HEALTH CARE FOR THE ELDERLY: THE NIGHTMARE IN OUR FUTURE

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EXECUTIVE SUMMARY

With each passing year, the fraction of our national income devoted to health care continues to rise, and there is no end in sight. One reason is the growing expense of health care for the elderly.

- On the average, health care spending on each elderly person is about four times greater than health care spending on individuals under 65 years of age.

- As a result, although the elderly represent only 12 percent of the population, they account for about one-third of all health care spending.

- Sometime in the next century, the percentage of the population that is elderly will be twice what it is today, and the elderly probably will consume at least two-thirds of our health care resources.

According to current estimates, the payroll tax necessary to finance Social Security and Medicare benefits already promised under existing law will reach as much as 38 percent of workers' incomes by the year 2050. And this estimate is probably too low, because forecasters consistently underestimate future medical expenses.

We do not have to wait for advances in medical science or for the aging of the population to experience the crushing burden of medical expenses for the elderly, however. Even though health care spending consumes more than one out of every ten federal dollars, pressures are mounting to greatly expand the role of government right now.

One of the big ticket items currently not covered by Medicare is long-term care in nursing homes. As a result, for every elderly person in a nursing home there are two more, equally disabled patients who are not in nursing homes. Yet expanding Medicare coverage to include nursing home care threatens to be enormously expensive.

- If every elderly person in America spent just one year in a nursing home, the cost would be $627 billion.

- That figure exceeds more than 60 percent of our federal budget, and is about 50 percent more than the entire amount the nation now spends on all health care services.

We are traveling on a course that is unsustainable. As a result, we face one of two public policy options: Either we will move to a system of national health insurance that severely rations health care for the elderly, or we must move to a system that encourages individuals to accumulate savings in private, medical IRA accounts and allows them to make their own decisions about how they will spend these funds during their retirement years.

AN UNSUSTAINABLE COURSE

America is sitting on a ticking time bomb. That time bomb is the financial burden of health care spending for the elderly. For as far as anyone cares to forecast into the future, the financial commitment the federal government already has made to medical care for the elderly will continue to claim an ever-increasing share of our national income. And, as recent events in Congress clearly indicate, there is growing political pressure to increase the government's commitment, making our future burdens even greater.

Rising Health Care Costs. Over the last three decades there has been a continuous, almost unbroken increase in the percent of U.S. gross national product devoted to health care:

- In 1960, health care spending in the U.S. amounted to six percent of GNP.
- By 1986, that figure reached 10.9 percent of GNP -- higher than the total for any other nation in the world.
- Spending on health care last year totalled about $460 billion, or about $1,900 for every man, woman and child in the country.

Inflation in the health care sector last year was 7.9 percent -- about seven times the increase in the consumer price index. For 1987, inflation of medical prices probably will be at least 50 percent higher than the general rate of inflation. As a result, spending on health care is expected to reach 11.9 percent of GNP in 1987, and it is expected to grow to 13 percent of GNP within the next five years.[1]

Part of the reason for the explosion in medical costs is that we have been living under a cost-plus system of medical care, in which health care providers have been given strong financial incentives to increase spending. Among other features, this system has given a blank check to the R & D industry with an implicit promise: Invent it, show us that it will improve health, and we will buy it. As a result, procedures that are expensive and experimental one year become expensive and routine the next. For example:[2]

- Once organ transplants became covered by Medicare and by some private health insurance policies, their incidence rose dramatically.
- In 1986, the number of heart transplants increased by 26 percent, liver transplants increased by 25 percent, and pancreas transplants increased by 48 percent.

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[1] See Frank E. James, "Medical Expenses Resist Controls and Keep Going One Way: Higher," The Wall Street Journal, September 29, 1987.

[2] Data source: the American Council on Transplantation, reported in Hospitals, April 5, 1987, p. 28.

TABLE I

MEDICARE AND MEDICAID SPENDING

	1970	1975	1980	1985
Percent of Total Spending on Personal Health Care	18.8 %	24.9 %	27.7 %	29.7 %
Percent of Total Spending on Hospital Care	26.1 %	31.1 %	35.0 %	38.0 %
Percent of Total Spending on Physician Care	16.1 %	21.3 %	22.0 %	25.0 %
Percent of Total Spending on Nursing Home Care	36.2 %	50.5 %	50.0 %	43.5 %

Source: Health Care Financing Administration, Health Care Financing Review, Vol. 8, No. 1, 1986.

Government Spending. The federal government, through Medicare and Medicaid programs, has added to the cost-plus pressures of the U.S. health care system and driven health costs even higher than they would have been. As Table I shows:

- Health care spending by the federal government has been growing at a much faster rate than spending increases for the nation as a whole.
- From about 19 percent of total personal health care spending in 1970, Medicare and Medicaid outlays have grown to a point where they account for almost 30 percent today.

Medicare is predominantly designed to pay for the acute (short-term care) medical bills of the elderly. Although Medicaid is a health care program for the poor, the elderly consume a disproportionate and growing percentage of Medicaid dollars. This is partly because Medicaid pays for chronic (long-term care) expenses, including some non-medical expenses.

- When the market value of in-kind benefits (such as government provided housing, food stamps, medical care, etc.) is included in family income, the poverty rate among the elderly is only 2.9 percent -- the lowest poverty rate for any population group.[3]

- Despite this fact, the elderly constitute 16 percent of all Medicaid beneficiaries and account for almost 38 percent of all Medicaid spending.[4]

Medicare and Medicaid combined currently cost about $120 billion a year. They consume more than one out of every ten dollars now spent by the federal government, and they represent about 25 percent of all income transfer payments. Yet despite the tremendous growth in these two programs, the elderly spend a larger proportion of their budgets on health care today than they did before the Medicare and Medicaid programs were started.

Growth in the Elderly Population. Because of a steady increase in life expectancy and because of a drop in the birth rate, the percentage of the population 65 and older has been growing and will continue to grow for the foreseeable future:

- In 1900, only four percent of the U.S. population was over 65 years of age.

- By 1980, the elderly population had grown to 11.3 percent.

- By the year 2030, that figure will reach 20 percent or higher.

Medical Expenses for the Elderly. It is inevitable that the larger the number of elderly people, the greater the demand will be for health care resources. Elderly patients see physicians more often than the non-elderly; they are admitted to hospitals at twice the rate of the non-elderly; and once in the hospital, the cost of their care is higher.

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[3]Statistics are for 1985. See U.S. Bureau of the Census, Statistical Abstract of the United States: 1987 (Washington, D.C.: U.S. Government Printing Office, 1986,) p. 446.

[4]Thomas W. Grannemann and Mark V. Pauly, Controlling Medicaid Costs: Federalism, Competition and Choice, (Washington, D.C.: American Enterprise Institute, 1983), Table 2, p. 7.

- On the average, people today can expect to incur more than half of their lifetime health care costs after they reach the age of 65.

- In any given year, average health care spending for the elderly will be about four times higher than average health care spending for the non-elderly.

- In 1984, average health care spending for each elderly person was $4,200, compared with $1,100 for each individual under the age of 65.[5]

Not only are health care costs higher for the elderly than the non-elderly, but per capita health care spending for the elderly is rising faster than for the non-elderly. Moreover, the increasing proportion of the "old" elderly is creating an especially expensive burden:[6]

- On the average, hospital costs for persons 85 years of age and older are about 67 percent more costly than for those age 65 to 75.

- Long-term care for the "old" elderly is about ten times more costly than long-term care for the "young" elderly.

Yet individuals age 85 years and older constitute the fastest growing segment of the U.S. population:[7]

- In 1980, individuals age 85 years and older represented nine percent of the elderly population.

- By the year 2040, they will account for more than 30 percent of the elderly population.

Future Burdens for Taxpayers. How bleak does the future look? According to the Social Security Administration's "pessimistic" projection:

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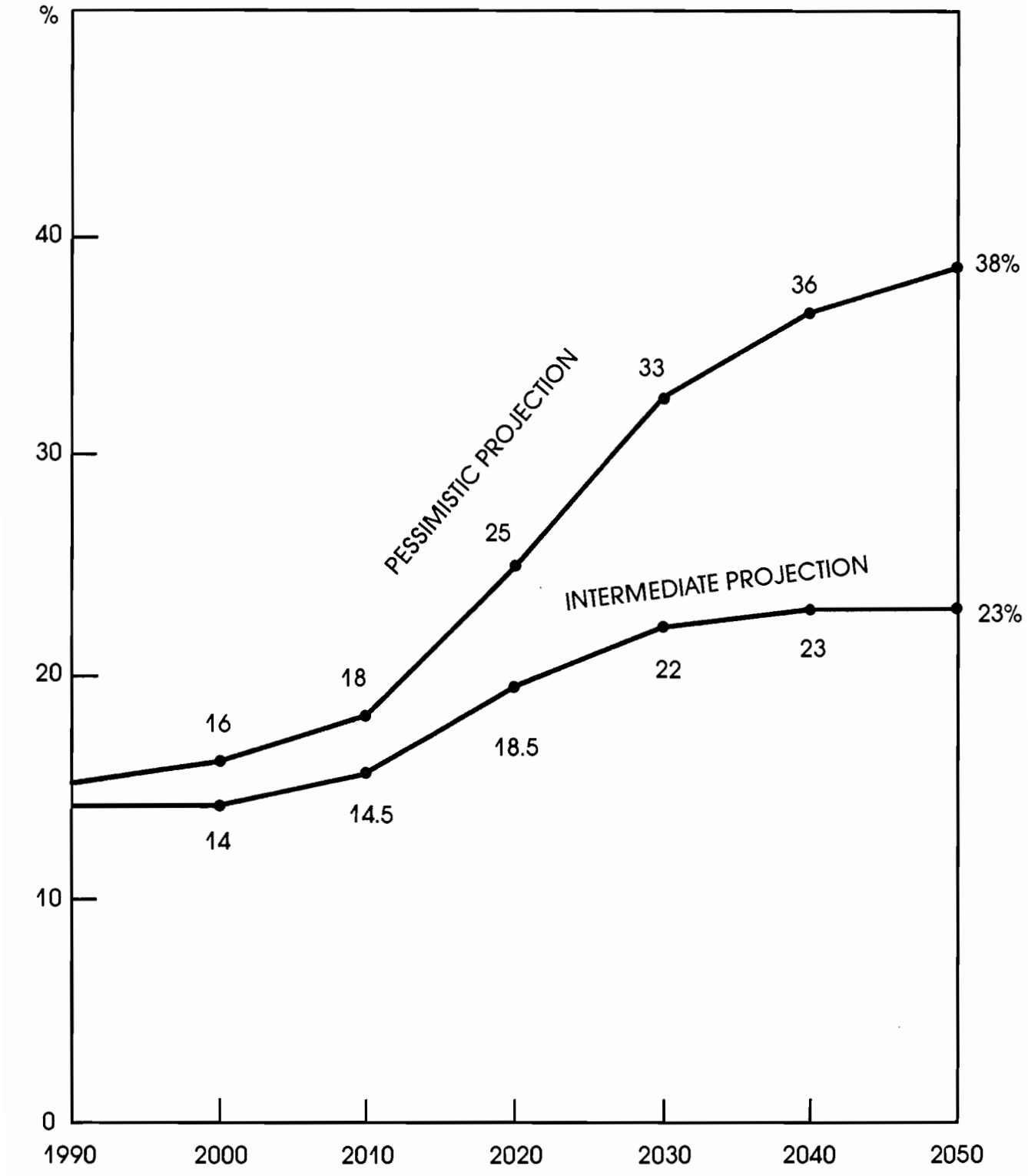
[5]Department of Health and Human Services, Catastrophic Illness Expenses: Department of Health and Human Services Report to the President, (Washington, D.C.: DHHS, November, 1986) p. 8.

[6]Estimates of the U.S. Health Care Financing Administration. For a recent discussion of these projections and related issues, see Peter G. Peterson, "The Morning After," The Atlantic Monthly, October, 1987, pp. 62-64.

[7]Dallas L. Salisbury, "The Need for Setting Funds Aside Today" in America's Health Care Challenge: New Directions for Business, Government and Individuals, (Minnneapolis: Northwestern National Life Insurance Co., 1986), p. 44.

SOCIAL SECURITY AND MEDICARE EXPENDITURES AS A PERCENT OF THE NATION'S TOTAL TAXABLE PAYROLL



SOURCE: SOCIAL SECURITY ADMINISTRATION

- The taxes needed to pay for Social Security and Medicare benefits promised under current law will reach 38 percent of workers' incomes by the year 2050.

- This projection assumes no increase in the current structure of benefits, such as those currently being considered by Congress, and no dramatic breakthroughs in medical science, such as discoveries that will significantly prolong the life of the elderly or significantly increase their health care costs.

We may not have to wait for the future, however, in order to face a calamitous crisis in health care spending for the elderly. Currently, Medicare pays for less than half of the medical expenses of the elderly, and one of the big ticket items that is not covered is long-term care in nursing homes. Yet increasing pressure is mounting to extend Medicare coverage to include nursing home care, as well as other uncovered expenses. How expensive could that be? Consider that:

- If every elderly person in America spent just one year in a nursing home, the total cost would be approximately $627 billion.

