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Study of Racial and Ethnic Relations in Portland

Report of the

HEALTH AND WELFARE SUBCOMMITTEE

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The City Club membership will vote on this report on October 25, 1991. Until the membership vote, the City Club does not have an official position on this report. The outcome of the membership vote will be reported in the City Club Bulletin (Vol. 72, No. 21) dated November 1, 1991.
EXECUTIVE SUMMARY

The Health and Welfare Subcommittee of the City Club's *Study of Racial and Ethnic Relations in Portland* focused on two areas: the major income maintenance programs administered by the State of Oregon Department of Human Resources (welfare) and health care provided through the Medicaid program and some community-based agencies.

Contrary to stereotype, the overwhelming majority of welfare clients is white. However, because disproportionate numbers of minorities are poor, a correspondingly disproportionate number of minority persons relies upon the meager support offered by public assistance.

In the welfare system:

- The Subcommittee was unable to obtain information on complaints filed with Adult and Family Services Division, and is therefore unable to ascertain if there are complaints of discrimination in the welfare system.

- Present and former welfare clients as well as welfare workers told the committee that subtle discrimination persists on an individual basis in welfare. Whether labeled racism or cultural insensitivity, this bias is a barrier to full access to services.

- An additional bias exists—a prejudice against poor people. While this affects clients of all races, it is a special burden for minority clients when racial and ethnic discrimination is layered on top of poverty.

In health care:

- Medicaid benefits, as measured by the dollars spent per recipient, demonstrate a clear bias in favor of white clients. The disparity appears across all age groups. It is most pronounced in elderly clients, where white patients receive 40%-180% more care dollars than minority patients.

- Studies done by the State Health Division on the African-American and Native American communities show startling facts of higher death rates, inadequate prenatal care, and higher infant mortality rates.

In both welfare and health care, cultural and language barriers impede access to services. Improved cultural training and greater emphasis on hiring and promotion of minority staff and management are needed in virtually all of the public agencies studied.
TABLE OF CONTENTS

I. Introduction 136

II. Background 138
   A. Public Welfare: "Income Maintenance Programs" 139
   B. Publicly Funded Health Care 142

III. Analysis and Discussion 145
   A. Racial and Ethnic Discrimination in the Provision of Welfare Services 145
   B. Racial and Ethnic Discrimination in the Provision of Health Care 148

IV. Conclusions 151

V. Recommendations 152

VI. Appendix 153
   A. National Statistics 153
   B. Persons Interviewed 154
   C. Bibliography 155

This report is one of six such reports prepared by subcommittees of the City Club’s Study of Racial and Ethnic Relations in Portland. The six reports address the relationship between Portland’s white majority and members of the community’s African-American, Asian, Hispanic, and Native American minority groups. The other five subcommittee reports have been prepared by subcommittees on (a) social association/citizen participation, (b) housing, (c) law enforcement and the administration of justice, (d) education, and (e) employment. For copies of, or information regarding, the other five subcommittee reports, contact the City Club of Portland, 317 SW Alder, Portland, Oregon, 97204; (503) 228-7231.
Study of Racial and Ethnic Relations in Portland

Report of the
HEALTH AND WELFARE SUBCOMMITTEE

I. Introduction

When addressing poverty issues in the context of a study on racial and ethnic relations in Portland, it is important to bear in mind the following: It is not the case that most minorities are poor. It is not the case that most of the poor are minorities. It is the case that the higher incidence of poverty among minorities gives special emphasis to poverty issues in discussing minority concerns. It is further true that poverty is perceived as a minority issue by our society, as the very existence of this report attests.

For health care and welfare recipients of all races, the bare subsistence level of benefits provided by government programs does little to alleviate the emotional costs of poverty. Where racial and ethnic bias overlays the distress of poverty, suffering is increased.

Scope of Study

To attain a manageable scope of study, the committee has defined the public welfare system to mean the major income maintenance programs administered by the State of Oregon Department of Human Resources. This does not include the broad array of other social services offered by the many public and private agencies active in this area.

For similar reasons, our study of health care services is largely focused on Medicaid, with only limited research into other public and community-based agencies serving minority groups. (See Persons Interviewed)

This report necessarily deals with welfare and health programs as they are constituted at the time of writing (Fall, 1990). Some of the changes scheduled in the federal welfare programs and those proposed in the state Medicaid program are intended to broaden coverage and benefits for all recipients, including minority clients. These programs are discussed later in this report.

Prior City Club Study

The 1968 Committee's study of welfare issues differed from this report in several areas. The study reported only on the public welfare system and did not deal with publicly provided health care.

The inclusion of Asian, Hispanic and Native American groups in this report has brought into focus issues of cultural sensitivity which were barely touched on twenty years ago. Recent immigration affects and informs the lives of many Asians and Hispanics in ways which are different from the African-American experience. The special position of Native Americans in our national fabric raises other issues. Different racial and ethnic groups have different conceptions of racism and different concerns and needs.
The 1968 study contained a strong component on the federal role in the welfare system, excerpting comments from the Kerner Report. The following are a few key points from that City Club report, compared with our present research.

