oregon is commonly known as the only state that spends more Medicaid dollars on home and community-based care than on institutional care.

Nursing homes have staffing and care capabilities that are difficult for smaller or less specialized care options to address. In Multnomah county, the most populated area in Oregon, skilled nursing facilities (SNFs) specialize in providing care for a number of difficult-to-serve populations of seniors: those with late stage dementias, those who are unable to engage directly in their care, and those

who may need skilled care from registered nurses. These care homes may also be locked to prevent danger to residents who are unable to understand their own limitations. Many SNF residents are severely disabled.

The options to nursing homes in Oregon have included: (a) in-home care provision, (b) adult foster-care homes, and (c) residential care and assisted-living facilities. Some of these homes are specifically equipped to manage care for severely debilitated residents. The highest paid, ventilator homes, provide care for individuals who require total care, are supported by a ventilator and are in need of specialized nursing intervention. Regulatory monitoring of these homes is very stringent, with high requirements for safety features. There are very few ventilator homes.

Adult-care homes provide a lower level of care. Some specialize in care for those with Alzheimer's disease or the long-time homeless. Many accept residents difficult to place elsewhere. Care ranges from minimal to very extensive. Levels of care coincide with different licenses. In each case, the resident is responsible for the set room and board rate of \$453.70 per month.

People at all care levels are able to receive care in their own homes as long as possible, and as long as skilled-care providers are available. Care may increase as a person becomes more debilitated. Additional care providers may be added. Around-the-clock care is allowed as long as care does not exceed the cost of a nursing home. Few people utilizing in-home services require 24-hour care.

These options make a difference. The bottom line on nursing home care is its expense. Under Oregon's Medicaid contract, nursing homes are paid approximately \$3,060 per month; assisted living is closer to \$1,800, and adult foster care closer to \$1200. The monthly costs for

*(continued on Page 7)*

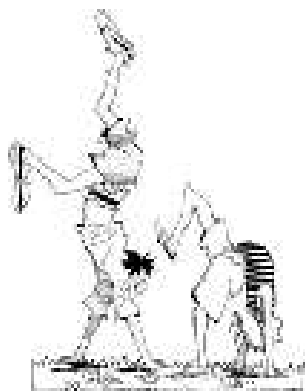
## Oregon pioneers

(from Page 6)

ventilator homes can be much more, reaching \$5,800 to \$6,800.

The winning combination here is that seniors favor the less-expensive options. Few relish the thought of going to a nursing home. The most common statement heard from seniors in need of placement is that they would rather die than end up in a nursing home. Most seniors have one request of family members: to let them stay at home until the end of their life.

The in-home care option provided through Oregon's Medicaid program allows that to happen.



## Who's the fool in Oregon?

(from Page 5)

ADS staff in Multnomah County are determined to inform legislators of the travesties these budget cuts will impose on the most vulnerable of our seniors. Although agency staff cannot take action during business hours, letters and phone calls to legislators have been encouraged by management on off hours and staff are responding. Lists of legislators phone numbers and addresses have been disseminated to all ADS staff in the district. Brief tutorials on what to include in a conversation with legislative staff are provided via e-mail. Example letters have been distributed.

Central ADS has taken the additional step of coordinating a drive to obtain case

## Red Cross asks to share health

by Eric Brown

American Red Cross Pacific Northwest Regional Blood Services is excited and proud to be a new organizational member of the OPHA. This new partnership will provide Oregonians another opportunity to get involved in the public health of our community. Giving blood is one of the most tangible ways for individuals to contribute to the public health of the community. The need for blood is constant as area hospitals are filled with cancer and surgery patients, premature babies, accident victims, and other ill and injured people who need transfusions to live.

ARC Pacific NW Region is the sole supplier of blood and blood products to over 80 hospitals in Oregon, Washington, and Southeast Alaska. As the tenth largest of the 36 American Red Cross blood regions, the Pacific NW Region must collect at least 5,000 pints of blood each week. The ability to collect blood is based on an invaluable partnership that the American Red Cross has with the public. Community commitment is the key to successfully being able to meet the needs of patients in our region's hospitals.