- That figure alone exceeds 60 percent of the entire federal budget.

Political Choices. America is traveling along a path that is unsustainable. Few believe that future taxpayers will be able or willing to shoulder the tax burden necessary to pay for promised future benefits. In what follows, we will demonstrate that there are only two long-term options. Either we can follow the example of other countries and adopt a system of national health insurance under which health care for the elderly is severely rationed, or we must move toward a system under which individuals are given the opportunity to save for their own retirement needs and are given the freedom to make personal choices concerning how their retirement income is spent.

HEALTH CARE FOR THE ELDERLY IN OTHER COUNTRIES

A survey of the health care systems of developed countries around the world reveals the following:

1. In all developed countries, taxpayers are significantly involved in paying for health care for the elderly.

2. In virtually every developed country other than the U.S., the elderly are part of a more general system of nationalized health care.

3. In every developed country, including the U.S., governments face a continuing problem of rising health care costs.

4. In every developed country outside the U.S., governments have attempted to slow the rise of health care costs by denying health care services to people through the non-price rationing of health care services.

5. Wherever governments have become extensively involved in rationing health care, vast inequities result; and these inequities generally work to the disadvantage of low-income, less well-educated patients.

6. Where health care is rationed, there also tends to be a bias against the elderly; and, the greater the degree of rationing, the greater the degree of discrimination.

The patterns that have emerged in other countries have important implications for the United States. In most cases, these countries share many cultural similarities with the U.S. In all cases, they have responded to the pressures of democratic political systems. As a consequence, a brief look at the patterns that have developed elsewhere can serve as an important guide in identifying similar trends and pressures in this country.

In many ways the health care systems of other countries, with all their problems and unattractive features, represent a picture of what health care will someday look like in America unless we act now to avert it.

Rising Health Care Costs Abroad

The U.S. is not alone in facing the problem of rising health care costs. International comparisons reveal that:[8]

- Between 1960 and 1983, the share of gross domestic product (GDP) devoted to health care increased by about 100 percent in Sweden and Japan -- about the same increase as the U.S. experienced.

- Even in countries where governments have made notable efforts to control rising health care costs -- such as Canada, Australia, Britain and New Zealand -- the fraction of GDP devoted to health care increased by roughly 50 percent.

We know of no advanced country that has failed to devote an increasing share of its national resources to health care over the last several decades. Why is this so?

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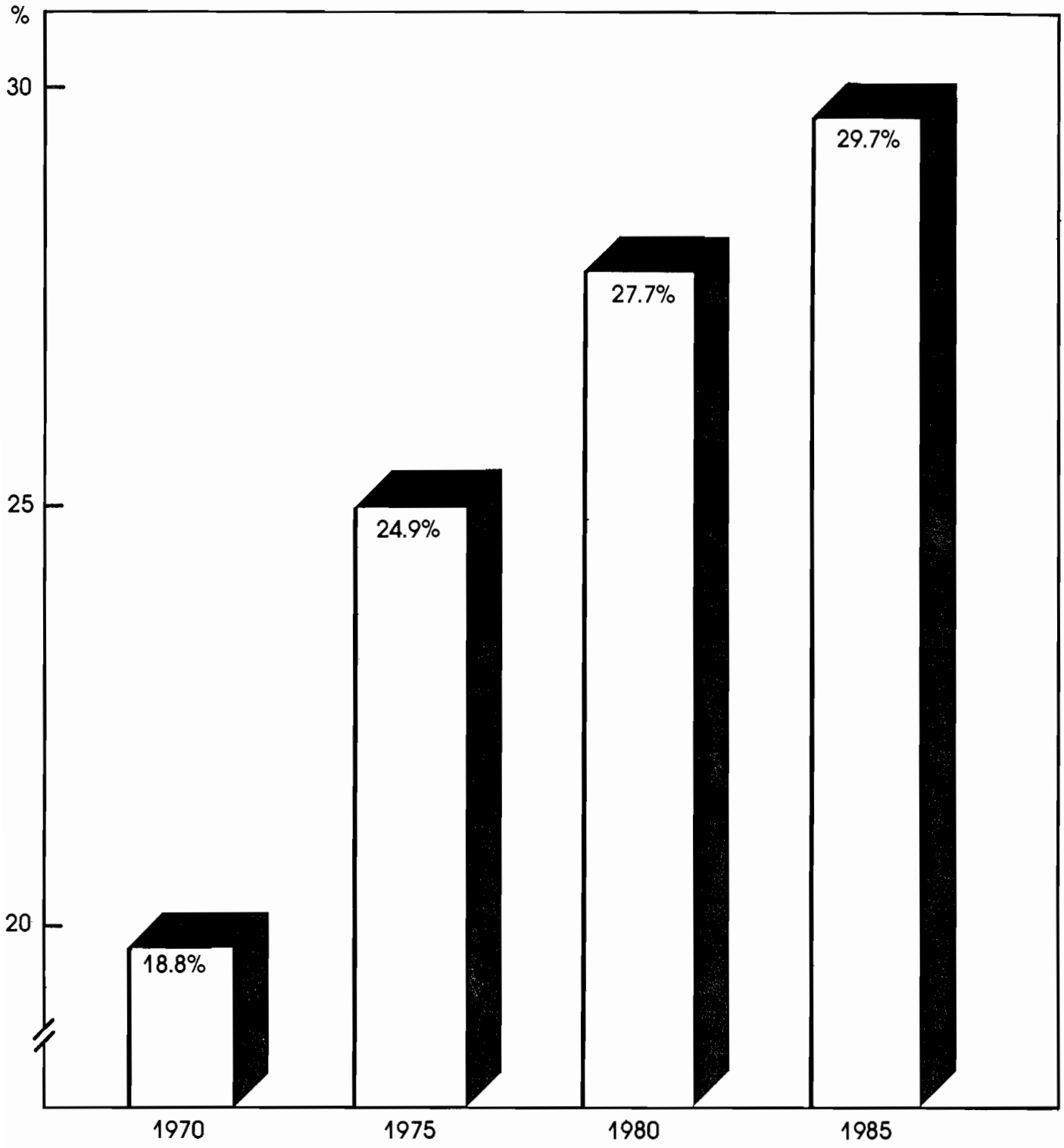
[8]G. J. Schieber, The Financing and Delivery of Health Care in OECD Countries: Past, Present and Future, (Paris: OECD, 1985).

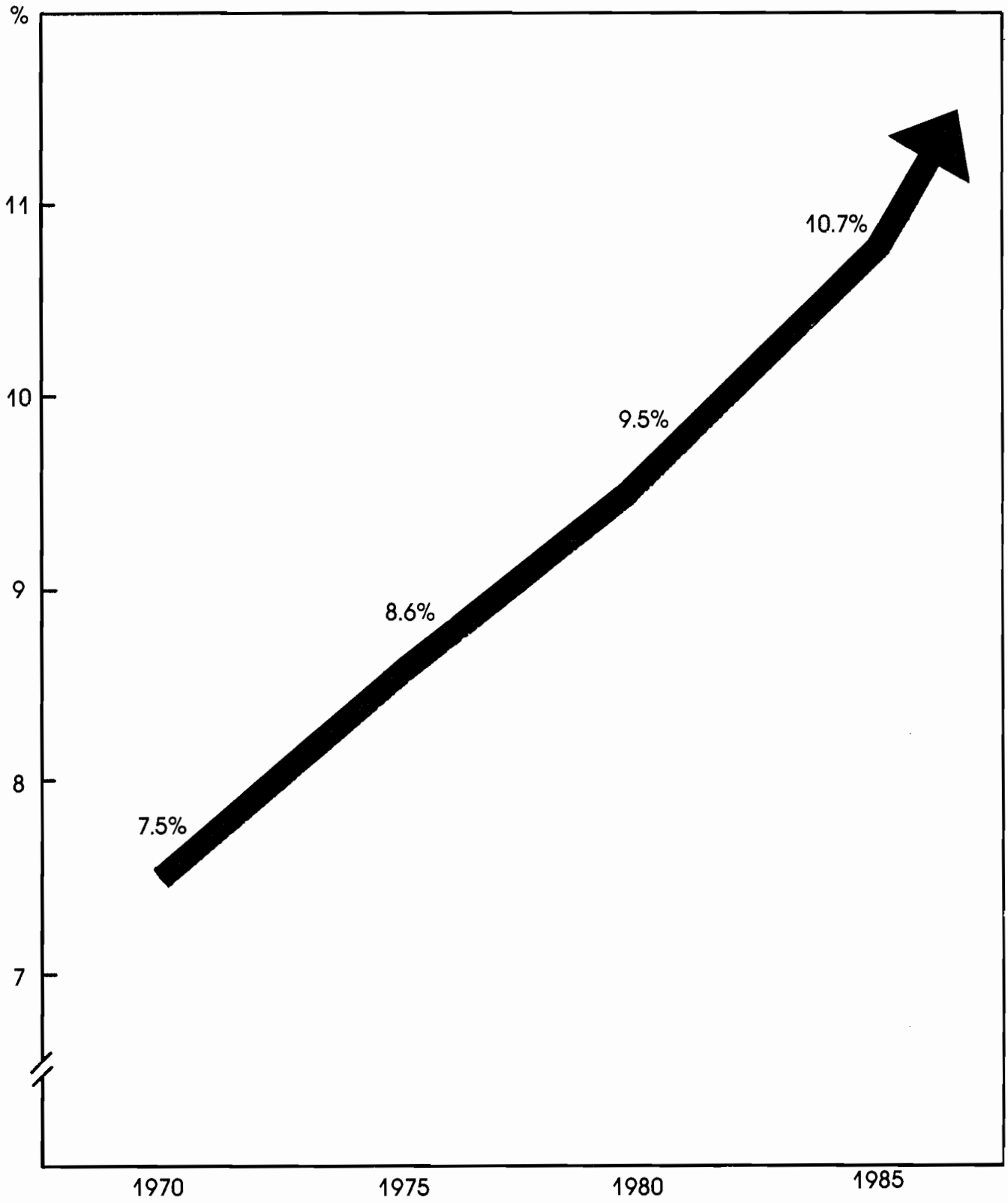
MEDICARE AND MEDICAID SPENDING AS A PERCENT OF ALL U.S. HEALTH CARE SPENDING*



SOURCE: HEALTH CARE FINANCING ADMINISTRATION

**Spending on personal health care*

U.S. HEALTH CARE SPENDING AS A PERCENT OF GNP



SOURCE: NATIONAL CENTER FOR POLICY ANALYSIS

One reason is that there has been a significant increase in the quantity and quality of services which the health care system has to offer. People are willing to spend more because health care providers offer more and better services. A second reason is that shoppers in the health care marketplace are rarely spending their own money -- private and public health insurance invariably picks up most, if not all, of the tab. Evidence suggests that when health care services become "free" at the point of consumption, there is almost no practical limit to the demand for them.[9] A third reason is that every developed country has experienced a substantial increase in the number of elderly people relative to the rest of the population.

The U.S. is not alone in facing a rising problem of elderly dependency. In many other countries, the problem is worse:[10]

- In the United States, the ratio of the elderly population to the population age 15 to 64 is about 18 percent.
- In Belgium, Britain, Denmark, Germany and Sweden that figure exceeds 20 percent.
- The ratio of the elderly population to the population age 15 to 64 in Sweden, for example, is almost 28 percent.

Moreover, because most European countries have a lower fertility rate than the U.S. does, the problem of elderly dependency in these countries will be even more severe than in the U.S. as we move into the next century.

As in the U.S., health care for elderly patients in other countries is about three to four times more expensive than health care for the non-elderly. Yet, because there are severe limits on how much politicians can extract from taxpayers to pay for health care, governments in other countries have intervened in the health care marketplace to control this spending.

Rationing Health Care: Waiting for Surgery

By U.S. standards, one of the cruelest aspects of government-run health care systems in other countries is the degree to which these systems engage in non-price rationing of health care services. Take the health care systems of Britain and New Zealand, for example. In both countries, hospital services are completely paid for by government. Yet both countries also have long waiting lists for hospital surgery:

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[9] See the discussion in John C. Goodman, National Health Care in Great Britain: Lessons for the U.S.A., (Dallas, Texas: Fisher Institute, 1980), Ch. 4.

[10] R. Gisser, "Recent Demographic Developments in the Member States of the Council of Europe," Population Trends, Vol. 14, 1985, pp. 21-25.

- In Britain, with a population of about 55 million, the number of people waiting for surgery is almost 800,000.[11]

- In New Zealand, with a population of three million, the waiting list is currently about 50,000.[12]

In both countries, the adverse effects on patients is about the same. Elderly patients in need of a hip replacement can wait in pain and discomfort for years. Patients waiting for heart surgery often are risking their lives.

In response to severe rationing by waiting, both Britain and New Zealand have witnessed a growing market in private health insurance -- where citizens willingly pay for coverage for private surgery, although they are theoretically entitled to "free" surgery in public hospitals. As a result, the privately insured pay for health care twice -- through taxes to support the government-run system and through premiums for private health insurance.