The Kerner Report stated that "The failures of the [federal welfare] system alienate the taxpayers who support it, the social workers who administer it, and the poor who depend on it." Further, a welfare system "designed to save money instead of people, tragically ends up doing neither." Testimony before this Subcommittee confirms the continuation in 1990 of a system designed more to save money than people.

The 1968 City Club committee strongly recommended implementation of a federal welfare reform program separating eligibility determination from service provision. This was seen as a way to free case workers to spend time assisting clients and as a way to keep clients from viewing their case worker only as an investigator whose role was to protect the system from welfare cheats.

Most agency staff and other observers speaking to this Subcommittee have agreed that idea was good but did not work out as expected. Primary contact with clients is now in the hands of vastly overworked eligibility workers whose function is primarily administrative. Furthermore, many witnesses charged that these workers believe it is their function to save the state money, rather than to help clients gain access to all of the programs available. Most of the more highly trained personnel with Masters of Social Work (MSW) are found in the Children's Services Division dealing with child protection issues or in other counseling or supervisory positions, effectively removed from the primary welfare benefit-dispensing programs of Aid to Families with Dependent Children (AFDC).

In other recommendations, the 1968 City Club report exhorted the State Welfare Commission to seek out and act as spokesman for the poor and urged the state and county welfare departments to conduct outreach programs to seek out potential recipients of welfare benefits. While this Subcommittee heard from many individuals in government and private agencies who care deeply about the plight of the poor, on an institutional level, we can detect no sense of championship for the poor on the part of any state agency.

On the subject of outreach, this Subcommittee was told by former and current state employees that until the very recent past, the state's policy has been to actively discourage outreach in order to control costs. Indeed, members of this Subcommittee were told a joke current among social workers about the desirability of having an office on wheels, so it can be moved as soon as clients locate it. There is a recognition on the part of the Adult and Family Services (AFS) administration of the need for outreach, to the extent that budget constraints and political pressures allow.

In 1968, the City Club also recommended that the legislature act to raise welfare benefits to a level at least compatible with current costs of living.

Benefits have been raised (see figure 1), but not enough to keep pace with inflation. Changes in the AFDC program render these comparisons approximate; however, from 1969 to 1990 the payment standard for a three-person household (the average size for AFDC families) increased from $172 to $432. On a constant dollar basis, this increase represents a 40% decline in the true value of the cash
payment. (These numbers do not include Food Stamp benefits, which are much more significant now than previously.)

**FIGURE 1**

MONTHLY ADC ASSISTANCE IN OREGON
ACTUAL AND IN 1967 DOLLARS

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**II. Background**

In this country, government has gradually assumed from private charity the primary responsibility for providing basic subsistence to the poor through a variety of income, social service and health care programs. This has evolved into a situation where the (largely white) middle class majority provides care for the poor which, in the eyes of many, consists largely of non-whites. This perception of poverty as being a minority problem has contributed to a disassociation from the issue on the part of many white, middle class citizens. Most know little about the evolution and composition of the social services system and have had no practical experience with it. Negotiating one's way through a maze of bureaucratic requirements and procedures to obtain food, shelter and health care is foreign to many including, this Subcommittee suspects, most City Club members.

Therefore, to set the stage for an analysis of the relationship of minorities and the poverty programs, this report contains brief background sections on the development and features of the major government income maintenance and health care programs for the poor. Included are data describing racial and ethnic minority participation in these programs. The discussion to follow deals with some of the perceptions and realities of minority participation in government programs.
A. Public Welfare: “Income Maintenance Programs”

The antecedents of public welfare in the United States are found in the British Elizabethan Poor Laws of 1597-1601, which were brought to colonial America and enacted by British settlers. Subsequent reforms and expansions of benefits followed in the aftermath of the Civil War. In the early days of this century the government initiated public pensions for mothers of dependent children. The public assistance needs created by the Great Depression culminated in the Social Security Act of 1935, the foundation of contemporary income maintenance policy.

The purpose of public welfare programs is not to emancipate people from poverty, but to provide a subsistence living standard. Today's income maintenance programs have many shortcomings. However, the transfer of needed income to millions of Americans provides important social and economic stability in our society.

Several income maintenance programs dominate the system by virtue of their overall importance to recipients and to society in general. The following programs are considered mainstays of the system.

1. “Social Insurance Programs”

“Social insurance programs” are those in which beneficiaries (and/or their employers) must make a financial contribution before they can establish eligibility. Benefits are viewed more as rights than as privileges. There is little, if any, social stigma attached to their receipt. Social Security is the largest of the social insurance programs, with benefits received mainly by the non-poor.

In “public aid programs” the applicant must show evidence of need and be without an alternate source to meet that need. The recipient is generally not expected to have made a contribution prior to receipt of benefits. Benefits are available only to certain categories of individuals and families. Childless couples and the working poor are usually excluded. These programs are often described as “safety net” programs; a stigma frequently accompanies receipt of benefits. The major public aid programs are Aid to Families of Dependent Children (AFDC), Supplemental Security Income (SSI), General Assistance (GA), and Food Stamps.