Emphasizing the most recent APHA theme of "Putting the public back into public health," ARC Pacific NW Region relies on more than 130,000 blood donors voluntarily sharing their health with people they will likely never meet. In addition, the American Red Cross relies on volunteers to support many aspects of the operation outside of giving blood. There are simple and safe opportunities for individuals to be directly or indirectly involved in saving lives.

Collaboration between OPHA and American Red Cross will send a strong message that every individual can contribute to the public health of the community. Ensuring the public health of our community does not solely rely on public health professionals.

Are you interested in giving blood? To schedule an appointment to give, please call 503-284-4040 or 1-800-GIVE LIFE. For more information, please visit <[www.pdxredx.org](http://www.pdxredx.org)> ore-mail <[CanIDonat@usa.redcross.org](mailto:CanIDonat@usa.redcross.org)>

**WITH PERSONAL AND PUBLIC  
RESPONSIBILITY FOR HEALTH:**

*We can become that  
civilized nation  
we once thought  
was our destiny*

### Nominate a health genius

Community Health Partnership is currently accepting nominations for the 2003 Public Health Genius Awards. Nominees must be Oregon residents.

Awards up to \$3000 will be split between the recipient and a community health charity of their choice. Deadline for nominations is May 23.

For a brochure with complete nomination details, call (503) 416-3690 or <[chp@careoregon.org](mailto:chp@careoregon.org)> Website = <[community.oregonlive.com/cc/foph](http://community.oregonlive.com/cc/foph)>

histories and situations of people who have been impacted. While ensuring confidentiality, these personal scenarios will be presented to legislative staff and committees, news reporters, and wherever else fruitful.

Perhaps the highest cost Oregon pays in this debacle is what one client called the Mississippification of Oregon: reverting to system where seniors are warehoused, dignity is nonexistent, and choices are available only for the financially secure minority.

Oregon has enjoyed a reputation as one of the most progressive states, indeed a pioneer, in providing care to the elderly. Evidently, the era of pioneering is coming to a close.

# World unprepared for

The Center for Economic and Social Rights (CESR) and Physicians for Social Responsibility (PSR) sponsored a research mission to Iraq, January 17-30, to "establish a baseline of current conditions and assess the consequences of war." Michael McCally, M.D., professor of public health and preventive medicine at OHSU and president of PSR, was on the research team, which also included physicians Ronald Waldman, Michael van Rooyen and Charles Clements, plus nutrition expert Dr. Peter Pellet, and human rights attorney Elizabeth Benjamin.

The team's report, *The Human Costs of War in Iraq*, was released March 20. The report is dedicated to "the 24 million Iraqi civilians who have lived through 12 years of hardship." Now one week later, in the awe and shock of brutal war, the population figure is certainly smaller, and the years of hardship considerably longer. The following text is a condensed version of the report's executive summary and main findings. For full reference, find the report online at <[www.psr.org/documents/psr\\_doc\\_0/program\\_4/CESRIraqReport.pdf](http://www.psr.org/documents/psr_doc_0/program_4/CESRIraqReport.pdf)>



Source: University of Texas <[www.lib.utexas.edu](http://www.lib.utexas.edu)>

The research team's main finding is that the international community is unprepared for the humanitarian disaster of another war in Iraq. The research team: (1) conducted interviews; (2) collected extensive data from Iraqi civilians, clinic and hospital staff, government and United Nations (U.N.) officials, and staff of non-governmental organizations (NGOs); and (3) conducted a thorough literature review. In addition, the team obtained confidential U.N. documents on humanitarian conditions and emergency planning, and conducted a review of available literature.

The research team was afforded an unusual level of independence by the Government of Iraq. Most interviews and visits were conducted without Iraqi "minders" and with independent bilingual translators from Jordan. This report focuses exclusively on the humanitarian implications of war to encourage informed public discussion and effective

international action on this crucial yet overlooked element of the Iraq crisis.

**1 The Iraqi population is far more vulnerable to the shocks of war than it was in 1991, having been reduced after 12 years of sanctions to a state of dependency on government and international aid.**

Previously, Iraq was classified as a rapidly developing country with a modern urban infrastructure, an extensive welfare system, and a thriving middle class with significant personal assets. After 12 years of sanctions, the population has been impoverished and the civilian infrastructure remains fragile. Many characteristics of Iraqi society today are comparable to the circumstances found in long-term refugee settings than to those in developing countries.