- In Britain, the number of people with private health insurance policies has doubled in the last ten years, currently totalling about eight percent of the population.[13]

- In New Zealand, one-third of the population is covered by private health insurance, and private hospitals now perform 25 percent of all surgical procedures.[14]

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[11] Office of Health Economics, Compendium of Health Statistics: 6th Edition, 1987, (London: OHB, 1987) Section 3, p. 52. See also the discussion in Goodman, National Health Care in Great Britain, Ch. 6. Enoch Powell, former Minister of Health, has argued that waiting lines of this magnitude are inevitable under the NHS, regardless of the amount of resources devoted to health care. See Enoch Powell, Medicine and Politics, 1975 and After, (New York: Pitman, 1976).

[12] For an analysis of the waiting list in New Zealand, see Choices for Health Care: Report of the Health Benefits Review, (Wellington, New Zealand: Health Benefits Review Committee, 1986), pp. 78-79.

[13] Compendium of Health Statistics, Section 2, p. 28.

[14] Choices for Health Care, p. 75.

Rationing Health Care: Modern Medical Technology

One of the ways in which other governments put a lid on health care spending is by imposing tight controls on the purchase of expensive medical equipment and the use of expensive medical procedures. The painful result is that many patients die because they are denied lifesaving medical treatment. Take Britain, for example:[15]

- CAT scan technology was invented in Britain, and until recently Britain exported about half the CAT scanners used in the world -- probably with government subsidies.

- Yet the British government has purchased only a handful of CAT scanners for use in the National Health Service, and has even gone so far as to discourage gifts of CAT scanners to the NHS by wealthy donors.

- Britain also was the co-developer of kidney dialysis, a lifesaving method of treating patients with chronic renal failure; yet Britain has one of the lowest dialysis rates in all of Europe.

In an extensive study of the use of medical technology in Britain's National Health Service, economists at the Brookings Institution made estimates of the number of British patients denied treatment each year, based on U.S. levels of treatment. In most cases, the patients suffered from life-threatening diseases and the denial of treatment meant certain death. Table II presents these estimates, along with estimates of what it would cost the NHS to bring British treatment rates up to U.S. standards.

In most cases where Britain falls considerably behind the U.S., the type of disease is one that is more likely to afflict the elderly. For expensive-to-treat diseases that affect the young, working-age population, however, Britain has been far more willing to make the necessary expenditures. For example:[16]

- For bone marrow transplantation, British treatment levels are about the same as in the U.S.; yet this is a treatment which is only useful for patients under age 40.

- Similarly, British treatment for hemophilia also is equivalent to U.S. treatment levels, and hemophilia usually first aflicts people when they are young.

Britain is not alone. As Table III illustrates, every developed country has been less willing than the U.S. to purchase lifesaving (and expensive) medical technology. This is even true when the technology has been shown to be medically effective as well as cost effective.

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[15]See Goodman, National Health Care in Great Britain, pp. 96-104.

[16]See Henry J. Aaron and William B. Schwartz, The Painful Prescription: Rationing Hospital Care, (Washington, D.C.: The Brookings Institution, 1984).

TABLE II

RATIONING CARE IN THE
BRITISH NATIONAL HEALTH SERVICE

Service	Number of Patients Denied Treatment Each Year	Added Cost of Treating These Patients (In Millions)
Renal Dialysis	9,000	$140
Cancer Chemotherapy	10,000 - 15,000	40
Total Parenteral Nutrition (TPN)	450 - 1,000	45
Coronary Artery Surgery	4,000 - 17,000	175
Hip Replacement	7,000	50

Source: Authors' calculations based on Henry J. Aaron and William B. Schwartz, The Painful Prescription: Rationing Hospital Care, (Washington, D.C.: The Brookings Institution, 1984).

TABLE III

USE OF MODERN TECHNOLOGY

Country	Pacemakers per 100,000 Population, 1976	CAT Scanners per Million Population, 1979	Kidney Dialysis and/or Transplants per Million Population, 1976
Australia	7.3	1.9	65.8
Canada	2.3	1.7	73.4
France	22.6	0.6	111.3
W. Germany	34.6	2.6	105.0
Italy	18.8	NA	102.0
Japan	2.7	4.6	NA
United Kingdom	9.8	1.0	71.2
United States	44.2	5.7	120.0

Source: National Center for Policy Analysis.

Rationing Health Care: Inequality

One of the most surprising features of the health care system of European countries is the enormous amount of attention that is given to the notion of equality and the importance of achieving it. Such rhetoric rarely has any relation to the facts. Britain is a country whose ministers of health, for over three decades, have been assuring the British people that they were leaving no stone unturned in a relentless quest to root out and eliminate inequalities in health care. But, after an unofficial government campaign to suppress it, an official task force report concluded that there was little evidence of more equal access to health care in Britain in 1980 than there was when the NHS was started in 1948.[17] Virtually every scholarly study of the issue has pointed to a similar conclusion.[18] Other studies have documented widespread inequalities in health care in Sweden, Canada, New Zealand, and elsewhere.[19]

Rationing Health Care: Discrimination by Age

One of the difficulties in learning about inequalities in access to medical care is that very rarely is such information collected and distributed by the source best suited to do it: the governments themselves. There are, however, some international statistics available on treatment rates for certain diseases according to the age of the patients being treated. Take chronic kidney failure, for example:[20]

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[17] Inequalities in Health (Black Report), (London: Department of Health and Social Security, 1980).

[18] See Julian LeGrande, "The Distribution of Public Expenditure: The Case of Health Care," Economica, Vol. 45, No. 178, 1978; Anthony J. Culyer, Need and the National Health Service, (Totowa, New Jersey: Rowman and Littlefield, 1976); Michael H. Cooper, Rationing Health Care, (New York: Halstead Press, 1975); Michael H. Cooper and Anthony J. Culyer, "Equality in the N.H.S.: Intentions, Performance and Problems in Evaluation," in M. M. Houser, ed., The Economics of Medical Care, (London: Allen and Unwin, 1972); J. Noyce, A. A. Smith, and A. J. Trickey, "Regional Variations in the Allocation of Financial Resources to the Community Health Services," The Lancet, March 30, 1974; and Goodman, National Health Care in Great Britain, Ch. 9. For a recent update on government failures to make any progress in achieving equality of access to health care, see "Dying of Inequality, "The Economist, April 4, 1987, p. 52.

[19] See Ingemar Stahl, "Can Equity and Efficiency be Combined: The Experience of the Planned Swedish Health Care System," in Mancur Olson, ed., A New Approach to the Economics of Health Care, (Washington, D.C.: American Enterprise Institute, 1981), pp. 187-190; Cotton M. Lindsay, Canadian National Health Insurance: Lessons for the United States, (Nutley, New Jersey: Hoffmann-La Roche, 1979); and Choices for Health Care, pp. 19-22.

[20] End Stage Renal Failure, (London: Office of Health Economics, 1980), pp. 3 and 6.

- Across Europe generally, 22 percent of the dialysis centers reported that they refused to treat patients over 55 years of age in the late 1970s.

- In Britain, 35 percent of the dialysis centers refused to treat patients over the age of 55; 45 percent refused to treat patients over the age of 65; and British patients over the age of 75 rarely received treatment at all for this disease.

Table IV presents the number of new kidney patients treated each year, per million population, for four European countries in 1978. Since the incidence of renal failure rises with age, the treatment rates in all four countries indicates a systematic tendency to discriminate against elderly patients. This experience contrasts markedly with the experience of the U.S., where the treatment rate for those over 65 is nearly the same as the treatment rate for the middle-aged population.

How serious is the problem of the denial of life-saving medical technology to elderly patients in other countries? Lacking hard data, one can only speculate. In general, health economists are reluctant to take population mortality rates as an indicator of the quality of health care patients are receiving. This is because whether a person lives or dies in any given year is far more likely to be determined by that person's lifestyle and environment than by anything that hospitals or doctors are likely to do. In the U.S., for example, it is estimated that as many as 75 percent of all deaths are directly related to lifestyle and behavior.[21]

Despite these caveats, international statistics on population mortality rates are consistent with the proposition that the elderly in other countries have less access to lifesaving medical care than the elderly in the U.S. As Table V shows:

- A white, 65-year-old male in the U.S. can expect to live 1.3 years longer than a 65-year-old British male.

- A white, 65-year-old female in the U.S. can expect to live 1.4 years longer than a 65-year-old British female.

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[21] Jack A. Meyer and Marion E. Lewin, "Introduction," in Meyer and Lewin, eds., Charting the Future of Health Care, (Washington, D.C.: America Enterprise Institute, 1987), p. 5.

TABLE IV

TREATMENT FOR CHRONIC KIDNEY FAILURE
(Acceptance of new patients per million population, 1978)

Age	W. Germany	France	Italy	United Kingdom
Under 15	2.3	3.9	3.5	4.0
15-24	13.1	13.9	12.5	17.7
25-34	22.8	27.6	22.0	26.9
35-44	41.7	34.2	37.2	33.1
45-54	58.8	59.8	55.7	43.5
55-64	71.3	69.5	69.5	22.7
65-74	49.9	56.6	52.2	3.5
75+	8.6	17.6	7.3	0.0
All Ages	30.9	30.4	29.0	19.2

Source: Proceedings of the European Dialysis and Transplant Association, Vol. XVI. Reported in End Stage Renal Failure, (London: Office of Health Economics, 1980), pp. 3 and 6.

TABLE V

REMAINING YEARS OF LIFE
FOR 65-YEAR-OLDS, 1983

	Male	Female
United States[a]	14.5	18.7
Britain[b]	13.2	17.3
Difference	1.3	1.4

[a] U.S. figures are for whites only.

[b] British figures are for England and Wales only.

Source: U.S. National Center for Health Statistics and Office of Health Economics, London.

TABLE VI

MALE MORTALITY FROM ALL NATURAL CAUSES

Country	Male Mortality Rate as a percent of the U.S. Rate, Age 25-34	Male Mortality Rate as a percent of the U.S. Rate, Age 75+
Australia	77 %	107 %
Canada	80 %	103 %
France	94 %	101 %
West Germany	104 %	119 %
Italy	88 %	115 %
Japan	81 %	100 %
United Kingdom	76 %	115 %
United States	100 %	100 %

Source: World Health Organization.

In general, mortality rates for the elderly population in other countries tend to be higher than mortality rates in the U.S. -- particularly for the very old. This is true even in countries that have much lower mortality rates than the U.S. has for the working-age population. Table VI presents international mortality rates from the late 1970s. As the table shows,

- The British mortality rate for males, age 25 to 35, is 24 percent lower than the comparable rate in the U.S.; but among males 75 years of age and older, the mortality rate in Britain is 15 percent higher than it is in the U.S.

- Italy's mortality rate for males, age 25 to 34, is 12 percent lower than the rate for the U.S. But among those 75 years of age and older, it is 15 percent higher than the U.S. rate.

- The comparable figures for Germany are four percent higher for males between 25 and 34 and 19 percent higher for those 75 years of age and older.

Rationing Health Care: Inefficiency

A widespread international myth is the notion that the percentage of GNP spent on health care is an indicator of the overall efficiency of a health care system. Thus, defenders of national health insurance in some countries often point to the low level of health care spending in their countries as "proof" of efficient health care management. Nothing could be further from the truth. By and large, countries that have succeeded in slowing the growth of health care spending have done so by denying people services, not by making efficient use of resources.

How much does it cost a hospital to perform an appendectomy? Outside the U.S. it is doubtful that there is a public hospital anywhere that could answer that question. Nor do hospitals in other countries typically keep records that would allow anyone else to answer it. When it comes to organizational skills and managerial efficiency, the public hospitals of other countries cannot begin to match hospitals run by Hospital Corporation of America, Humana, or American Medical International.

More often than not, hospitals run by governments in other countries are disastrously inefficient. For example, it is not unusual to find a modern laboratory and an antiquated radiology department existing side by side in the same hospital. Nor is it unusual to find one hospital with a nursing shortage in the vicinity of another hospital with a nursing surplus. Where excellence exists, it usually is distributed randomly throughout the hospital system -- often the result of the energy and enthusiasm of a few people in isolated departments rather than because of any decision that hospital management has made. What about bed management? Consider that:

- While 50,000 people wait for surgery in New Zealand, at any point in time one out of every five hospital beds is empty.[22]

- While nearly 800,000 people wait for surgery in Britain, at any point in time about one out of every four hospital beds is empty.[23]

- Moreover, in both Britain and New Zealand, about 25 percent of all acute beds, desperately needed for surgery, are clogged by chronically ill patients who are using the hospitals as expensive nursing homes -- often at six times the cost of alternative facilities.

The most widely used measure of hospital efficiency is average length of stay. In general, the more efficient the hospital, the more quickly it will admit and discharge patients.[24] By this standard, U.S. hospitals are way out in front of their international rivals. For example:

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[22]Estimate of the New Zealand Department of Health.

[23]Compendium of Health Statistics, Section 3, p. 38.

[24]Ibid, pp. 129-136.