The AFDC program is governed by state and federal regulations. It provides cash and medical assistance to eligible one-parent families with children. Since the Oregon standard for eligibility is 67% of the official poverty level, there are large numbers of the poor who are not sufficiently poor to qualify for AFDC. In 1989, the Census Bureau poverty level was $1,056 per month for a four-person family. The average AFDC benefit in Oregon for that four-member family was $836 per month or $220 per month below the poverty level. Oregon’s payment rank is 15th of all 50 states, according to AFS figures. In June 1990, 9,760 families (26,167 persons) received assistance in this program in northwest Oregon. Of these families, 3,951 were minorities. (See Table 1)

1. Several government bodies issue definitions of the “poverty level”, generally taken from an inflation-adjusted “market basket” of essential goods and services. The State of Oregon Department of Health and Human Services issues “administrative poverty income guidelines” covering a large number of different household and asset combinations. Their standards are said to be very similar to the Census Bureau’s cited above.
In the same month, June 1990, financial and medical assistance were provided to children in 271 eligible two-parent families under the AFDC-UN program. This program provides benefits to children of qualifying two parent families where both parents are unemployed.

**Food stamps** are issued through a federally funded program administered by the state. Eligibility is much more broadly defined than for the AFDC programs, and is based on family size, income and general level of resources. In December 1989, 24,189 households received food stamps in the Portland metropolitan area, with 13.3% of these being racial and ethnic minority recipients.

**SSI** is federally funded and provides assistance to low-income elderly, blind or the disabled. **GA** is a state funded program which provides cash assistance and limited medical benefits to some of those not eligible for other assistance.

Other important public aid programs are Employment Related Day Care, which provides assistance to low-income households who must have day care to enable a parent to be a wage earner and the Emergency Assistance Program, which provides grants to eligible lower-income families to meet emergency needs on a once-a-year basis.

As shown in Table 2, many low-income Oregonians do not receive benefits from these programs. A variety of complex issues affect their participation. These include the fact that the major welfare program, AFDC, is to protect children from undue hardships of poverty. Poor adults without children, and families that aren’t poor enough, i.e., having family income below the poverty level but above the cutoff point, are not eligible for AFDC benefits. Other factors, such as fear of social stigma, lack of information about programs, complexity of accessibility, language and cultural barriers to applying for help, and problems associated with determining eligibility account for some of the non-participation. The Subcommittee heard repeatedly that these factors cause a higher degree of nonparticipation in public aid programs among the minority poor.

A striking example of the lack of participation is typified by comparing the numbers of low-income people with the actual number of those who participate in the AFDC and/or Food Stamp programs.
TABLE 2
INCOME MAINTENANCE PROGRAM PARTICIPATION 1989

Persons Below Poverty  Participants AFDC, AFDC-UN  Participants Food Stamps (incl AFDC)

Multnomah County  562,000 population
62,584  22,474  49,636

Clackamas County  255,100 population
14,971  3,571  8,847

Washington County  280,000 population
15,510  3,907  9,118

Source: Oregon Dept of Human Resources

Many of the public welfare programs reviewed above were altered with the implementation of the federal Family Support Act of 1988 which began in October, 1990. This act calls for: 1) new and more stringent enforcement of payment of child support by absent parents, including the establishment of paternity, 2) the creation and implementation of a job opportunities and basic skills training program for each participating household, 3) supportive medical and child care services for recipient families, 4) an expanded AFDC-UN program (for two-parent families), and 5) increases in allowed earned income. The Act is the culmination of decades of welfare reform attempts in the United States. It sets up an incremental approach to reform and its success depends on the strength of the federal and state economies, long term federal support and the commitment and dedication of state government to making it work.

2. Oregon Welfare Reform Program

In 1988 Oregon instituted a job training pilot program, NEW JOBS, similar to that required in the Family Support Act. Of the initial seven special jobs programs in the state, the only one in Portland was located in the predominantly white southeast section. AFS administrators say that site selection was based on internal considerations having to do with the capability of the branch offices to successfully manage the transition to a NEW JOBS site. Other observers, however, have speculated that the sites were chosen to enhance legislative support and to attract participants deemed most likely to succeed.

AFS also now offers access to a full range of welfare reform services to Portland residents through the Steps To Success program operated from the Immaculate Heart School site in Northeast Portland.

3. Ballot Measure 7: "Workfare"

Ballot Measure 7 was passed in November 1990 by a 57% to 43% majority, calling for a six-county pilot program on the elimination of welfare, food stamps and unemployment benefits. In their place, government was to provide people qualifying for public assistance with guaranteed state-paid jobs at 90% of the state minimum wage. There were no provisions for education, job training, or child care.

The federal departments involved (Health and Human Services, Labor and Agriculture), which provide major funding for these programs, apparently will not grant the waivers needed to put Measure 7 into effect at this time. While it appears,
therefore, that this effort to bring about a "Workfare" system has failed, the large vote in favor of Measure 7 demonstrates a strong desire for a simplified solution to the problems and costs of public assistance.