Since 1991, Iraq's rank on the United Nations Human Development Index has fallen from 96 to 127. No other country has fallen so far, so fast. Over 60% of the population – 16 million people – depend for survival on a comprehensive government food rationing system. The ration is purchased through the sale of Iraqi oil and supplied through funds controlled and administered by the Oil-for-Food Program (OFFP)[...] Civil servant salaries averaging US\$3-6 per month cannot cover even subsistence needs.

While nutritional status has improved recently due to increased humanitarian supplies under OFFP and two years of good harvests, any disruption to the food distribution or health care systems will cause a rapid setback. Iraqis have been extremely isolated from the outside world for 12 years; the mental, physical, and educational development of an entire generation has been adversely affected by the extraordinary trauma of war and sanctions.

**2 International agencies are not adequately prepared to respond to the humanitarian consequences of war, especially if civilian infrastructure is attacked or disabled.** Military attacks against electricity, transportation, telecommunications, and other necessities of modern civilian life would cause the immediate collapse of Iraq's water purification, sanitation, public health, and food distribution systems, leading to increased hunger, sickness, and death,

# human disaster in Iraq

especially among children. Similar attacks in the 1991 war contributed to 47,000 excess child deaths within eight months.

The team observed that few physicians or nurses have the necessary training to care for traumatic injuries. During war it is almost certain the emergency health system would be overwhelmed. A confidential U.N. document warns that "the collapse of essential services in Iraq could lead to a humanitarian emergency of proportions well beyond the capacity of U.N. agencies and other aid organizations." The document also reports: "In event of a crisis, 30 percent of children under five [approximately one million children] would be at risk of death from malnutrition."

UNHCR is preparing for 600,000 refugees" [and] expects shortage of essential drugs, especially antibiotics.

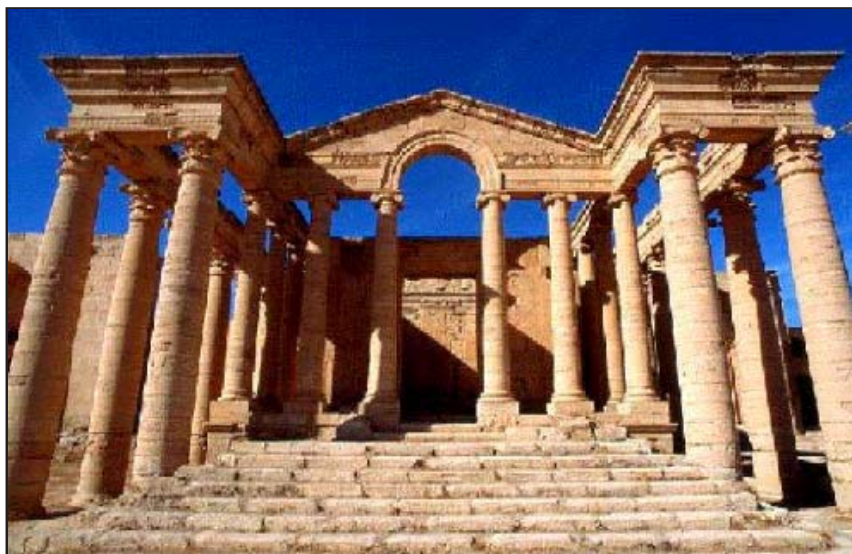
**3** Any attempts to replace rather than supplement Iraqi public health, food distribution, and infrastructure will exacerbate the humanitarian crisis. While Iraqi systems are severely stressed, they are functional and the majority of the population relies on them. The research team was struck by

the dedication of thousands of professional staff and civil servants who maintain these crucial survival systems despite extraordinary obstacles.