- Average length of stay in U.S. hospitals is well below that of most other developed countries.[25]

- Average length of stay in British hospitals in some cases is more than twice as long as it is in proprietary hospitals in the U.S. for the same type of treatment.[26]

Almost all health care economists agree that widespread inefficiencies exist in the U.S. health care system. But we will not create greater efficiency in this country by adopting the practices of other developed countries.

Rationing Health Care: Allocating Resources

Of all the characteristics of foreign health care systems, the one that strikes American observers as the most bizarre is the way in which limited health care resources are allocated among competing health care needs. Foreign governments do not merely deny lifesaving medical technology to patients under national insurance schemes. They also take millions of dollars that could be spent to save lives and cure diseases, and spend this money to provide a vast array of services to people who are not seriously ill. Often these are services which have little, if anything, to do with health care.

Britain, once again, serves as a classic case of this tendency. Throughout the National Health Service, there is a systematic and pervasive tendency to divert funds away from expensive care for the small number of people who are seriously ill toward the large number of people who seek relatively inexpensive services for a variety of minor ills. Take the British ambulance service, for example:[27]

- English "patients" take more than 21 million ambulance rides each year -- about one ride for every two people in all of England.

- About 91 percent of these rides are for non-emergency purposes (such as taking an elderly person to a local pharmacy) and amount to what an official task force report described as little more than a "free taxi service."

- Yet for genuine emergencies, the typical British ambulance has little of the modern, lifesaving equipment considered standard in most large American cities.

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[25]Rita Ricardo-Campbell, The Economics and Politics of Health, (Chapel Hill: University of North Carolina Press, 1982), Table 3, p. 85.

[26]Cotton M. Lindsay et. al., National Health Issues: The British Experience, (Nutley, New Jersey: Hoffmann-La Roche, Inc., 1980), pp. 74-78.

[27]These and other statistics presented in this section are taken from Department of Health and Social Security, Health and Personal Social Services for England: 1985 Edition, (London: Her Majesty's Stationary Office, 1985).

While as many as 9,000 people die each year for lack of treatment for chronic kidney failure, the NHS provides a wide array of comforts for the large majority of elderly and handicapped people whose kidneys are in good working order.

- Each year, about 3.8 million people in England are treated in their homes by "health visitors;" more than 1.1 million are treated in their homes by chiropodists; and "meals on wheels" serves almost 29 million meals in peoples homes.

- Social workers attending to the needs of the elderly and the handicapped help with the installation of more than 17,000 telephone and telephone attachments, help arrange more than 93,000 telephone rentals, help more than 49,000 people with home alterations, assist in arrangements for 63,000 vacations and help an additional 346,000 people with other personal appliances and aids.

While tens of thousands of people who are classified by their physicians as being in "urgent need" of surgery wait for hospital beds, the NHS is spending millions on items that have only marginal effects on health. On the average:

- The NHS spends more than $70 million each year on tranquilizers, sedatives and sleeping pills; almost $19 million on antacids; and about $21 million on cough medicine.

- About 9.7 million people receive "free" eyesight tests every year, and of these, about 4.5 million receive free or subsidized eyeglasses.

If the NHS did nothing more than charge patients the full costs of the sleeping pills and tranquilizers they consume, enough money would be freed to treat 10,000 to 15,000 additional cancer patients each year and save the lives of an additional 3,000 kidney patients. Yet options such as these are not even seriously considered within the British National Health Service.

A telephone-sized book would be needed for a full description of the many ways in which "caring" services take priority over "curing" services within the British National Health Service, and readers may consult other references for a additional examples.[28] Suffice it to say that the tendency is endemic and pervades every aspect of British medicine.

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[28]See John Goodman, "The Envy of the World?" in Arthur Seldon, ed., The Litmus Papers: A National Health Dis-service, (London: Centre for Policy Studies, 1980), pp. 125-132; and Goodman, National Health Care in Great Britain, pp. 192-196.

Rationing Health Care: The Politics of Medicine

The characteristics of national health insurance described above are not accidental by-products of government-run health care systems. Instead, they are the natural and inevitable consequences of politicizing medical practice.

Why are low-income and elderly patients so frequently discriminated against under national health insurance? Because national health insurance is always and everywhere a middle-class phenomenon. Prior to the introduction of national health insurance, every county had some government-funded program to meet the health care needs of the poor. The middle-class working population not only had to pay for its own health care, but it also was paying taxes to fund health care for the poor. National health insurance extends the "free ride" to those who pay taxes to support it. Such systems are created in response to the political demands of the middle-class working population, and they are designed to serve the interests of this population.

Why do national health insurance schemes skimp on expensive services to the seriously ill while providing a multitude of inexpensive services free of charge to those who are only marginally ill? Because numerous services provided to the marginally ill create benefits for millions of people (read: millions of voters), while acute and intensive care services concentrate large amounts of money on a handful of patients (read: small number of voters). Democratic political pressures in this case dictate the redistribution of resources from the few to the many.

Why are sensitive rationing decisions and other issues of hospital management left to the hospital bureaucracies? Because no matter how indefensible the results of this practice, the alternative is politically impossible. As a practical matter, no government can afford to make it a national policy that 9,000 people will die every year because they will be denied treatment for chronic kidney failure. Nor can any government announce as a matter of public policy that some people must wait for surgery so that other elderly patients can use hospitals as surrogate nursing homes, or that elderly patients must be moved so that surgery can proceed.

These decisions are so emotionally loaded that no elected official can afford to claim responsibility for having made them. Important decisions on who will receive care and who will not, and on how that care shall be delivered, are left to the hospital bureaucracy because no other course is politically possible.

HOW IS THE U.S. HEALTH CARE SYSTEM DIFFERENT?

The U.S. health care system differs from the health care systems of other developed countries in two important respects. First, government spending on health care in this country is largely confined to the poor and the elderly. The vast majority of the middle-class working population participates in a private health care marketplace, although they shoulder the increasing tax burden of medical expenses for the elderly and the poor. Second, through both public and private health insurance, the U.S. health care system has been a cost-plus system throughout most of the post-World War II period. Not only have we not experienced significant health care rationing, if anything we have experienced the reverse phenomenon: Hospitals and doctors have felt free to utilize virtually every new technique medical science has to offer, secure in the knowledge that someone would always pay the bill.

Cost-Plus Medical Care

In the summer of 1985, 85-year-old Leon Alger spent 19 days in a Houston hospital being treated for cerebral-spinal inflamation. On leaving the hospital, Alger was confronted with a 32-page bill, totalling $45,797.63. Because he was a Medicare patient, Alger's share of the bill was only $257. But Alger, furious at some of the items on the bill, wrote letters to Houston newspapers complaining that neither Medicare nor anyone else should be paying the prices he saw. For example, Alger's bill listed a daily charge of $180 for oxygen. Yet Alger happened to know that a large oxygen tank, lasting a full day, could be filled for as little as $3.80.[29]

What Alger did not know was that the bill he saw is not the bill that would be presented by the hospital to Medicare. Whether under the old system of reimbursement or under the new one, Medicare has never paid hospitals according to the prices they charge for services. Under cost-based reimbursement, Medicare paid hospitals according to the costs they incurred. For example, under one formula, Medicare reimbursed hospitals based on the percentage of hospital days accounted for by Medicare patients. If Medicare patients accounted for 30 percent of the hospital's patient days during a given year, Medicare would pay for 30 percent of the hospital's total costs that year. Blue Cross and most other private insurance companies reimbursed hospitals based on similar formulas. As a result, until recently, about 90 percent of all hospital revenues consisted of reimbursement for hospital costs.[30]

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[29] Janet Elliott, "Fees for Care Called Exorbitant," Houston Post, July 7, 1985.

[30] For a general description of cost-plus reimbursement and difference it makes, see John Goodman and Gerald Musgrave, "The Changing Market for Health Insurance: Opting out of the Cost-Plus System," NCPA Study #118, September 25, 1985, pp. 1-26. For an analysis of the specific reimbursement formulas, see Sylvia A. Law, Blue Cross: What Went Wrong? (New Haven: Yale University Press, 1973), pp. 59-114.

Whether under public or private insurance, cost-plus reimbursement of U.S. hospitals created financial incentives on the part of health care providers to over-provide medical services. Since the only way hospitals and doctors could increase their income was by increasing the use of medical services, small wonder we have experienced an explosion of health care costs.

The New DRG System

In 1983, the federal government initiated a major change in the way hospitals are reimbursed under Medicare. Under the system, hospitals are now paid a fixed sum of money for each of 467 categories of illness called "diagnosis-related groups" (DRGs). In principle, the revenues hospitals receive under the DRG system are unrelated to the cost of treating any particular patient. Thus, if the hospital keeps its costs below the DRG reimbursement price, it makes a profit. If the hospital has costs in excess of the DRG reimbursement price, it suffers a loss.

Take the case of the 32-page hospital bill presented to Leon Alger, for example. Although the bill totalled $45,797.63, Medicare's DRG price was only $8,740. Add to that the $257 paid by Alger, and the hospital faced shortfall of about $36,800.

On the surface, the DRG system has certain attractive features. Instead of reimbursing hospitals for waste and inefficiency, the federal government has limited its exposure -- it pays a fixed fee and lets hospitals sink or swim. The DRG system leaves certain important questions unanswered, however. If Medicare doesn't pay for the hospital's $36,800 loss, who will pay for it? And, if no one pays for it, what are the implications for health care delivery in the U.S. in the future?

PRESSURES FOR CHANGE

The institution of the DRG system was seen by others as an attempt by the federal government to opt out of the cost-plus system of hospital finance. But the federal government was not alone. Most of the nation's largest employers have been facing rising premiums for health insurance and they too have grown tired of paying for unnecessary costs and wasteful procedures. Thus, at the same time the federal government was changing its method of reimbursement under Medicare, private companies were dropping conventional health insurance and self-insuring for medical costs under programs that utilized sophisticated cost management techniques. For example:[31]

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[31] For a description of self-insurance plans and cost management techniques used by employers, see Goodman and Musgrave, "The Changing Market for Health Insurance," pp. 16-27.

- In 1983, among the 1,500 largest U.S. employers, 83 percent were relying on some form of self-insurance.

- That same year, 32 percent of all private health insurance was accounted for by plans that were either self-insured or largely self-insured.

Opting out of the Cost-Plus System

The combined effect of private sector cost management programs and the change in Medicare reimbursement by the federal government was quick and dramatic.[32]

- Hospital admissions fell by 3.7 percent in 1984 -- the first decline in recent memory.

- Average length of stay for all patients fell from 7.1 days in 1983 to 6.7 days in 1984, and average length of stay for Medicare patients fell by 20 percent.

- The percent of hospital beds occupied fell from 74.4 percent in 1983 to 66.6 percent in 1984, even though there were 11,000 fewer beds in 1984.

- Health care spending as a percent of GNP actually declined from 10.9 percent in 1983 to 10.6 percent in 1984.

Undoubtedly, hospitals are being forced to become more efficient and more competitive than ever before. But as these changes occur, they are creating casualties along the way, and these casualties are creating pressure for more government involvement in health care.

Uncompensated Health Care Costs

As in other countries, the U.S. has always faced the problem of how to finance the health care of individuals who are not adequately covered by public or private insurance and who do not have the financial means to pay for the medical services they consume. The cost-plus system of hospital finance had an answer to that problem. Those who could pay were charged more, to cover the costs of those who could not pay. Thus, when government and private insurance reimbursed hospitals for their costs, one element of these "costs" was hospital bad debts.

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[32]Richard A. Rettig, "Medical Technology in a Changing Health Care Environment," in Meyer and Lewin, Charting the Future of Health Care, p. 101.

The cost-plus system, therefore, operated as an income redistribution scheme. It financed the medical services of the poor and the uninsured by overcharging the non-poor and the insured through higher hospital prices and through higher health insurance premiums. All of this is changing in the new health care marketplace, however. As hospitals become more competitive and as consumers (or their agents) become more aggressive, we are moving toward a market in which it is becoming more and more difficult to get one group of patients to subsidize the health care of another group of patients.

The upshot is that people who are not participating in sophisticated cost-management schemes are facing rising insurance premiums, and those without insurance, or with limited insurance, are creating financial problems for hospitals. For example:[33]

- Although estimates vary, it is believed that at least 30 million Americans have no health insurance of any kind.
- This is up from 25 to 26 million in the late 1970s.

Although the uninsured population is less likely to incur medical costs than the insured, when they do enter a hospital they are far more likely to incur unreimbursed hospital costs.[34]

- In 1984, $9 billion of hospital charges (equal to about five percent of hospital operating revenues) were charity care or bad debt.
- This is up from $6.2 billion in 1982 and from $4 to $5 billion in 1978.

Naturally, there are increasing pressures to pay for these costs by turning to taxpayers.

Adverse Effects of DRGs

Some would have the public believe that the DRG system is a market-based approach to health care. While it is true that the DRG system stimulates efficiency by creating financial incentives to encourge cost reductions, the DRG system is not structured so that government is simply one more buyer in a competitive market. Instead, the DRG system is a price-fixing scheme in which the government is attempting to create an artificial market.

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[33] Catastrophic Illness Expenses, p. 52.

[34] Ibid, p. 58.