B. Publicly-Funded Health Care

1. Medicaid

The federal government’s involvement in financing medical care for the poor dates to the economic depression of the 1930s. The Social Security Act of 1935 introduced the concept of federal matching payments to the states for medical services provided to public assistance recipients. The Medicaid program, as it is known today, was officially established by Title XIX of the Social Security Act Amendments of 1965.

Medicaid is the principal source of public funds for medical care for the poor in the United States. The program is administered by the states within federal guidelines specifying who is eligible, which services are covered, and how providers are paid. By federal law, anyone receiving AFDC or SSI automatically qualifies for Medicaid.

The federal government requires states to pay for certain mandatory services, such as hospital care, lab and x-ray services and physician services. Federal matching payments are also available for other state-designated “optional” services including, in Oregon, limited dental care, prescribed drugs and the services of chiropractors, naturopaths, optometrists and podiatrists. States are free to limit the quantity and duration of all optional and mandatory services.

Jointly funded by the state and federal governments, Medicaid uses a matching formula based upon each state’s per capita income. Oregon’s current federal match is 63%. If states so choose, as Oregon does, the federal government will also match state expenditures for certain “medically needy” individuals whose income and resources exceed AFDC and SSI cash assistance standards, but who meet all other eligibility standards.

Statistics kept by the state show minor variations in usage of Medicaid services among the populations surveyed as shown in Table 3. The same table also shows significant differences in the expenditures per recipient among the groups surveyed. Nearly twice as much money is spent on white recipients as on any minority group.

<table>
<thead>
<tr>
<th>TABLE 3</th>
<th>MEDICAID UTILIZATION AND EXPENDITURES BY RACIAL AND ETHNIC GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered by Medicaid</td>
<td>Used Medicaid</td>
</tr>
<tr>
<td>All Oregonians</td>
<td>247,256</td>
</tr>
<tr>
<td>White</td>
<td>210,285</td>
</tr>
<tr>
<td>African-Amer.</td>
<td>15,023</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>4,656</td>
</tr>
<tr>
<td>Hispanic</td>
<td>5,222</td>
</tr>
<tr>
<td>Native Amer.</td>
<td>11,458</td>
</tr>
</tbody>
</table>

Source: Oregon Health Division, HCFA 2082, Fiscal Year 1989
*Figures not included
Table 4 shows further that the differences in expenditure are even more dramatic when broken down by age. Costs for children show less disparity than those for the elderly, but it is clear that there are significant differences in all age groups in the quantity of health care services provided to white Medicaid clients versus those provided to minority clients.

**TABLE 4**

<table>
<thead>
<tr>
<th></th>
<th>All Ages</th>
<th>Under 21</th>
<th>21-64</th>
<th>65+</th>
<th>% 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>$1,935</td>
<td>$738</td>
<td>$2,771</td>
<td>$5,064</td>
<td>11.6%</td>
</tr>
<tr>
<td>African-American</td>
<td>$1,157</td>
<td>$664</td>
<td>$1,897</td>
<td>$1,864</td>
<td>8.7%</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>$1,235</td>
<td>$722</td>
<td>$1,982</td>
<td>$3,702</td>
<td>3.9%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>$1,100</td>
<td>$575</td>
<td>$1,642</td>
<td>$1,925</td>
<td>16.5%</td>
</tr>
<tr>
<td>Native American</td>
<td>$ 923</td>
<td>$640</td>
<td>$1,490</td>
<td>$2,813</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

Source: Oregon Health Division

In seeking to understand the reasons for these differences, this Subcommittee compared Oregon's experience with the rest of the country. Except for minor variations in the size of the differences, it found the same pattern nationwide—i.e., significantly higher Medicaid expenditure rates for whites than for minority groups. (See Appendix A). Indeed, using federal statistics (*Medicare and Medicaid Data Book, 1990*), we were able to trace the same basic pattern as far back as 1975 when Medicaid benefit levels for the average minority recipient were only 60% of those for the average white recipient. These nationwide discrepancies have worsened since then; by fiscal year 1986, the average minority recipient received only 51% of the Medicaid benefits received by the average white recipient.

Again using national statistics, this Subcommittee also examined whether differences in the service utilization patterns of whites and minorities could possibly explain these discrepancies in benefit levels. Indeed, this Subcommittee found white recipients much more likely than minority recipients to use costly, long-term services such as skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). Conversely, racial and ethnic minority groups, particularly African-Americans, were slightly more likely to use lower-cost clinical, laboratory and family planning services, as well as outpatient services in hospitals. These differences in utilization rates are especially pronounced in the case of long-term care services provided by SNFs and ICFs. For example, whites are 6.0 times more likely than African-Americans to use SNFs; 8.4 times more likely than Asians; 10.5 times more likely than Hispanics; and 14.0 times more likely than Native Americans.

Whether these utilization differences are due to corresponding differences in the age composition of the Medicaid populations in white and minority communities, we do not know. It is also important to remember that these are national patterns, although the same basic trends are prominent in Oregon as well.