- Iraq has 929 primary health care centers, compared to 1,800 prior to 1990.
- Iraq's food distribution system, the largest such operation in world history, supplies 24 million people with approximately 2,470 kilocalories per day through a network of 46,000 rations agents in the South and Center of Iraq. Despite its massive scope, this system serves to mitigate, rather than end, deprivation associated with sanctions.
- Iraq's electricity system has an installed capacity of 9,500 megawatts to power its modern infrastructure [ . . . ] current capacity remains at 43% of installed capacity.
- The national output of potable water remains at 50% of previous capacity and water quality remains substandard. Through repairs and rationing, access to safe water is approaching 1990 levels: 94% urban and 45.7% rural coverage.

**4** The secrecy of humanitarian preparations by the United States and the United Nations is impeding efforts to develop an effective emergency response capacity.

The U.N. has closely guarded its operational planning for emergency relief, making effective humanitarian coordination with international NGOs difficult. The U.S. Department of Defense has prepared a classified humanitarian proposal that has been shared with members of Congress but not with the members of the international relief community. A consortium of American NGOs has received grants of almost US\$2 million from USAID for relief aid in Iraq, yet relatively few have received necessary government licenses to operate in Iraq or adjacent countries.



**5** All parties to war are obligated to respect well-established principles governing humanitarian action: humanity, neutrality, independence, impartiality, and accountability. Under this framework, there is a clear separation between humanitarian actions and political, military, or economic actions carried out by governments during a

conflict.

Military operations need to be distinct from humanitarian activities. Civilians should not associate humanitarian organizations with military objectives.

In off-the-record interviews, NGO staff expressed widely shared concerns that funding and access are being politicized to favor those humanitarian organizations most sympathetic to war aims of the U.S. government. International relief agencies, especially in Europe, have publicly criticized the U.S. for politicizing aid and failing to guarantee humanitarian access to post-war Iraq as a right protected under international law.

The tactic of airdropping individual food rations, condemned by the U.N. and independent relief agencies in Afghanistan as an ineffective and dangerous conflation of military and humanitarian operations, will apparently be conducted on a much greater scale in Iraq. Subordination to military goals undermines principles of humanitarian action, neutrality in particular, and risks exposing aid workers to

*(continued on Page 10)*

# Research team assesses civilian tragedy in

(from page 9)

military attack and civilian anger, as happened in Afghanistan.

## CONCLUSION

The Iraqi people already suffer severe deprivation under sanctions and will be in much greater need of humanitarian assistance in the event of another war. The total amount of grants pledged by governments (US\$65 million from the United States and US\$15 million the United Kingdom) is a tiny fraction of the revenues from Iraqi oil sales under the OFFP.

For Phase XIII (December 5, 2002 to June 3, 2003), the Sanctions Committee has already approved more than \$1 billion of humanitarian supplies (food, medicine, vaccines, and spare parts) out of an expected total of \$4.93 billion in oil sales revenue.

The Office of the Iraq Program has estimated that OFFP would be terminated in the event of war, and that the \$10.9 billion worth of supplies already in the pipeline – paid for by Iraq but not yet delivered – would not be released without a new Security Council resolution.

It is safe to predict that the humanitarian crisis resulting from another war in Iraq would far exceed the capacity of U.N. and international relief agencies. It is therefore essential that the Security Council, and the U.S. in particular, respond to a number of urgent questions:

# WAR

*In event of a crisis, 30 percent of children under five [approximately one million children] would be at risk of death from malnutrition.*

- Are civilian life support systems, in particular electricity, water, and sanitation, considered military targets as in the 1991 war? What are the contingency plans to prevent repetition of the "cycle of death" caused by increased mal-

nutrition and disease, especially among children?

- What will happen to Iraqi government food distribution and public health systems in areas occupied by U.S. and other military forces?
- What will happen to the food, medicine, and other humanitarian supplies currently provided through the OFFP Program?
- How will the international community mobilize the enormous aid package necessary to prevent or mitigate a disaster?
- Why are humanitarian response plans being developed in secrecy and without necessary coordination among key actors?
- Will the U.S. military allow international relief agencies independent access to affected populations as required by humanitarian principles and international law?

The humanitarian community, and the international public in general, deserve answers to these life and death issues...in order to make informed decisions about the crisis in Iraq. With the world poised on the brink of a potentially catastrophic war, this does not seem too much to ask.

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