DRG reimbursement prices do much more than limit the amount that government will pay. The Medicare system literally fixes the price of services rendered, and does so independent of conditions of supply and demand. For example, hospitals are forbidden to charge more than the DRG price, even if patients are willing to pay more. Hospitals also are forbidden to lower their price by giving rebates to patients who use their services. Moreover, current plans are to move to a single, national rate of reimbursement which will ignore differences in local conditions. This is comparable to attempting to establish one uniform room rate for the nation's hotels.

This attempt to establish an artificial market in place of a genuine market creates perverse incentives for providers, which lead to adverse health effects for patients and greater health care costs.

Incentives to Over-Provide Health Care Services. Under the DRG system, physicians and hospitals receive revenues only if they perform services. As a result, health care providers still have a financial incentive to perform surgery, even when the decision to operate is questionable on medical grounds. A study by the Rand Corporation, covering the period before the implementation of the DRG system, concluded that:[35]

- About 40 percent of all hospitalizations in the U.S. probably are medically unnecessary.

- In the study, 23 percent of admissions were for conditions that could have been treated medically in a physician's office or clinic, and 17 percent were for surgical procedures that could have been performed on an outpatient basis.

The new DRG system does encourage outpatient surgery over inpatient surgery. But it still encourages surgery. It also encourages early release after surgery and numerous other practices that increase the use of medical services and increase the cost to taxpayers.[36]

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[35]Albert L. Siu, et.al., "Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans," New England Journal of Medicine, Vol. 315, No. 20, November 13, 1986, pp. 1259-1266.

[36]For a review of these perverse incentives see John E. Wennberg, Klim McPherson, and Phillip Caper, "Will Payment Based on Diagnosis-Related Groups Control Hospital Costs?," New England Journal of Medicine, Vol. 311, No. 5, August 2, 1984, pp. 296-300; and Robert S. Stern and Arnold M. Epstein, "Institutional Responses to Prospective Payment Based on Diagnosis-Related Groups: Implications for Cost, Quality and Access, " New England Journal of Medicine, Vol. 312, No. 10, March 7, 1985, pp. 621-627.

Incentives to Reduce the Quality of Care. In recent testimony before the House Government Operations Subcommittee on Human Resources and Intergovernmentmental Relations, William Roper, head of the Health Care Financing Administration (which administers Medicare) testified that as many as 891,000 Medicare patients receive "dangerous care" each year. These include:[37]

- 22,000 cases of avoidable deaths;
- 149,000 cases of avoidable trauma, including medication errors and the removal or "repair" of healthy organs; and
- 198,000 cases of avoidable infections.

It is not known to what extent these cases are directly related to the incentives created by the new DRG system. What is known is that the DRG system has created a serious problem of maintaining the quality of care. There have been numerous reports of patients being denied admittance into hospitals because of DRG rules, and many more reports of patients being prematurely released. In one recent poll of physicians,[38]

- 78 percent of the physicians responding reported being "pressured to discharge Medicare patients before they were ready to leave the hospital."
- 88 percent reported that "the DRG program is adversely affecting the quality of medical care for Medicare patients."

DRGs and Health Care Rationing

Currently the federal government is attempting to set prices and monitor quality for 28 million potential patients and as many as 5,000 hospitals. It is a job that the federal government cannot adquately perform. No matter what set of reimbursement rules are adopted, the medical marketplace is so complex that there will be literally thousands of ways for health care providers to exploit these rules for financial gain. Moreover, there is an inevitable conflict between price and quality of care. In the early years of the Medicare program, quality took precedence over health care costs. Under the new reimbursement rules, the reverse is beginning to occur.

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[37] Associated Press wire service report cited in The Dallas Morning News, October 21, 1987.

[38] These results should be taken as indicative, since the poll was not random. See Private Practice, October, 1985, pp. 18-19.

Although individual hospitals are paid on a prospective basis, independent of their costs, the system as a whole has not fully escaped the pressures of cost-plus medical care. Under current practice, national DRG rates this year are determined by last year's average hospital costs. Thus, as hospital costs go up, DRG payments also go up.

The federal government can, of course, resist these cost pressures by making DRG reimbursement rates increasingly stingy. But any attempt to do so would have even more adverse affects on the quality of care patients receive. Indeed, as the DRG system is now structured, it could be used as a health care rationing device -- an eventuality that some have argued is inevitable.[39] By simply refusing to pay hospitals enough to cover the costs of expensive surgery, DRG administrators will soon be in a postion to force hospitals to ration health care, whether they want to or not.

THE CHAIN-LETTER ECONOMICS OF MEDICARE

Quite apart from the particular method of reimbursing hospitals, Medicare faces a more serious problem: Young people today are paying increasingly higher payroll taxes to support a system with an uncertain future. Like Social Security, Medicare is structured as a pay-as-you-go system under which taxes paid by today's workers finance the health care benefits of today's retirees. When today's workers retire, they will depend on new and higher taxes to be collected from tomorrow's workers -- if tomorrow's workers are willing to pay.

Moreover, like Social Security, the "deal" Medicare promises to different people depends on how old they are. As in the case of a chain letter, those who have the opportunity to cash in early receive benefits far in excess of their contributions. The latecomers pay far more in contributions than they can expect to receive in benefits. For example, take a male worker earning the median wage who retired in 1983:[40]

- In just two years this retiree could expect to receive more in Medicare benefits than he paid throughout his working life in Medicare taxes.
- Over the remainder of his life, this retiree could expect to receive about $25,615 more in Medicare benefits than he paid in Medicare taxes.
- If the worker has a dependent spouse, the couple together could expect to receive about $59,720 more in Medicare benefits than they paid in Medicare taxes.

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[39]See David Stipp, "Medical-Cost Trend after 1990 Disputed: Growth Rate May Soar Unless Care Is Rationed," Wall Street Journal, January 9, 1987.

[40]Based on estimates made by the U.S. Department of Health and Human Services.

A far different scenario confronts today's young workers, however. As Table A-1 in Appendix A shows, under current law, a 20-year-old male can expect to pay considerably more in Medicare taxes than he will receive in Medicare benefits. For example:

- If the worker is a high-income worker, he can expect to pay from four to eight times more in Medicare taxes than he will receive in Medicare benefits.

- If he is a median-income worker, he can expect to pay from three to five times more in taxes than he will receive in benefits.

- Even if the worker is a low-income worker, earning only 50 percent more than the minimum wage, he can expect a substantial loss under Medicare -- equal to as much as one-third of his current annual income.

Table A-2 shows that female workers, age 20 today, face similarly dismal prospects under Medicare, and Table A-3 shows that virtually all workers under age 50 can expect substantial losses as a result of forced participation in the system.[41]

Medicare, then, is a program that redistributes a vast amount of wealth from the population of working age to today's elderly citizens. For today's beneficiaries, this transfer is a windfall. For today's taxpayers, it is a losing proposition, even if they are fortunate enough to convince future taxpayers to shoulder the enormous burden of the benefits they are being promised.

Such transfers might be justified if Medicare functioned as an anti-poverty program, transferring income from those who had more to those who had less. In fact, just the reverse is occurring. On the average, today's elderly have more after-tax income and more wealth than individuals under 65 years of age. For example:[42]

- In 1984 the average income of elderly families was $26,000.

- In addition, about 75 percent of the elderly owned their own homes in 1984, with an average equity of $54,700.

As reported in a previous NCPA study, increased taxpayer resistance to funding Medicare and Social Security in the future is inevitable.[43]

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[41]Note that in all these calculations, the expected benefits probably are overstated. This is because, unlike Social Security retirement pensions, Medicare benefits are not paid in cash. They are benefits in-kind. In many cases, the value people place on the benefit is much less than the cost to the government of providing it.

[42]Estimates of the Health Care Financing Administration.

[43]"Social Security: Who Gains? Who Loses?," NCPA Policy Report #127, May, 1987.

THE POLITICS OF MEDICINE AT WORK: RECENT DEVEVELOPMENTS IN HEALTH CARE POLICIES

In an amazingly frank discussion of the system that he once managed, former British Minister of Health Enoch Powell wrote that "whatever is entrusted to politicians becomes political even if it is not political anyhow."[44] He went on to say that,[45]

> The phenomena of Medicine and Politics . . . result automatically and necessarily from the nationalization of medical care and its provision gratis at the point of consumption . . . These phenomena are implicit in such an organization and are not the accidental or incidental results of blemishes which can be "reformed" away while leaving the system as such intact.

In what follows, we show that many of the same political pressures that have governed the operation of national health insurance programs in other countries are asserting themselves in this country and are influencing the direction of federal policy.

The Politics of Catastrophic Health Insurance

An important principle of insurance is that under all insurance schemes, insured people have an incentive to take advantage of the system. For example, when people know that the bills they incur are going to be paid by someone else, they have an incentive to make purchases they would otherwise avoid if they were spending their own money. As a result, total spending is higher than would be the case if there were no insurance.[46]

One way to contain this problem is through the use of deductibles and co-payments that leave insured people responsible for the small bills, while leaving the insurance company responsible for the large bills. In medical care, as in other fields, the small bills often are the ones over which patients exercise the greatest control. It is with respect to these expenditures that patients have the greatest opportunities to impose wasteful costs on others if they are insured and to economize on spending if they are not insured. For example, a study by the Rand Corporation found that:[47]

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[44] Powell, Medicine and Politics, p. 5.

[45] Ibid., p. 67.

[46] The more general problem described here is the problem of "moral hazard." See Paul J. Feldstein, Health Care Economics, (New York: John Wiley & Sons, 1979), pp. 118-121.

[47] Arlene Leibowitz, Willard G. Manning, Jr., Emmett B. Keeler, Naihua Duan, Kathleen N. Lohr, and Joseph Newhouse, The Effect of Cost Sharing on the Use of Medical Services by Children: Interim Results from a Randomized Controlled

- The use of medical services for children was one-third greater by families who were completely reimbursed for medical expenses than it was for children of families who were reimbursed for only five percent of medical expenses.

- Despite the significant difference in medical services by the two groups of families, researchers found no significant difference in the health status of the children in the two plans.

Insurance policies with low deductibles are very expensive. It is for this reason that most health care economists and employee benefits managers strongly encourage policies that leave patients responsible for small bills that they can afford to pay themselves, while leaving the insurance company responsible for the very large bills, which would be financially devastating to most families.

Despite the best advice of the experts, however, the Medicare program, as it is currently structured, pays too many of the small bills while leaving the elderly at risk for the very large ones. Moreover, recent proposed changes in Medicare coverage for the most part would retain that approach.

Catastrophic Medical Expenses Under Medicare. Medicare currently pays 80 percent of the costs of physicians' fees for a patient who suffers from a headache or a common cold. Yet elderly patients with acute hospital stays face increasingly costly bills -- not paid by Medicare -- which rise with the duration of their illness. For example:

- Following an initial deductible of $520, a Medicare patient faces no additional costs for a hospital stay up to 60 days.

- Beginning on the 61st day, however, the patient is charged $130 per day.

- After the 90th day, the patient's cost rises to $260 per day.

- After the 150th day, the patient is responsible for the <u>full cost</u> of each hospital day.

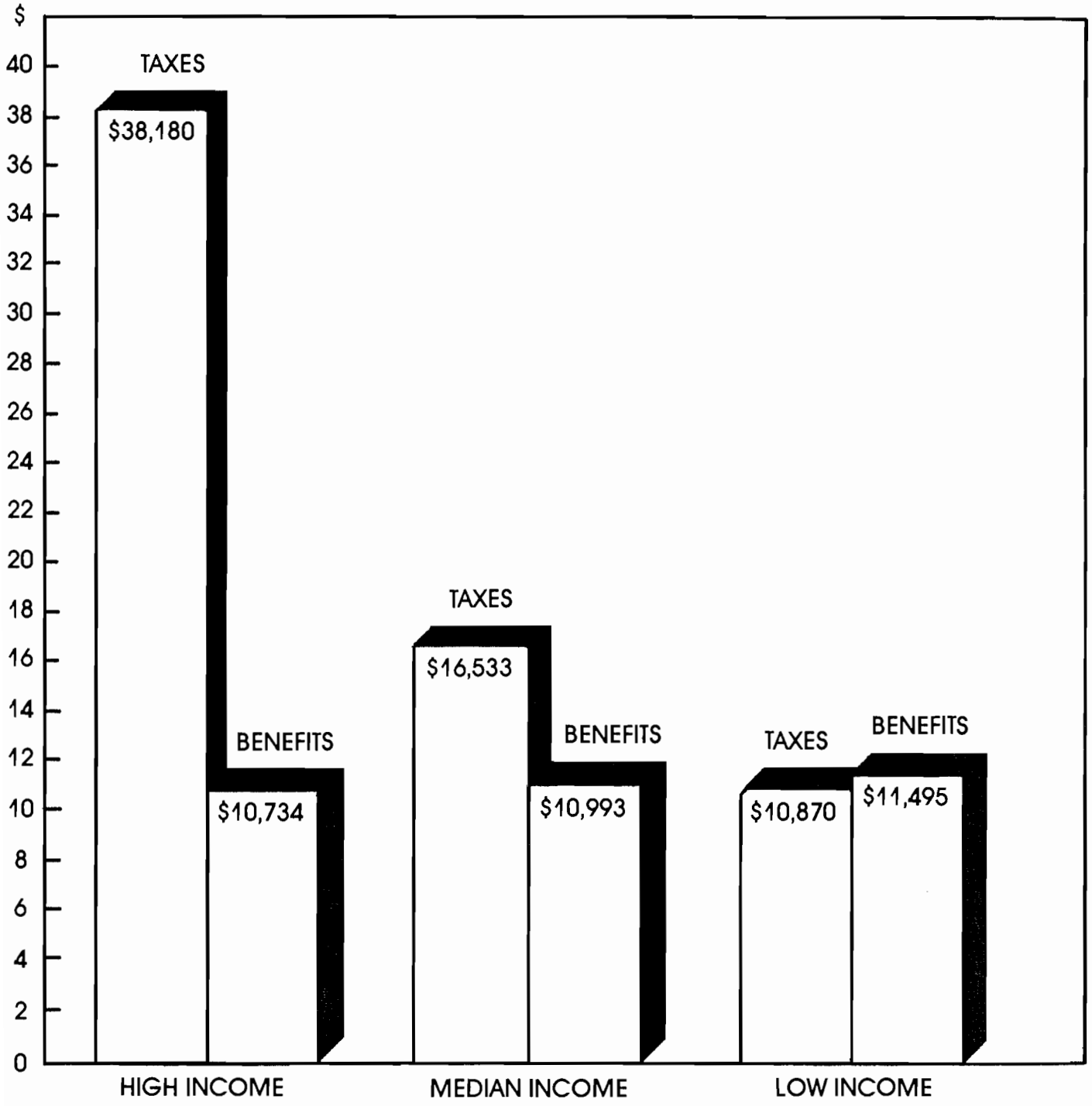
Medicare "insurance," therefore, is designed so that those with the most severe health problems face the greatest financial burdens.