2. New Legislation: Oregon Health Priorities Initiative

The State of Oregon has been thrust into the national spotlight with its highly publicized plan to expand Medicaid coverage by rationing health care services. The centerpiece of the state's rationing plan is the expansion of medical assistance coverage to all poor Oregonians by limiting Medicaid to high priority health ser-
vices. To implement the policy a new Health Services Commission was created under the 1989 Senate Bill 27. The eleven-member commission, which included racial and ethnic minority representatives, has published a prioritized list of health services from most to least important in terms of the benefits of each service to the entire population to be served. No distinctions were drawn among different minority or service groups as the intent is to produce the maximum benefit for the greatest number of Oregonians. Since services will not be targeted to specific population groups, the plan’s impact on Portland’s minority communities remains a uncertain.

It is generally agreed that certain medical conditions occur with greater frequency among certain minority populations. While clearly not the intent of the plan, application of the priorities without regard to that fact could lead to undesirable effects on the health services utilization of minority groups. On the other hand, to the extent that minorities are represented in the working poor groups which would become eligible for services under this program, they would obviously benefit from it.

The Oregon Legislature has approved a funding level which would cover at least 587 of the 709 identified medical services. This appropriation represents a $30 million addition to Medicaid funding. Implementing Senate Bill 27 will require a waiver of federal Medicaid regulations if the state is to receive federal matching funds for the proposed program. Proponents of the program feel that the prospects for approval have improved, but the final outcome remains in doubt at this writing.

3. Health Care Needs

The Health Division of the State Oregon State Department of Human Resources has done a series of recent studies on the births, deaths and other health factors of two of Oregon’s minority populations, African-Americans and Native Americans. A study of the health status of Asian refugees was done in 1981 and a study on Hispanics is underway. The information included in these studies shows a picture of poorer health conditions for these groups of people than for the white majority. Some startling facts emerge about the health of ethnic minorities in the State of Oregon:

• Almost 17% of all African-American mothers in Oregon receive inadequate prenatal care, compared with 8.4% of mothers of all other races. Between 1980 and 1987, the proportion of African-American mothers with inadequate prenatal care increased 57.5%.

• African-American infants in Oregon are 62.7% more likely to die in their first year of life than infants of all other races.

• The age-adjusted death rate is 32.2% higher for African-Americans compared to all races. Specific death rate differences are sharpest between African-Americans and all Oregonians 45-54 years of age, with African-Americans 2.2 times higher. (Age-adjusted death rate is defined by the Health Division as the number of deaths in a certain age group divided by the population of that age group. For the statistic cited, in the age group 45-54, African-Americans are 2.2 times as likely to die as all Oregonians.)

• One in six Native American mothers in Oregon receives inadequate prenatal care compared to one in 14 of all other races.
• Native American infants in Oregon are 40.4% more likely than infants of all other races to die in their first year. One half of those infants who die had mothers with inadequate health care.

• Age-adjusted death rate differences are sharpest between Native Americans and all Oregonians 15-44 years of age. The death rate is 87.8% higher for Native Americans.

• Accidents cause more deaths among Native Americans (one in five deaths) than among the state’s population as a whole (one in seventeen). Motor vehicle accidents account for 64.2% of all unintended injury deaths among Native Americans compared to 52.3% of all races. And 80% of those who died in motor vehicle accidents had been drinking alcohol. The comparable figures for other races: 48.3% of whites and 37.5% of African-Americans.

• The 1981 report on Asian refugees updated earlier reports on the health of the refugees. Nearly 80% of those diagnosed with disease at entry had tuberculosis. The incidence was about 4,300 cases per 100,000 population, a 9% increase over 1979-1980.

Because the report on Hispanics was not completed, information on health care needs comes from health care professionals serving the Hispanic community.

They report that language barriers, lack of transportation and child care and lack of knowledge about how to access health care prevent many poor Hispanic women from getting prenatal care. And for migrant workers, lack of services in the evening and on weekends effectively prevents them from getting needed health care services.

For many of the working poor of all racial and ethnic groups, lack of employer-supported health care insurance constitutes a major health care need. The committee was repeatedly told that a poor mother who has a marginal job with no health care coverage for herself and her children will be forced to quit her job and go on welfare so that she can become eligible for Medicaid in order to provide for a sick child. This was cited as a major reason for the revolving door of welfare dependency.

III. Analysis and Discussion

A. Racial and Ethnic Discrimination in the Provision of Welfare Services

1. General

The Health and Welfare Subcommittee interviewed witnesses and collected statistics to determine whether evidence exists of barriers to racial and ethnic minority participation in public welfare programs. While the specific responses varied from speaker to speaker, all of those interviewed agreed that the law and administrative policy are both clear: discrimination is illegal when providing publicly funded services.

Administrators of public agencies would agree with an academic observer who said that unless policy and practice are teemed together to exclude persons based
on race, there is no official racism. Therefore, because agency policies and philosophy are not racist, the agencies are no longer racist, although some individuals in the system may still exhibit racist behavior.