How can we explain a federal Medicare plan which either pays for or subsidizes a great many small bills, while leaving elderly patients exposed for truly catastrophic expenses that threaten to devastate them financially? Only one explanation is possible: Politics. Consider the amounts Medicare patients now pay (either out-of-pocket or through private insurance) for medical services "covered" by Medicare:[48]

<u>Trial</u>, (Santa Monica, California: The Rand Corporation, 1985).

[48]About 70 percent of Medicare beneficiaries had medical expenses falling in the range of $1 to $999. See <u>Catastrophic Illness Expenses</u>, Table 3.1, p. 27.

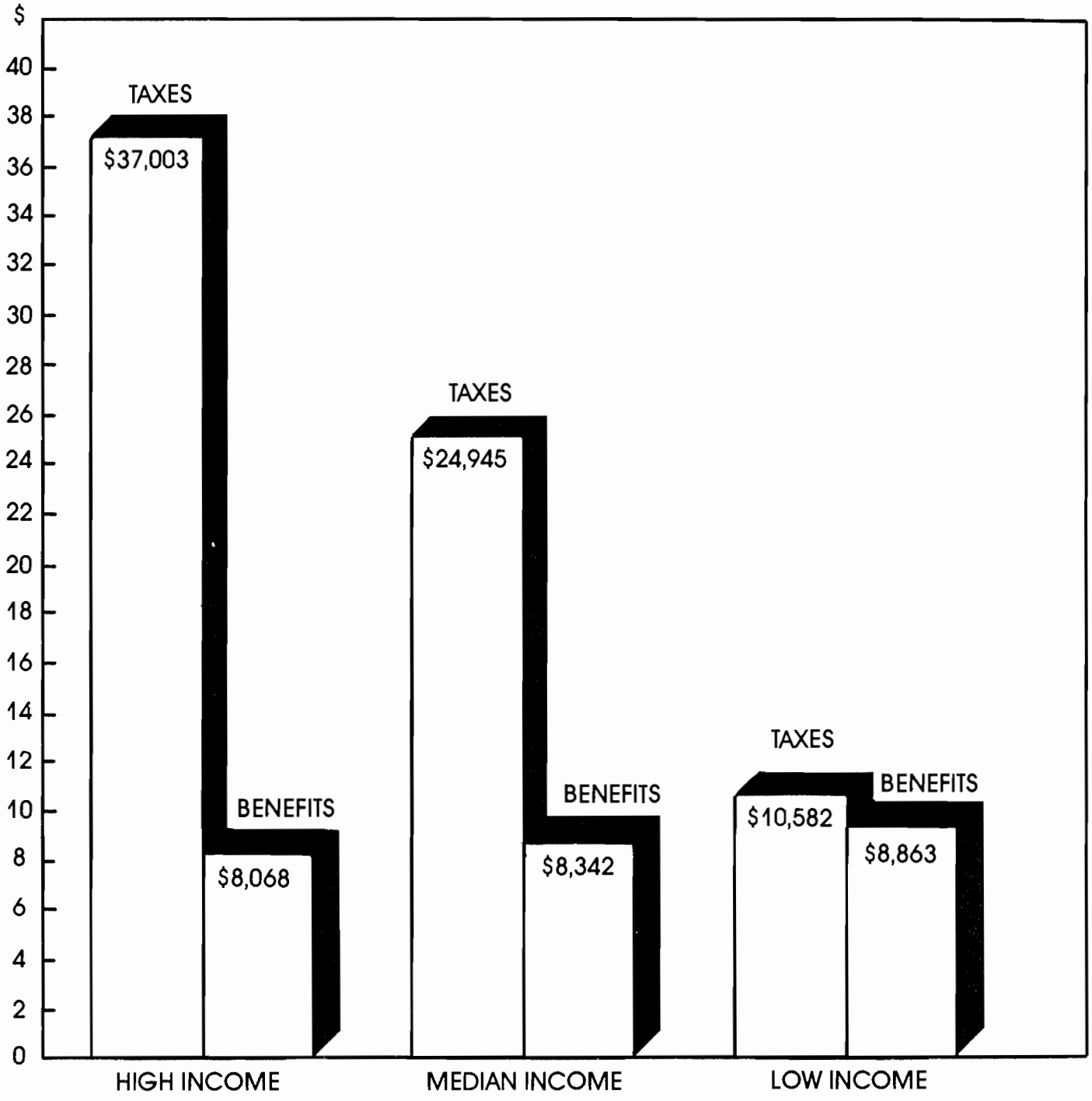
PRESENT VALUE OF MEDICARE FOR SINGLE FEMALE WORKERS AGE 20, IN 1986*



SOURCE: NATIONAL CENTER FOR POLICY ANALYSIS

**Evaluated at a four percent real rate of interest*

PRESENT VALUE OF MEDICARE FOR SINGLE MALE WORKERS AGE 20, IN 1986*



SOURCE: NATIONAL CENTER FOR POLICY ANALYSIS

**Evaluated at a four percent real rate of interest*

- In 1983, about 90 percent of all Medicare beneficiaries spent less than $1,000 for medical expenses partly covered by Medicare.

- By contrast, only 0.4 percent of all Medicare beneficiaries had expenses of $5,000 or more.

Clearly, Medicare is structured for the convenience of the vast majority of patients incurring minor medical expenses, not the small minority who face catastrophic health care bills.

Private Health Insurance. In response to the gaps created under Medicare, a thriving market has emerged in Medigap insurance -- insurance designed to pay for expenses not paid by Medicare. Yet through the Baucas Amendments,[49] passed by Congress in 1980, Medigap policies are required by law to cover certain benefits. And, like Medicare itself, the law directs Medigap policies to cover a great many small medical bills, while leaving coverage of the large bills discretionary. For example, a Medigap policy which exactly satisfied federal law would have the following features:[50]

- The Medigap policy pays for the first $5000 of physicians' fees not covered by Medicare, subject to a $200 deductible.

- After total physicians' bills of $25,000, however, the patient is responsible for 20 percent of the excess.

- The Medigap policy pays for hospital expenses not paid by Medicare up to the 150th day in the hospital.

- On the 151st day, however, the patient begins paying for 10 percent of the cost of the hospital stay; after 516 days, the patient is responsible for the entire cost of hospitalization.

Genuine catastrophic health insurance is rather inexpensive to provide. Very few patients stay in the hospital beyond 150 days, and a stay in excess of 516 days is extremely rare. However, by forcing private insurance companies to offer wasteful and inefficient first dollar coverage, Congress has insured that Medigap insurance is far more expensive than it needs to be. As in the case of Medicare itself, political pressures appear to have dictated socially indefensible policies governing Medigap insurance.

Reagan's Reform Proposal. During Ronald Reagan's first term, his Administration made an attempt to restructure Medicare -- to convert it from an unsound insurance policy into one conforming to generally accepted principles. Under the proposal, Medicare patients would incur greater out-of-pocket expenses for short hospital stays, and the savings would be used to finance catastrophic coverage for lengthy hospital stays. The proposal went nowhere.

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[49] P.L. 96-265.

[50] See Catastrophic Illness Expenses, p. 29.

It is not hard to understand why. In any given year, about 70 percent of Medicare beneficiaries spend between $1 and $999 on health care. Only 10 percent incur costs of $1,000 or more. Any proposal which raises the costs to the patient for small medical bills in order to pay a greater share of large medical bills is a proposal to shift money out of the pockets of 70 percent of the elderly and into the pockets of 10 percent. In a democracy, that's hard to do. As one health care economist has explained it:[51]

> White House proposals to enhance health care benefits for catastrophic illness by reducing benefits for short-term care have fallen on deaf ears in Congress. No matter how sensible this trade-off might be on ethical and analytical grounds, it would force Congress to disadvantage the many so that the few should gain.

More Recent Reform Proposals. On February 24, 1987, President Reagan sent yet another proposal to Congress -- this one the brainchild of Otis Bowen, Secretary of the Department of Health and Human Services, and his chief of staff, Thomas Burke.[52] Unlike the original administration approach, however, this one involved increasing the flow of money under the direct control of politicians. Under the proposal, current Medicare coverage would be expanded to cover catastrophic costs (costs in excess of $2,000) and would be financed by an increased premium of $60 per year paid by Medicare beneficiaries.[53]. The administration's proposal was made at a time when there was considerable criticism of Medigap policies, and was accompanied by the claim that the federal government could provide catastrophic care more cheaply than the private sector could provide it. Yet the administration's proposal would not have covered expenses that Medigap policies are required by law to cover. In fact, in Senate testimony, the chief actuary for Mutual of Omaha said that his company could provide exactly the same coverage as the administration's proposal for exactly the same premium.

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[51] Allen Schick, "Controlling the 'Uncontrollables:' Budgeting for Health Care in an Age of Megadeficits," in Meyer and Lewin, Charting the Future of Health Care, p. 31. Emphasis added.

[52] The details of the proposal are outlined in Catastrophic Illness Expenses.

[53] In theory the coverage offered was to be optional. The $60 premium would be tacked onto the current premium for part B coverage, which is optional for Medicare patients. However, since Part B insurance coverage is about 75 percent subsidized by general revenues, the option to pay for coverage is an offer few elderly citizens can afford to refuse.

Once the administration had opened the door, it took Congress no time at all to think of other, more politically popular variations on the Bowen-Burke proposal. Under the House version, Medicare deductibles would rise less rapidly,[54] coinsurance fees would be capped or eliminated altogether, and coverage would be extended to cover a number of non-catastrophic services, including prescription drugs. The original Senate version was similar, with the major difference being the exclusion of coverage for prescription drugs.[55] Both versions share a common feature: All Medicare beneficiaries would realize increased benefits, not merely those who are faced with catastrophic health care bills.

There are four major problems with these bills: (1) they are enormously expensive; (2) they will be largely financed by imposing high marginal tax rates on the elderly; (3) about 85 percent of the elderly already have coverage for the bulk of the benefits being promised; and (4) they do not cover the most severe catastrophic expenses currently not covered by Medicare.

Although estimates of the costs of these bills vary, and although the specifics of the legislation may be changed, under any realistic scenario the costs will be huge. For example, according to Treasury Department estimates:[56]

- By the year 2005, the annual cost of the House bill would be about $66 billion in constant 1988 dollars.

- The original Senate bill would cost $32 billion by 2005 in constant 1988 dollars.

How would these benefits be financed? By charging the elderly income-related premiums which amount to an effective "tax" on income.[57]

- Under the Senate bill, a 16 percent surtax on the tax liability of the elderly would increase the marginal tax rates of elderly couples from 15 percent to 17.4 percent, or from 28 percent to 32.5 percent, depending on the couple's tax bracket.

- The House bill is even worse. A worker facing a 15 percent tax rate today would face a 25 percent tax rate by 1992 if the worker is retired.

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[54]Both deductibles and coinsurance fees would be indexed to the general inflation rate, rather than to the rise in hospital costs.

[55]At the time of this writing, a compromise bill is being negotiated in Congress.

[56]Estimate of the U.S. Treasury reported in Peter J. Ferrara and Edmund F. Haislmaier, "The Catastrophic Health Tax on America's Elderly," Issue Bulletin No. 132, Heritage Foundation, July 21, 1987, Figure 6, p. 12.

[57]Ibid., p. 9.

Under both bills, the elderly would be facing the highest marginal tax rates of any group of taxpayers in the nation. In addition, unlike other taxpayers they would be facing tax brackets that are not indexed, meaning that the tax burden will rise with increases in inflation.

To make matters worse, about 85 percent of the elderly will be paying for benefits they are already entitled to under existing health insurance arrangements. Currently:[58]

- About 72 percent of the elderly have additional health insurance under Medigap policies or through employer provided post-retirement health care plans.
- Another three percent of Medicare beneficiaries are enrolled in HMOs.
- An additional 10 percent of the elderly are currently covered by Medicaid.

As a result, the bulk of newly promised benefits merely duplicate existing coverage for the vast majority of Medicare beneficiaries.

Finally, neither the current Medicare program, nor any of the proposals for catastrophic health care currently before Congress, address the most serious catastrophic expenses currently faced by the elderly -- expenses for nursing home care.

- About 42 percent of out-of-pocket health care expenses of the elderly now goes to nursing homes.
- For out-of-pocket health care expenses that exceed $2,000 per year, 81 percent goes for nursing home care.
- This is about eight times as much as the elderly spend on hospital care, 31.5 times as much as they spend on physician care and 67.5 times as much as they spend on prescription drugs.

Many elderly voters are being deluded in thinking that catastrophic health care bills now before Congress will help them with financial burdens created by a medical disaster such as Alzheimer's disease. In fact, these bills will barely put a dent in the cost of such care.

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[58] Ibid., p. 13.

TABLE VII

ANNUAL OUT-OF-POCKET EXPENSES
FOR THE ELDERLY:
AMOUNTS IN EXCESS OF $2,000 PER YEAR

Type of Expense	Percent
Nursing Home	81.0 %
Hospital	10.0 %
Physician Services	6.0 %
Dental	1.7 %
Drugs	1.2 %

Source: J. Gabel and T. Rice, "Protecting the Elderly Against High Health Costs," Health Affairs, 5, Fall, 1986, p. 12. Cited in the Task Force on Long-Term Care Policies, Report to the Congress and the Secretary, (Washington, D.C.: U.S. Department of Health and Human Services, 1987), p. 17.

The Politics of Nursing Home Care

Clearly, the prospect of entering a nursing home is the single most significant catastrophic health care expense faced by the elderly. On the average:[59]

- Elderly persons age 65 to 69 have a five percent probability of entering a nursing home within the next five years and a 43 percent probability of entering a nursing home sometime before they die.
- Among those age 75 to 79, there is a 16 percent probability of entering a nursing home within the next five years and a 48 percent probability of entering a nursing home sometime before they die.

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[59]Task Force on Long-Term Health Care Policies, Report to the Congress and the Secretary, (Washington, D.C.: U.S. Department of Health and Human Services, 1987), p. 18.

Once in a nursing home, elderly patients face staggering costs. Because of federal fire, health and safety regulations, a nursing home today can withstand fires, storms and other disasters that would devastate most deluxe hotels. These regulations have more than doubled the cost of nursing homes to the point where the average stay now runs about $22,000 per year.[60]

How are these costs born? As Table VIII shows, the vast majority of nursing home expenses are met either by Medicaid or through out-of-pocket expenditures by the elderly. Medicare pays for less than two percent of these costs. Private insurance pays for less than one percent. As a result, long-term residents of nursing homes tend to fall into one of two categories: either they are relatively wealthy or they are very poor (or soon to be poor). It is significant that half of nursing home residents covered by Medicaid did not qualify for Medicaid upon entering a nursing home. These residents qualified for Medicaid by exhausting their financial resources and becoming "poor."

A Federal Task Force, recently formed to address these problems, included representatives of insurance companies, friends of insurance companies (state insurance commissioners), and actual and potential clients of insurance companies (nursing home administrators). The result? A list of recommendations that are great for the insurance industry but not necessarily good for the country as a whole. Chief among these are a series of special tax favors that would be created for people who buy long-term care insurance. These are favors that would be denied to people who bypass insurance companies to make direct purchases of long-term care or any other kind of health care.

Currently, residents of nursing homes cannot deduct food and lodging expenses unless they are deemed "medically necessary." Even then, they can deduct only those medical expenses in excess of 7.5 percent of adjusted gross income. Yet if the Task Force gets its way, people who purchase insurance would get a much better deal. The premiums would be automatically deductible, whether or not they satisfy the 7.5 percent test and whether or not the care turns out to be medically necessary.

People with IRAs, Keogh plans, and other private pensions would be allowed to make tax-free transfers of their retirement money to purchase long-term care insurance. But such transfers would not be allowed for the direct purchase of long-term care, for the purchase of other forms of health care, or even for the purchase of other kinds of post-retirement health insurance.

Employers would be given tax advantages for pre-funding their employees' post-retirement health care. But these tax advantages would be denied to individuals who want to set up their own reserves to pre-fund their own post-retirement health care needs. The reason? The Task Force was afraid that individuals might choose to self-insure, rather than buy insurance.

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[60] Ibid.

The Task Force staff economists estimate that even after all of these changes are made, only 30 to 40 percent of the population will actually buy long-term care insurance. What will happen to the 60 to 70 percent who don't? Obviously, there will be increased pressure to solve their problems by turning to government.

The Task Force report was not all bad. Commendably, it called for eliminating some government obstacles to the development of a healthy long-term care insurance market. And, the idea of letting employers pre-fund post-retirement medical expenses is surely better than having government do it. But the big ticket items just described are so self-serving that it is doubtful that the report did little more than help build the case for more government involvement.

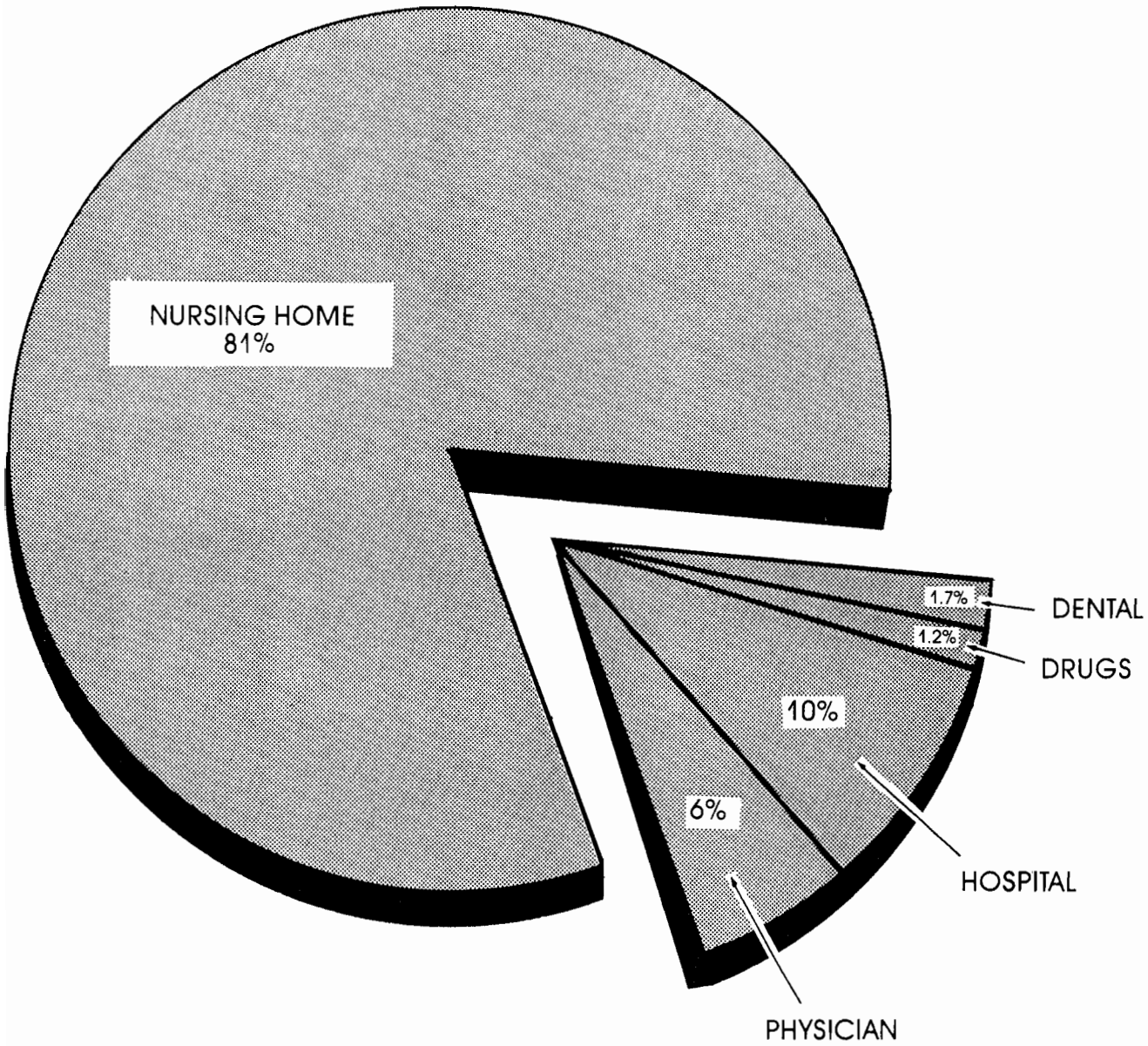
TABLE VIII

SOURCES OF NURSING HOME CARE EXPENSES (1984)

Source	Percent of Total
Out-of-Pocket	49.4 %
Private Insurance	0.9 %
Medicare	1.9 %
Other Government Programs	4.1 %
Medicaid	43.4 %
Other	0.6 %

Source: Task Force on Long-Term Care Policies, Report to the Congress and the Secretary, (Washington, D.C.: U.S. Department of Health and Human Services, 1987), p. 69.

ANNUAL OUT-OF-POCKET EXPENSES FOR THE ELDERLY IN EXCESS OF $2,000



SOURCE: HEALTH CARE FINANCING ADMINISTRATION

The Politics Of Tax Reform

Federal government policy toward the retirement needs of elderly citizens is essentially a chain letter approach in which retirement expenditures are financed on a pay-as-you-go basis. We collect taxes today to pay for today's retirement needs rather than encouraging people to accumulate savings during their working years to fund their own retirement. With the exception of federal policy toward private pensions, this pay-as-you-go philosophy pervades virtually every major government program affecting the elderly, and it is chiefly responsible for creating the financial nightmare in our future.

There is no evidence that the public supports this philosophy. Indeed, public opinion polls show quite the opposite. In the face of great uncertainty over the financial future of these programs, there is considerable public support for creating private alternatives to the chain-letter approach. So far, however, Congress not only has resisted this pressure, but has enacted legislation making private funding more difficult.

Pre-Funding of Post-Retirement Health Care Expenses by Private Companies. Just as almost all large companies provide for private pensions as part of their employment benefit packages, many large companies now pay for certain post-retirement health care expenses as well. Yet the cost of this commitment is soaring.[61]

- In 1974, when many companies began covering post-retirement medical expenses, Fortune 500 companies, on the average, had 12 employees for every retiree.
- Today, there are only three workers for every retiree.
- As a result, for many companies the cost of retiree health plans is greater than retiree pension benefits.

What is the total magnitude of these commitments? The estimates vary widely:[62]

- The Department of Labor estimates that total current employer liabilities are $125 billion and are growing at the rate of $5 billion per year.
- Other estimates place the liability of Fortune 500 companies as high as $2 trillion -- a total which far exceeds the value of their current assets.

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[61] Estimate of Northwestern National Life Insurance Company.

[62] See Dallas L. Salisbury, "The Need for Setting Funds Aside Today," in America's Health Care Challenge, p. 46.

Unlike private pensions, however, companies cannot set aside funds today to cover health care expenses that will be incurred tomorrow.[63] Tax deductions for retiree health expenses can only be taken in the year in which the expense occurs -- and not in the year in which the commitment to pay was made. What this means is that federal policy is forcing private companies to adopt a chain-letter approach to retiree health care. As a result, today's workers are being forced to subsidize the health care expenses of today's retirees, and the future health care needs of today's workers must be financed by the next generation of workers.

Until recently, many large companies believed that their commitment to pay for post-retirement health care expenses was not a legally binding commitment. Companies assumed that if they got in financial trouble, they could cut back on such expenses. Recent court decisions, however, imply that these liabilities are binding, and the Financial Accounting Standards Board has announced that companies will be required to calculate and report such liabilities in the future.

The upshot is that private companies not only have been prevented from instituting financially sound post-retirement health care plans, but they also have been saddled with financial liabilities, ensuring that their economic self-interest lies in expanding the federal government's Medicare commitment.

Medical IRA Accounts. We first proposed the concept of the Medical IRA (MIRA), or the Individual Medical Account (IMA), in 1984.[64] The idea generated strong bi-partisan support, leading to the introduction of numerous bills before Congress. In some versions, MIRAs would be used to phase out and replace Medicare. In other versions, MIRAs would be used to pay for medical expenses not covered by Medicare. In all versions, MIRAs are based on the principle that each generation should pay its own way, rather than becoming financially dependent on the next generation of workers.