Beyond the requirements of the law, agency staff and administrators point to their efforts to increase minority staff in all agencies, to provide interpreters and materials in a variety of languages for non-English speaking clients, and to present workshops on cultural sensitivity issues as signs of the state’s commitment to carrying out the spirit and letter of the law.

However, representatives of racial and ethnic minority organizations and former agency clients tell a different story.

Former welfare recipients said there is discrimination in the system that discourages people from seeking the services to which they are entitled. Few clients will file racial discrimination complaints because they fear that such an action will result in a loss of benefits. Former clients reported that they had heard of such retaliation against clients who had complained. AFS administrators say that such behavior is not permitted and that all complaints are handled appropriately—at the branch office level, if possible.

Despite repeated requests, this committee has not been able to obtain data from the state office of AFS on complaints and so is unable to document the extent of complaints and the disposition of them. The agency’s practice is to refer complaints to the branch level. The administration was unresponsive to our requests for data on the composition and resolution of complaints.

2. Racism and Cultural Insensitivity

In many cases, instances of unfair or demeaning treatment were attributed to cultural insensitivity, rather than to racism. Racial and ethnic minority groups may choose to talk about “cultural insensitivity” because it seems less threatening to the white majority. But cultural insensitivity, coupled with a language barrier, is viewed by many as having the same effect as overt racism. It also prevents access to needed services because potential clients may not be able to find out about services or may be discouraged from seeking services by the way they are treated.

Whether labeled “racism” or “cultural insensitivity,” these actions and misunderstandings are perceived to be discriminatory. The subcommittee was given several examples, including these:

- African-Americans believe that there are differences in the way AFS branch offices are treated by the Salem headquarters, and racism is believed to be a factor. For example, clients say the North Portland office, which handles a majority of African-American clients, is not as well maintained and has shabbier furnishing than offices serving white clients.

- Some actions taken by AFS are perceived as racially motivated. The example given was the issuance of identity cards only to North Portland AFS clients to use in cashing welfare checks. While this action was probably taken to help clients of this office who have no other proof of identification, it was perceived differently.
According to witnesses from racial and ethnic minority groups, cultural misunderstanding contributes time and again to problems.

In Asian cultures, there are biases against trusting institutional authority and concern about losing face. Such distrust of the system appears to white social workers as non-cooperation or evasiveness.

In Hispanic societies many members have a reluctance to question institutional authority. Dropping one’s eyes can be a sign of respect. Looking someone in the eyes may be a sign of disrespect. The firm handshake is not common. The hug is. Hispanic cultures are very private; agencies ask prying questions and can be intimidating. Good, helpful communication is impossible when the cultural clues are misread.

For immigrant groups there are language discrimination issues. The influx of Asians with a variety of languages has put a strain on public welfare staff. Federal rules require that for branch offices with 35 or more clients who speak a specific language, materials and translators in that language must be provided. AFS lists staff language skills in a directory; however, many of the staff members listed are not fluent. The tone of the translation, the choice of words, and the message are sometimes inappropriate.

3. Poverty and Race

One problem was cited repeatedly by public assistance recipients and workers alike: a bias against the poor erects barriers to obtaining services. Complaints about treatment by assistance workers comes from both minority and non-minority clients. The stigma, witnesses said, is primarily being poor and on welfare, not necessarily being a member of a minority group.

This prejudice was described as a class bias by some. Indeed, some researchers even contend that an “underclass” of chronically poor, permanently welfare-dependent persons is developing. Other observers argue strongly that no rational person chooses a life of extreme poverty, the fault lies in a system which offers no meaningful way to escape from poverty.

Unfortunately the concept of an “underclass” plays into some people’s prejudicial stereotypes, leading to such myths as most welfare clients are minorities (in fact, most welfare clients are white), that people return to welfare because they don’t like to work (most people return to welfare because they cannot get health care coverage from their employment). In whatever way it is labeled, adding class bias or prejudice against the poor to racial bias exacerbates the problems minority clients have in obtaining services.

4. AFS Personnel Policies and Training

The relationships between agency workers and clients are the key to the treatment of minorities in the system. Two important components of this interaction are minority representation among agency workers and the cultural sensitivity training of all agency workers.

The stated policy of the present AFS administration is to achieve minority representation in the staff which exceeds minority representation in the labor force.
at large. AFS minority employment statewide is 14.8% compared to a minority labor force of 12.7% (December 1989). On the face of it, AFS has succeeded in meeting that goal.

However, the distribution of minority employees among job classifications is another element in the equation. Branch managers are especially important in setting the tone for their offices and in acting as role models for clients and staff. We do not suggest that it is necessary that a manager be a member of a minority group to achieve cultural competence in the staff; still, managers are rightly seen as holding key positions in the affirmative action plans of the agency. In the appointment of minority managers, improvement is needed.

Racial and ethnic minority representation in upper management of AFS is 18.4%, although this represents only a few persons. In the lower branch/unit manager ranks, only 6.3% are members of a minority.