Despite the concept's widespread appeal, MIRAs have been a continuing casualty of the politics of medicine. Having first endorsed the principle for catastrophic care, Secretary Bowen then abandoned it in constructing the administration's proposal. MIRAs are fine for nursing home care, but not for catastrophic care, said the task force report on Catastrophic Illness Expenses. Then the task force report on Long-Term Health Care Policies said existing IRAs should be used for nursing home care insurance, but opposed the creation of new MIRA options for workers. Meanwhile, the Tax Reform Act of 1986 (TRA) greatly restricted the use of IRA deductions.

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[63]Under the Deficit Reduction Act of 1984 (DEFRA), tax deductions are not allowed for the pre-funding of future medical expenses.

[64]Peter Ferrara, John Goodman, Gerald Musgrave and Richard Rahn, "Solving the Problem of Medicare," NCPA Policy Report #109, January, 1984.

Congress faces the same political dilemma each time it considers methods of prefunding the medical expenses of the elderly. Additional tax deductions today create new budget pressures today. Yet the problems these tax deductions are designed to remedy will not appear until decades into the future -- long after most current members of Congress have retired.

In the absence of strong leadership from the administration, it has proved impossible to make current political sacrifices in order to avert a disaster that is far beyond Washington's time horizon.

ADOPTING A NEW PHILOSOPHY OF HEALTH CARE FINANCE

National health insurance enjoys widespread popularity in other countries partly because it institutionalizes certain assumptions that are widely held -- by politicians, by the medical community, and by the general public. These assumptions not only pervade public thinking in other countries, but they also have heavily influenced public policy toward health care in this country. Unfortunately, each of these assumptions is false.

One false assumption is that ill health is a random event, unrelated to individual behavior. From this assumption the conclusion is drawn that it is unfair to ask individuals to bear the cost of events over which they have no control.

A second false assumption is that it is wrong to ask individuals to choose between health care and money. From this assumption the conclusion is drawn that no one should be forced (or even be given the opportunity) to forego health care services because of an unwillingness to pay.

A third false assumption is that the profit motive is inappropriate, if not unethical, in the medical marketplace. From this assumption the conclusion is drawn that we should forbid doctors, hospitals and insurance companies to compete in the marketplace by offering a variety of services which differ with respect to quality and price.

To avert the painful choice between severe health care rationing and the crushing burden of mounting health care costs, each of these assumptions must be replaced by different assumptions -- ones that are consistent with the reality of the world in which we live.

Individual Responsibility

Despite the view that ill health is a random event, an "act of God," or the result of circumstances outside an individual's control, mounting evidence suggests the reverse is true. Increasingly, experts are becoming persuaded that individual health and life expectancy are heavily influenced by the choices we make.

The central concept behind the idea of the medical IRA is that health status over an individual's lifetime is a consequence of choices made over a lifetime. No one is in a better position to predict what choices individuals will make than individuals themselves. No one is in a better position to plan for probable adverse contingencies than individuals themselves. And no one is in a better position to gage to what degree an individual will be able to draw on personal savings and family help in the face of adverse events than individuals themselves. For these reasons, MIRAs are designed to give freedom of choice to those who are best suited to exercise that choice.

A free society is one in which individuals are left free to make lifestyle choices, occupational choices and other choices that involve varying degrees of risk. But a responsible society is a society in which individuals bear the costs and reap the benefits of their choices. This means that individuals who take greater risks must be prepared to pay more -- both in terms of direct health care expenditures from personal savings and in terms of higher premiums for health insurance.

Not only is it desirable to ask people to bear the full costs of their risky decisions, but failure to do so subsidizes and encourages risky behavior. When people who take risks are forced to assume the costs of those risks, those people will take fewer risks. Conversely, when people who change their behavior are allowed to reap the financial benefits of that change, more behavioral changes are likely to occur. In both cases, there will be smaller health care costs.

Freedom of Choice

Full exercise of freedom of choice means more than the freedom to choose lifestyles and occupations and to engage in personal planning for future health care expenditures. It also means the freedom to choose whether or not to purchase health care services at all. That freedom is now greatly restricted.

Imagine confronting every candidate for hospital surgery with a choice: Undergo surgery or forego it and receive an amount of money equal to the cost of the surgery. In the face of such an option it is possible that U.S. surgery rates would be reduced from 25 to 50 percent. Or imagine giving every Medicaid patient in a nursing home a choice: Remain in the nursing home or leave with an annual income of $22,000 per year. It is probable that the Medicaid population in nursing homes would be cut in half.

The argument for freedom of choice is that health care is only one of a great many things that people value. We eliminate waste when we allow people the option to choose between health care and other goods and services. This insures that the money spent is allocated in a way that gives people maximum satisfaction.

In the U.S. today, an enormous amount of money is spent on health care for patients who are on death's doorstep. Consider that,[65]

- About 28 percent of all Medicare spending is for patients who are in the last year of their lives.

- About 11 percent of all Medicare spending is for the treatment of patients in the last 40 days of their lives.

Is this the way individuals and families would choose to spend their own money? In many cases it is not.

In only one area of U.S. health care do we routinely give patients and families the option of choosing between money and health care. This is the area of nursing home care for the elderly. In principle, any elderly person may enter a nursing home and "spend down" their resources. Once the patient has reached the point of poverty, Medicaid picks up the tab. In this system, no one is denied care. But people are forced to choose between the value of government-provided care and other uses of their money.

It is significant that for every individual in a nursing home, there are two other, equally disabled individuals who are not in nursing homes. Clearly, when people are asked to choose between health care sevices and other uses of their money, health care frequently is not the first choice.

Competition in Free Markets

In competitive markets for most consumer products, diversity abounds in quality and in price. There is no reason to expect the medical marketplace to be any different. All doctors are not the same. All hospitals are not the same. Yet the current DRG system treats them as though they were -- attempting to force a single price and maintain a single standard of quality for every medical procedure, regardless of where it is performed and regardless of who performs it. This approach is destined for failure.

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[65]Estimates of the U.S. Department of Health and Human Services.

In the short run, we should redirect the DRG system toward the goal of limiting the amount the federal government spends in the medical marketplace. Beyond that, doctors, hospitals and patients should be left free to enter into whatever financial arrangements they choose. The marketplace, not government, should be used to determine the price and quality of health care.

For the long run, our goal should be to separate medicine and politics as much as possible. Individuals should be given generous tax incentives to establish MIRA accounts during their working years. Funds that accumulate in these accounts would replace financial dependence on Medicare.[66] Eventually, the role of government should be confined to providing financial assistance to the small percentage of the population that is incapable of paying its own way.

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or of the Services Group, or as an attempt to aid or hinder the passage of any bill before Congress.

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[66]A mechanism for using MIRAs to phase out participation in Medicare is presented in Ferrara, Goodman, Musgrave and Rahn, "Solving the Problem of Medicare."

APPENDIX A

TABLE A-1

VALUE OF PARTICIPATION IN MEDICARE FOR SINGLE MALES AGE 20 IN 1986 AT REAL RATES OF INTEREST OF 4 % AND 6 %

(in 1986 prices)

Low-Income Workers

	4 %	6 %
Expected Benefits	$8,863	$3,732
Expected Taxes	9,984	6,784
Past Taxes	598	616
Net Present Value	- $1,720	- $3,668

Median-Income Workers

	4 %	6 %
Expected Benefits	$8,342	$3,339
Expected Taxes	24,945	16,561
Past Taxes	- 0 -	- 0 -
Net Present Value	- $16,603	- $13,222

High-Income Workers

	4 %	6 %
Expected Benefits	$8,068	$3,134
Expected Taxes	37,003	24,004
Past Taxes	- 0 -	- 0 -
Net Present Value	- $28,935	- $20,870

Assumptions:

1. Workers' lifetime average annual earnings are equal to 150 percent of the minimum wage ($10,050 per year in 1986) in the case of low-income workers, equal to the median income earned by adult male workers ($26,605 in 1986) in the case of median-income workers, and equal to the maximum taxable Social Security wage ($42,000 in 1986) for high-income workers.

2. Workers enter the labor market at age 18 for low-income workers, age 22 for median-income workers and age 24 for high-income workers.

3. At every age, workers are assumed to have worked continously since entering the labor market.

4. Addition explanation of the assumptions used in making these calculations is contained in Appendix B.

Source: Calculations made by William T. Rule, III of Peat, Marwick, Main & Co.

TABLE A-2

VALUE OF PARTICIPATION IN MEDICARE
FOR SINGLE FEMALES AGE 20 IN 1986
AT REAL RATES OF INTEREST OF
4 % AND 6 %

(in 1986 prices)

Low-Income Workers

	4 %	6 %
Expected Benefits	$11,495	$4,534
Expected Taxes	10,272	6,943
Past Taxes	598	616
Net Present Value	$624	- $3,025

Median-Income Workers

	4 %	6 %
Expected Benefits	$10,993	$4,143
Expected Taxes	16,533	10,921
Past Taxes	- 0 -	- 0 -
Net Present Value	- $5,540	- $6,778

High-Income Workers

	4 %	6 %
Expected Benefits	$10,734	$3,941
Expected Taxes	34,180	24,648
Past Taxes	- 0 -	- 0 -
Net Present Value	- $27,446	- $20,708

Assumptions: Same as Table A-1 except that median-income workers are assumed to earn the median wage paid to adult female workers ($16,472 in 1986).

TABLE A-3

VALUE OF PARTICIPATION IN MEDICARE
FOR SINGLE WORKERS AT DIFFERENT AGES
AT REAL RATES OF INTEREST
OF 4 % AND 6 %

(in 1986 prices)

Low-Income Workers

Workers' Age	Single Male		Single Female	
	4 %	6 %	4 %	6 %
20	- $1,720	- $3,668	$ 624	- $3,025
25	- 2,192	- 5,021	416	- 4,217
30	- 2,577	- 6,433	407	- 5,400
35	- 2,592	- 7,553	787	- 6,250
40	- 1,575	- 7,400	2,244	- 5,764
45	672	- 5,555	5,003	- 3,495
50	3,251	- 3,245	8,202	- 633

Median-Income Workers

Workers' Age	Single Male		Single Female	
	4 %	6 %	4 %	6 %
20	- $16,603	- $13,222	- $5,540	- $6,778
25	- 16,201	- 14,602	- 4,614	- 7,206
30	- 17,034	- 27,316	- 4,524	- 8,529
35	- 17,802	- 20,325	- 4,348	- 9,957
40	- 17,337	- 22,118	- 3,273	- 10,468
45	- 14,341	- 20,551	- 399	- 8,618
50	- 10,012	- 17,022	3,551	- 5,237

High-Income Workers

Workers' Age	Male Workers		Female Workers	
	4 %	6 %	4 %	6 %
20	- $28,935	- $20,870	- $27,446	- $20,708
25	- 28,282	- 22,756	- 26,455	- 22,407
30	- 29,584	- 26,633	- 27,271	- 26,012
35	- 29,327	- 29,147	- 26,537	- 28,228
40	- 27,694	- 30,280	- 24,413	- 29,019
45	- 24,263	- 29,250	- 20,427	- 27,560
50	- 18,361	- 24,624	- 13,835	- 22,352

Assumptions: Same as Tables A-1 and A-2

APPENDIX B

ASSUMPTIONS BEHIND THE CALCULATIONS OF THE PRESENT VALUE OF MEDICARE

Labor Market Participation. Workers are assumed to enter the labor market at age 18 (for low-income workers), age 22 (for median-income workers), and age 24 (for high-income workers). They are assumed to work continuously until they reach age 65, unless disabled. The computer program calculates the probability that a worker will become disabled at some time in the future, and also calculates the probability that a worker, once disabled, will later re-enter the labor market.

Expected future taxes and benefits are calculated for workers at different ages. In each calculation, it is assumed that the worker has worked continuously from the time of entry into the labor market until the time the calculation is made. However, the calculation includes the probability of future disability.

Future Wages. Workers enter the labor market at a certain wage. From that point forward, the worker's real income is expected to grow at the same rate as the rate of growth of real wages in the economy as a whole. This rate is 1.5 percent, according to the Social Security Administration's intermediate assumptions.

Future Benefits. Medicare benefits are Part A benefits only. It is assumed that the benefit formulas currently written into law will remain in effect indefinitely into the future. It is further assumed that the future amount spent per beneficiary will grow according to the intermediate assumptions. Note that individuals under age 65 may receive Medicare benefits as a result of disability, in addition to normal coverage at age 65.

Future Taxes. All projections are based on the assumption that promises made under Social Security and Medicare will be kept and will be financed by increases in the payroll tax, whenever necessary, in order to pay promised benefits. For the purposes of these calculations, the portion of the total payroll tax counted as "Medicare taxes" is equal to the proportion of all spending from the trust funds allocated to Medicare benefits in any given year.

Expected Values. The computer program calculates the probability that an individual will live to all possible ages up to 105. For each possible lifespan, it calculates the costs and benefits associated with that lifespan. Expected value is the sum of all possible outcomes, each weighted by its probability of occurring. These calculations include the probability of disability, as well as the probability of death, at each age.