Employee training in cultural sensitivity and race relations offered through the Salem headquarters of AFS consists of portions of training for new eligibility-workers, which is mandatory for all new workers. A one-day cultural sensitivity training course entitled “Non-discrimination in the Delivery of Services” is not mandatory and attendance is at the discretion of branch supervisors. Other programs to increase cultural sensitivity are being designed by the central administration.

The Children's Services Division is just now adding a cultural competency accountability factor to employee performance reviews to give added incentive to case workers for appropriate behavior. AFS workers are not rated on cultural competency.

B. Racial and Ethnic Discrimination in the Provision of Health Care

1. General

The information cited in the background section indicates the greater need of minorities for improved health care and the importance of Medicaid in providing it.

The Medicaid program pays for medical services provided by a number of individuals, groups, agencies, clinics and hospitals. Community-based programs are important components of the health care system for minority poor. Whether paid for by Medicaid, by the patient on a sliding scale fee basis, or provided at no charge, racially and culturally focused community health care agencies provide services with respect for, and understanding, of diverse cultural values. This is especially important for the Hispanic community, with people from several dozen nations making up the Hispanic population, and the Native American community, with representation from many tribes.

An example of the problems health care providers can face in providing culturally appropriate service is illustrated by the federal government's Acquired Immune Deficiency Syndrome (AIDS) literature currently available for the Hispanic community. The material, prepared by the Health Department in Washington, DC, is targeted to the Hispanic community of the east coast, mainly Puerto Ricans. The Hispanic community of Oregon does not identify with either the culture or the vernacular used, making the materials inappropriate for Oregon.
Another concern is providing health care for migrant Hispanics. The Oregon Council for Hispanic Advancement’s Health Committee provides a forum for the coordination of services by its member agencies. The committee also conducts an annual health fair for Hispanic migrant workers in the Gresham area.

For African-Americans, the North Portland Nurse Practitioner Community Health Clinic provides needed, culturally-sensitive, health care regardless of the patient’s ability to pay. The health problems which staff treat mirror what is occurring in the community.

Crack-addicted babies are often brought to the clinic, the committee was told, by grandmothers who are raising them without medical insurance or Medicaid.

Rights to medical care for many Native Americans arise through their tribal treaties with the federal government. These treaty rights, however, are largely based on services available on tribal reservations. In Oregon, 86% of all Native Americans live off the reservation and must either travel to their reservations or seek services locally. The Portland Indian Health Clinic is the only community-based Native American facility available in the urban area. Among other reasons, because of the clinic’s cultural sensitivity, many Native Americans come from all over the state for treatment there. The clinic serves 6,000 patients a year. The waiting period for an appointment is approximately a month.

Southeast Asian refugees can receive care from two Multnomah County clinics: the Tuberculosis Clinic and the International Clinic. Both clinics cooperate with other community-based organizations to provide health education and interpreting services. The county has actively recruited minority professional staff members and has a cross-cultural committee which looks at delivery of services and personnel practices and retention issues.

Barriers to service at the county clinics are few. There is a sliding scale payment system, interpreters are readily available, cross-cultural training is ongoing and cultural health values and practices, such as acupuncture, are integrated into the services provided.

Racial and ethnic minority community health care leaders told the committee that greater coordination of services between private providers, who are excellent at providing services, and community-based services, which know the concerns of the community, would make services more efficient and effective. They also stressed the importance of recruiting and retaining minority staff members.

While community-based agencies deliver effective health care programs to minority patients, such programs are small in proportion to the minority population in need when compared to the medical services provided to minorities by major hospital and government facilities.

2. Disparity in Medicaid Services

The implications of unequal treatment contained in the health statistics and the Medicaid data cited in the background section are indeed troubling. The committee is unable to account for these differences. We can only speculate on the role of various factors which may present barriers to access to Medicaid services.
We have uncovered no evidence of overt discrimination in the provision of Medicaid services. The diffused nature of health care provision, not to mention legal and ethical strictures, makes widespread racial discrimination unlikely. Subtle discrimination may occur, particularly in the range and cost of services provided. Again, we have no evidence of this beyond the statistical data presented above.

Other factors may enter into the disparities cited above. Age of the patient population has some effect, and the higher death rate of minorities would reduce the pool of elderly minorities seeking medical care. This does not explain the great disparity in per-recipient expenses in the 65 and older age group.

It has been suggested that some cultural groups—especially Hispanic and Asian—place a greater value on caring for the elderly in the family setting, thereby reducing the demand for expensive nursing home care.

It is generally agreed that assertiveness, perseverance, and experience with the health care delivery system are needed to fully avail oneself of Medicaid services. Language barriers and cultural bias against challenging authority may well impede full access to care.

For many, frailty and lack of transportation, while not racial issues, may act as barriers to care.

Finally, the quantity—and therefore the cost—of services provided may be influenced in extremely subtle ways by the relationships between providers and clients. As to the quality of care, service delivery decisions are made by thousands of individual providers. It is virtually impossible to document the quality of care of minority and non-minority patients in this circumstance.
IV. Conclusions

Some of this Subcommittee’s findings apply to both welfare and health care provision; others are specific. The bias against the poor, which we observed frequently in the course of this study, must be seen as pervading all of these issues.

General Conclusions

1. Individuals experience discrimination in the course of receiving public health and welfare assistance.

2. Cultural insensitivity is broad-based and leads to bad feeling and underutilization of services on the part of racial and ethnic minority group members. Cultural insensitivity is amenable to change through education and understanding.

3. While efforts are being made to overcome the problems, there are significant barriers to access to welfare and health care services based on language and cultural differences.

Welfare Conclusions

4. The perception persists on the part of minority clients and providers that racial and ethnic minorities are treated differently than majority clients.

5. The apparent absence of a system for tracking and reporting on complaints of racial and ethnic discrimination in the welfare system impedes full assessment of the AFS Department’s compliance with legal mandates and its own policies.

6. There is not enough racial and ethnic minority representation among branch managers in the state welfare system.

Health Care Conclusions

7. The appearance of racial and ethnic discrimination in provision of Medicaid services is overwhelming and cannot be denied. That the problem is pervasive across the nation does not excuse the evidence of unequal treatment in Oregon.
V. Recommendations

Welfare

1. Cultural sensitivity training for all employees of the State of Oregon Department of Human Resources must be broadened and made mandatory, frequent and on-going. Cultural sensitivity in dealing with clients, fellow employees and the general public should become a part of job performance evaluation at all levels.

2. Adult and Family Services is encouraged to continue efforts to set and meet goals of racial and ethnic minority representation in hiring and promotion practices, especially at the branch manager levels.

3. The State of Oregon Department of Human Resources should document complaints of racial and ethnic bias and their resolution, and make this information available to the general public.

Health Care

4. The State of Oregon Department of Human Resources should investigate the disparity in money spent on health care for different racial and ethnic groups, report its findings to the legislature and the public, and take appropriate remedial action.

5. All providers of health care services in the Portland metropolitan area should examine their policies and practices to ensure culturally competent services to their patients through A) the employment of racial and ethnic minority health care professionals, B) use of interpreters and C) cultural sensitivity training of all staff members.

Respectfully submitted,

HEALTH AND WELFARE SUBCOMMITTEE

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Helen Lee, Chair

Approved by the Research Board on August 21, 1991 for transmittal to the Board of Governors. Approved by the Board of Governors on September 9, 1991 for publication and distribution to the membership and for presentation and vote on October 25, 1991
VI. Appendix

A. National Statistics

RACIAL DIFFERENCES IN MEDICAID PAYMENTS PER RECIPIENT
FY 1975 - FY 1986

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SOURCE: Medicare and Medicaid Data Book, 1990, Table 2.5 (p. 17) and Table 2.9 (p.24).
B. Persons Interviewed

Chamber of Commerce: Gordon Labuhn.

City of Portland, Northeast Neighborhood Office: Edna M. Robertson, Coordinator.

Commission on Indian Services: Bill Ray, Commissioner.

International Refugee Center of Oregon: Hongsa Chanthavong, Business Specialist.

Multnomah County Circuit Court: Steven Herrell, Judge.

Multnomah County, International Clinic: Bruce Bliapout.

Multnomah County, TB Clinic: Dave Houghton.

North Portland Nurse Practitioner Community Health Clinic: Mariah Taylor, Registered Nurse.

Oregon Adult and Family Services Division: John Heilman.
   Victor Merced, Deputy Administrator.
   Stephen D. Minnich, Administrator.
   Freddye Petett, former Administrator.
   Jean Pullen, Manager, West Portland Branch.
   Jean Thorne, Manager, Health Services Section.
   Panel of AFS recipients
   Panel of AFS and related services providers
   Erma Hepburn, Manager, Multnomah County Northeast Branch.

Oregon Children's Services Division: David Fuks.

Oregon Community Foundation: Greg Chaille, Executive Director.

Oregon Council for Hispanic Advancement: Victor Merced, former Executive Director.
   Virginia Quiroz, Health Coordinator.
   Oregon Department of Human Resources: Kevin W. Concannon, Director.

Oregon Health Division: Donna Clark, Acting Administrator.

Oregon Health Services Commission: Sharon Gary-Smith, Commissioner.
   Paige Sipes-Metzler, Director.

Portland Indian Health Clinic: Lowell D. MacGraw, Executive Director.
   Mike Stepetin

Portland State University, Department of Black Studies: Dr. Darrell Millner, Chairman.

Portland State University, School of Social Work: Norman Wyers, Professor.

The Private Industry Council: Carla Sosanya, Director.

Robert C. Shoemaker, Oregon State Senator, District 3.

Beverly Stein, Oregon State Representative, District 14.

United Way of the Columbia-Willamette: Diane Tutch, Vice President.
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The New York Times:
"Babies of Uninsured Found to Be at Risk," August 8, 1989.
"Childhood is Not Safe for Most Children, Congress is Warned," October 1, 1989.

The Oregonian:


