91st Congress
1st Session

COMMITTEE PRINT

HEALTH ASPECTS OF THE ECONOMICS OF AGING

A WORKING PAPER IN CONJUNCTION WITH THE OVERALL STUDY OF "ECONOMICS OF AGING: TOWARD A FULL SHARE IN ABUNDANCE"

PREPARED BY AN ADVISORY COMMITTEE

FOR THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

JULY 1969

(Revised)

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

32-440 WASHINGTON : 1969

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price 25 cents

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BERT SEIDMAN, *Director, Department of Social Security, AFL–CIO*

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FOREWORD

—Older Americans are victims of a retirement income crisis which is deepening rather than improving.

—Millions of the elderly in the United States are living today in poverty, and most did not become poor until they became old.

—Dismaying as the present situation is, all indicators point to a widening of the gap between income of retirees and income of those still in the labor force. The purchasing power of the retirees will continue to shrink unless we move promptly.

—What is needed are major new policy decisions and actions to assure economic security for those now old and for those now in middle-age or younger.

Such were the major conclusions earlier this year of a Senate Special Committee on Aging Task Force in a Working Paper called "Economics of Aging: Toward a Full Share in Abundance."

That document offered a powerful summary of the forces that have caused the present crisis, and it also gave suggestions for additional inquiry. The Task Force called in particular for close attention to health needs of the elderly and the effects of rising medical costs upon their economic security.

Accepting the Task Force recommendation, the Subcommittee on Health of the Elderly of the Senate Committee on Aging will conduct a hearing on "Health Aspects of the Economics of Aging" on July 17–18, 1969. To prepare adequately, an Advisory Committee was invited to issue a report summarizing basic issues and problems in this area.

The Advisory Committee has done its work and presents its conclusions in the pages that follow. Those findings and conclusions may differ from those finally adopted by the subcommittee and the full Committee on Aging, but there can be no doubt that the Advisory Committee has performed a timely and helpful service by providing an incisive summation of medical cost pressures that afflict aged Americans today despite the invaluable help of Medicare and other public medical care programs.

Those pressures are especially destructive and unsettling for the elderly because of the heavy inroads they make on fixed retirement income, and because they fall so unevenly. A middle-income elderly couple, for example, may find itself in financial jeopardy because either the husband or wife needs nursing home care. They may be disqualified from Medicaid or welfare because they have a savings nest-egg or because of a private pension. Or perhaps a man who has been healthy all his life may, in his mid-70's, become disabled by an illness in which he requires constant attention and medication, but little or no hospitalization. Since, essentially, Medicare coverage begins with hospitalization, it is of little help to him.

The fact is that Medicare pays for only 45 percent of all health care expenditures for the elderly today. Other programs provide

some help, but the threat of costly, catastrophic, disabling illness remains all too real among our aged population. That threat, intensified by today's rapid rise in medical costs, cannot be disregarded in any evaluation of the economics of aging in the United States today. If we in this Nation ever hope to establish an adequate retirement income maintenance program, we will have to resolve medical cost problems that otherwise will remain an intolerable drain upon the limited resources of the elderly and forestall every alternative in providing adequately for the economic security of the aged.

The Advisory Committee, working under formidable time pressures, has our gratitude for their generosity in sharing their knowledge and convictions with us. We are especially pleased to acknowledge the leadership of Mrs. Agnes W. Brewster in this effort. Mrs. Brewster, a medical economist with a long history of service in governmental agencies behind her, served on the original Task Force and has now made a major contribution to the report which follows.

HARRISON A. WILLIAMS, Jr.,
Chairman, Senate Special Committee on Aging.

EDMUND S. MUSKIE,
Chairman, Subcommittee on Health of the Elderly.

HEALTH ASPECTS OF THE ECONOMICS OF AGING

ADVISORY COMMITTEE REPORT

INTRODUCTION

Americans of age 65 and over—though drawing substantial, essential economic assistance from Medicare, and to a much lesser extent, from Medicaid—nevertheless continue to be the major victims of unresolved problems related to the costs, quality, and availability of medical care in the United States today.

Inflationary cost pressures of recent years in the health field intensify the uneven burden of expense, disability, and pain among our elders, creating acute financial problems for many and—for most of the others—the ever-present fear that similar problems will strike their households.

There is reason to believe that millions of old people in our Nation today postpone treatment until the crisis stage simply because (1) they expect old age to bring physical infirmity and misery, and (2) gaps in Medicare and Medicaid coverage make it difficult for them to receive high-quality health services and supplies except during and immediately after hospitalization.

Thus, the over-reliance on hospital care, the most expensive level of care available, is perpetuated and accentuated.

This brief working paper is not meant to be a definitive study of the dollars-and-cents realities faced by elderly Americans who need medical care. Rather, it is meant to comply with a recommendation of a Task Force which in March declared as part of its report on "Economics of Aging: Toward a Full Share in Abundance" that special attention should be given to rising medical costs, costs which compound the general problem of low income among the aged.

The Task Force report, made to the U.S. Senate Special Committee on Aging, was a profoundly disturbing document.

It declared that, for present and future generations of older Americans, their retirement income situation is deteriorating.

It declared that only major changes in social policy can deal adequately with the overall problem and its many components.

Implicit in every major finding of that Task Force was the realization that any needless or avoidable drain upon the limited incomes on which the great majority of the elderly must rely would endanger any public retirement income maintenance plan that might be developed.

Health care expenditures represent a major element in the ability of the elderly to maintain themselves financially. Many of the elderly, even with Medicare, are driven from a status of economic independence into dependency and must turn to Medicaid. Improvement of the plight of the elderly calls for major improvement in income maintenance programs combined with augmented health benefits.

What is discussed in this report are, therefore, matters that must, as a *prerequisite* for any realistic plans for economic security in retire-

ment now and in the decades to come, be dealt with as quickly and as thoroughly as possible.

Fortunately, the United States has already taken large strides toward such realistic plans.

Medicare, though certainly imperfect and hastily implemented, offers a good structure for improvements in our $50 billion health industry.

Medicaid is passing through troubled times caused in part by haste in its genesis, but it is focussing attention on the need for quality control, the need to eliminate waste and abuse, other clear goals in national policy, and greater understanding of the formidable economic barriers to high-quality medical care for all.

Faced by a deepening retirement income crisis, this Nation can ill afford to add to the burdens of the elderly by neglecting unresolved problems related to their health care.

In the following pages, some indicators of the extent and nature of those problems are presented.

MAJOR FINDINGS AND CONCLUSIONS OF THE ADVISORY COMMITTEE

- **Medicare has provided invaluable protection and peace of mind to millions of older Americans.**

  But—because it now covers only 45 percent* of all health costs of the elderly—the door is still open to catastrophic or steady, gnawing financial difficulties so serious as to be a source of great concern for all but the wealthy among the elder citizens of this Nation.

- **This problem, though not limited to those elderly living in or near poverty, affects low-income individuals and couples most directly.**

  Deductibles and coinsurance required under Medicare, together with problems related to availability of services and refusal of a majority of physicians to "take assignment" under Part B of Medicare, intensify the cash problems encountered by the low-income elderly.

- **Although Medicare and Medicaid have replaced a large segment of private spending for health care, 30 percent* of the cost of personal health care for the aged remains as a private responsibility for the aged and their children.**

  In addition to the 45 percent covered by Medicare, 25 percent of the fiscal 1968 expenditures of the aged were met by Medicaid and other public programs. Nevertheless, the amount paid *privately* by the aged remains higher per capita ($176) than for the nonaged ($153).*

  Private expenditure falls unevenly upon the aged population, causing desperate problems for many. Deductibles and coinsurance intensify such problems and in effect deny many elderly persons the care or services they need.

- **The refusal of nearly one out of two physicians (excluding those who are hospital-based)* to "take assignment" is accompanied by a rise in fees and a consequent inability on the part of many elderly to avail themselves of their Part B Medicare benefit, even when they have paid the premiums for Part B.**

- **Medicaid offers uncertain and uneven protection; and "meshing" with Medicare is far from adequate.**

  Cutbacks by the States in Medicaid benefits and beneficiaries will compound the problem.

- **About half of the aged population has supplemented its Medicare coverage with some form of private protection, but premiums for adequate benefits are beyond the reach of many.**

  The complementary coverage is more often than not limited so that benefits are paid only when the Medicare patient is

*See note on page 4.

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in the hospital; and those enrolled under Medicare Part B are already paying $96 per couple annually in premiums.

- **Inflationary tendencies in the health field have an intense impact upon care provided for the elderly.**

  While Medicare can and has generated powerful inflationary forces in the health-care market, more positively, it can also be a force against runaway costs.

- **There is some danger that the current investigations of fraud and near-fraud in Medicaid and Medicare may lead to a defeatist or negative attitude toward each program.**

  There is also a danger that such emphasis may well thwart efforts to deal with more fundamental deficiencies in each program.

  Reform is needed, but it should be thoroughgoing and it should be positive. This Nation has declared that high-quality medical care is the right of every American. We should be innovative and positive in making changes. We should be as insistent upon upgrading quality as we are insistent that wrongdoing be recognized and punished.

- **As consumers of health care and services now costing approximately 3 times* as much as for other age groups, the elderly have special needs.**

  They include long-term care in hospitals or nursing homes, and out-of-hospital drugs. Medicare coverage is deficient or nonexistent in these areas of special need.

- **Deficiencies in the delivery system for health care services play a direct role in creating dollars-and-cents problems for the elderly.**

  They, along with other age groups, suffer not only in terms of inconvenience, but also in terms of direct dollar outlays, because of irrational or outmoded delivery systems for medical care and services. A special cause for concern for the elderly is the lack of decent alternatives to expensive hospital care.

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*NOTE: At the time the Advisory Committee was preparing this report, data were not available on the health care expenditures of the aged during fiscal year 1968. For the detailed analysis in its report, the Committee has therefore used data for the preceding year—the first year of Medicare.

The major findings summarized above have now been updated to reflect information released by the Social Security Administration in a Research and Statistics Note, dated July 16, 1969.

The conclusions remain unchanged.

FOR ADVISORY COMMITTEE RECOMMENDATIONS, SEE PART V

CHARACTERISTICS OF THE AGED POPULATION

Certain facts are needed as a frame of reference for consideration of the economic position of the aged, now and in the future.[1] Who are the people now 65 and older? How is the aged group changing? What are the population characteristics that help to explain low incomes in old age?

Every tenth American is 65 or older. Currently, there are about 20 million aged individuals. Fewer than 9 million are men and more than 11 million are women.

The rate of growth in the population 65 and older has slackened in recent years. In contrast to a 3.0 percent annual rate of increase for the decade 1950–60, the rate has averaged just under 2 percent during the Sixties.

Projections for the decade ahead indicate a growth rate for the aged population about the same as the rate for the total population. The ratio of the population aged 65 and over, consequently, is expected to remain nearly a constant proportion (about 18 percent) of the population in the "working ages" of 20–64 through 1985.

The population 65 and older is not a homogeneous group at any given date; the composition of the group is constantly shifting.

On the average day, roughly 3,900 people will celebrate their 65th birthday but about 3,080 already past 65 will die, a net increase of 820 a day. In the course of a year, this means a net increase of 300,000. In the course of 5 years, 35 percent of the population 65 and older are new additions to this age group.

The aged population is getting older. Half of all people now 65 and older are about 73 years old or over. Of every 100 older persons today, 63 (almost two-thirds) are under 75; 31 (almost one-third) are between 75 and 85; and 6 are 85 or over.

In the years ahead, the growth in the aged population will be particularly great at the highest ages. The population 85 and older may nearly double over the years 1960 to 1985, in comparison to a 50 percent projected increase for the total population 65 and older.

More of the aged in the future will be women, and most of these women will be widows, many living alone. Women 65 and older already outnumber men by a ratio of 134 to 100 and this disproportion is expected to rise to 150 to 100 by 1985.

Also, as our population grows older, more people outlive their children. Probably as many as one-fifth of all older people today never had children or had children who preceded them in death.

[1] The facts used here have been drawn primarily from *A Profile of the Older American*, by Herman B. Brotman, Administration on Aging, U.S. Department of Health, Education, and Welfare. The Task Force is indebted to Mr. Brotman for his assistance in providing data more recent than those in his published analysis and for his helpful advice.

THE ROLE OF MEDICARE IN FINANCING HEALTH CARE EXPENDITURES FOR THE AGED DURING ITS FIRST YEAR (FY 1967)

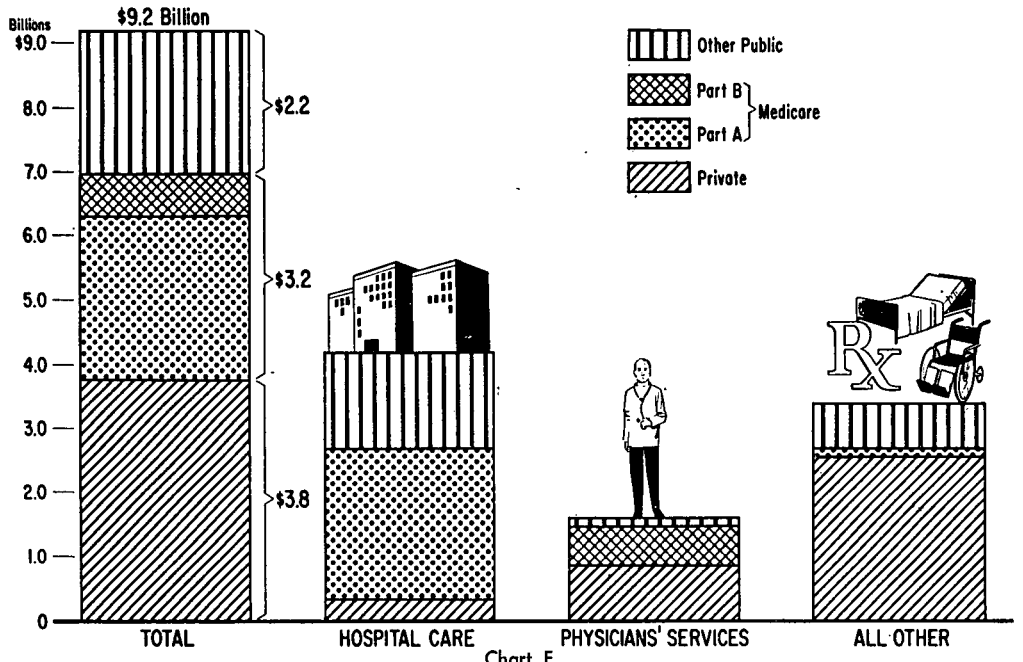

Chart E

Source: Social Security Bulletin, August 1968

CHART E. THE ROLE OF MEDICARE IN FINANCING HEALTH CARE EXPENDITURES FOR THE AGED DURING ITS FIRST YEAR

SOURCE: "Personal Health Care Expenditures of the Aged and Nonaged," by Dorothy P. Rice, Arne Anderson, and Barbara S. Cooper, *Social Security Bulletin*, August 1968, table 3, page 22.

TECHNICAL NOTE: Personal health care expenditures include all expenditures for health and medical care services received by individuals. Excluded are expenditures for medical-facilities construction, medical research, public health activities not of direct benefit to individuals (that is, disease prevention and control), and some expenses of philanthropic organizations. These data also exclude the net cost of insurance (the difference between health insurance premiums and benefits paid) as well as administrative expenses of several public programs.

Of the $9.2 billion in expenditures for the aged in fiscal year 1967, a total of $3.2 billion—or 34.6 percent—was expended under the public program of Medicare. In the distribution by source of funds, all expenditures under Medicare are classified as "public" even though the aged individual pays a monthly premium for Part B Medical Insurance. This serves to understate the amount financed by private funds and to overstate the public share.

The $626 million expended for physicians' services under Medicare in fiscal year 1967—its first year of operation—do not fully reflect the charges incurred under the program because there is a considerable lag between the time a patient visits a physican and the time the carrier receives payment from the trust fund for such a visit. (There are indications that incurred charges accruing under Part B Medical Insurance in fiscal year 1967 amounted to an estimated $1.1 billion instead of the $644 million actually expended; this would raise the proportion of total expenditures that were attributable to Medicare to roughly 37 percent.)

Public expenditures other than those under the Medicare program were largely through public assistance programs, commonly called Medicaid.

The category "all other" includes expenditures for dentists' and other professional services, drugs and drug sundries, eyeglasses and appliances, nursing-home care, and other health services.

THE FINDINGS: Medicare benefits paid in the first year of operation totaled $3.2 billion, 35 percent of the estimated personal health care expenditures of $9.2 billion for all people 65 and older. Of expenditures for hospital care, 57 percent was through the Medicare program.

AVERAGE HEALTH CARE EXPENDITURES PER PERSON

Aged & Younger, Fiscal Year 1967

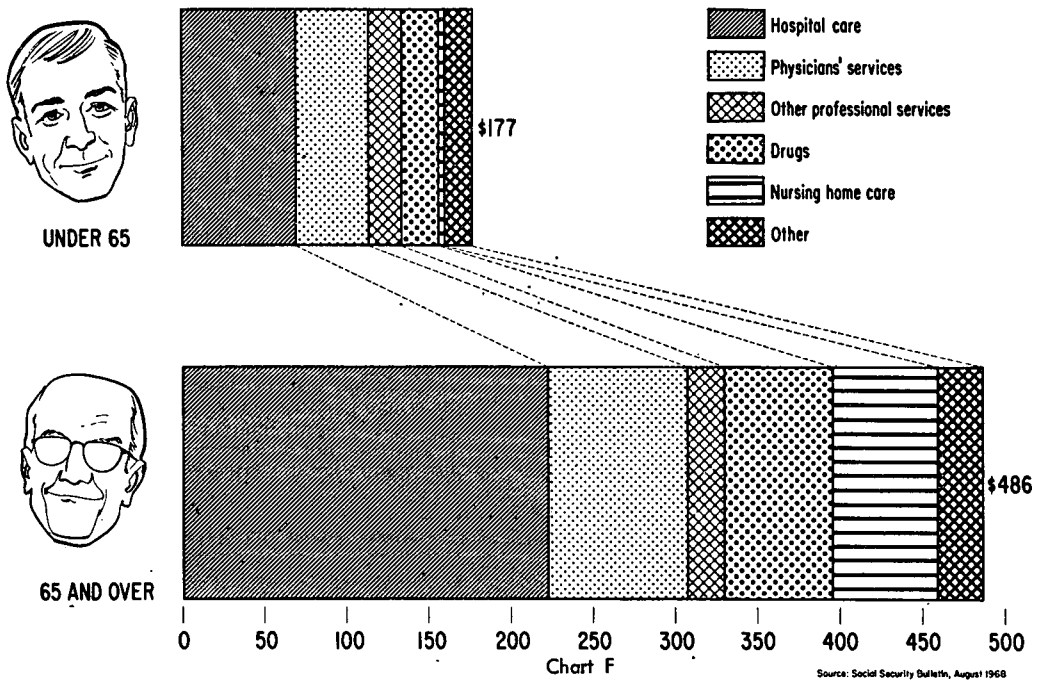

Chart F

Source: Social Security Bulletin, August 1968

CHART F. AVERAGE HEALTH CARE EXPENDITURES PER PERSON: AGED AND YOUNGER

SOURCE: "Personal Health Care Expenditures of the aged and Nonaged," by Dorothy P. Rice, Arne Anderson, and Barbara S. Cooper, *Social Security Bulletin*, August 1968, table 2, page 21.

TECHNICAL NOTE: Personal health care expenditures include all expenditures for health and medical care services received by individuals. Excluded are expenditures for medical-facilities construction, medical research, public health activities not of direct benefit to individuals (that is, disease prevention and control), and some expenses of philanthropic organizations. The data also exclude the net cost of insurance (the difference between health insurance premiums and benefits paid) as well as administrative expenses of several public programs.

The category "other professional services" includes expenditures for dentists' services and other professional services. The category "other health services" includes expenditures for eyeglasses and appliances and other health services.

THE FINDINGS: Personal health care expenditures in fiscal year 1967 averaged $486 per person 65 and older, about 2¾ times the average for younger persons ($177). The two age groups differ considerably in the average spent for the various types of medical care. For hospital care and for drugs, per capita expenditures of the aged are about three times those of younger people. The widest disparity is for nursing-home care; $64 was spent for the average aged person, compared with only about $2 per person under age 65.

HEALTH CARE EXPENDITURES PER AGED PERSON BY SOURCE OF FUNDS

FY 1966 and 1967 (Before and after Medicare)

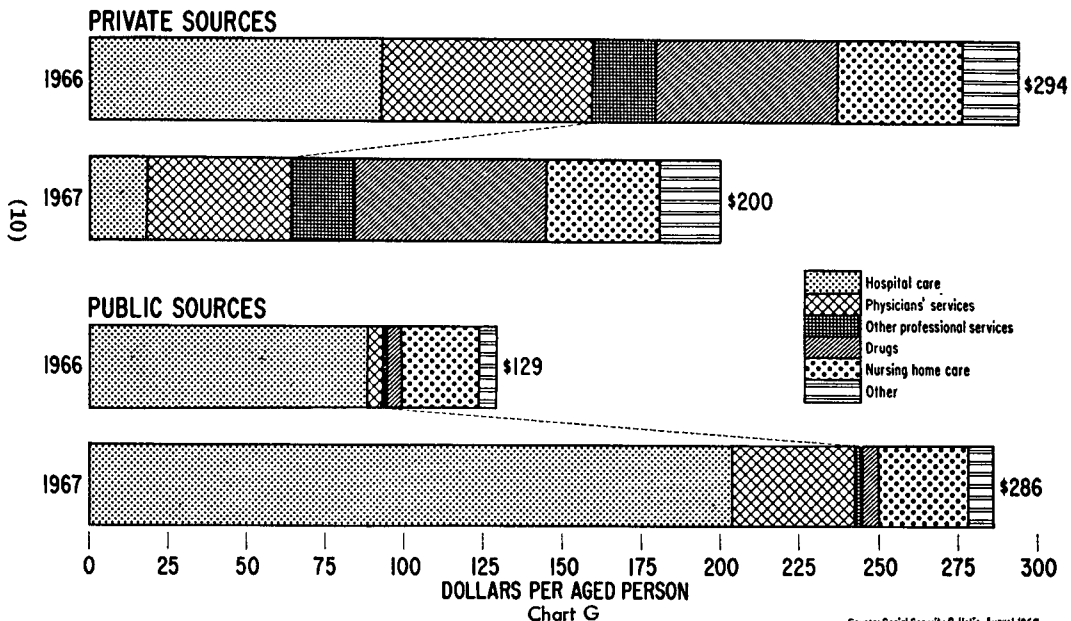

Chart G

Source: Social Security Bulletin, August 1968

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CHART G. HEALTH CARE EXPENDITURES PER AGED PERSON, BY SOURCE OF FUNDS

SOURCE: "Personal Health Care Expenditures of the Aged and Nonaged," by Dorothy P. Rice, Arne Anderson, and Barbara S. Cooper, *Social Security Bulletin*, August 1968, table 2, page 21.

TECHNICAL NOTE: Personal health care expenditures include all expenditures for health and medical care services received by individuals. Excluded are expenditures for medical-facilities construction, medical research, public health activities not of direct benefit to individuals (that is, disease prevention and control), and some expenses of philanthropic organizations. The data also exclude the net cost of insurance (the difference between health insurance premiums and benefits paid) as well as administrative expenses of several public programs.

In classifying health care expenditures by source of funds, the Social Security Administration attributes to public sources all expenditures made through *public programs*. Thus, all expenditures under Medicare are classified as "public," even though the aged individual pays a monthly premium for Part B Medical Insurance.

The category "other professional services" includes expenditures for dentists' services and other professional services. The category "other health services" includes expenditures for eyeglasses and appliances and other health services.

THE FINDINGS: The average health care expenditure per aged person in fiscal year 1967 was $486, nearly 15 percent more than in fiscal year 1966. Primarily as the result of Medicare, the portion financed from public funds rose markedly in the first year of operation—from $130 per aged person in fiscal year 1966 to $286 in fiscal year 1967. There was a less sharp drop—from $294 per capita to $200—in expenditures classified as from private sources.

PART ONE

WHAT THE ELDERLY PAY FOR HEALTH CARE

In fiscal year 1966, just before the advent of Medicare, the elderly of the United States accounted for approximately 21 percent of the $36.8 billion paid for the health care costs in that year. A total of $7.8 billion was spent on the aged in fiscal year 1966, 69 percent from private sources and 31 percent from public funds. Seventeen percent of the aggregate was from State and local funds, 14 percent Federal.

As chart E makes clear, Medicare changed the situation dramatically. The total health bill for the elderly in fiscal year 1967 was $9.2 billion, up $1.8 billion. Private funds paid $3.8 billion (41 percent) of the new total. This percentage will only drop slightly when the aged use Medicare fully. Chart F shows how the per capita expenditures differ by age.

What are public funds now used for?

I. THE NATIONAL SCENE: PUBLIC AND PRIVATE SPENDING

The source of expenditures changed in character under Medicare. State and local expenditures for the aged dropped nearly $300 million; Federal expenditures rose by $3.3 billion so $3 billion more tax moneys were used to finance the aged's health needs. At the same time, private expenditures, by and for the aged, decreased by $1.7 billion. In the first full year of Medicare, fiscal 1967, public funds accounted for 59 percent [1] of the medical bill of the aged. (Table I and chart G.) For hospital care, 92 percent was financed by public funds. About 46 percent of the money spent on physicians' care on behalf of the aged, came from tax sources. That only 24 percent of the combined expenditures for dentists, drugs, eyeglasses, nursing home care, et cetera, was met by tax moneys, arises from the gaps in Medicare coverage.

[1] The Social Security Administration estimate of public spending includes the $4 monthly premium charge paid by Part B Medicare enrollees. Asked by the Senate Special Committee on Aging whether such payments might be listed as private expenditures, SSA replied: "It seems to us much more realistic to treat the entire program as a public program, and to treat the premium payments just as we treat employee contributions for social insurance." SSA acknowledged that the $300 million paid by enrollees, "if added to private outlays, would increase private as a percent of the total personal health care expenditures of the aged from 41.2 percent to 44.5 percent."

TABLE I.—ESTIMATED PERSONAL HEALTH CARE EXPENDITURES OF PERSONS AGED 65 AND OVER BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, FISCAL 1967

Type of expenditure	Total	Private	Public		
			Total	Federal	State and local
	In millions				
Total	$9,156	$3,774	$5,382	$4,331	$1,051
Hospital care	4,188	348	3,840	3,161	679
Physicians' services	1,602	864	738	675	63
Other professional services	425	383	42	30	10
Drugs and drug sundries	1,232	1,139	93	46	47
Nursing-home care	1,209	678	531	311	220
Other health services	500	362	138	107	31
	Per capita				
Total	$485.91	$200.29	$285.62	$229.85	$55.77
Hospital care	222.26	18.47	203.79	167.75	36.04
Physicians' services	85.02	45.85	39.17	35.82	3.35
Other professional services	22.55	20.33	2.23	1.59	.64
Drugs and drug sundries	65.38	60.45	4.94	2.44	2.50
Nursing-home care	64.16	35.98	28.18	16.50	11.68
Other health services	26.53	19.21	7.32	5.68	1.64
	Percentage distribution				
Total	100	41.2	58.8	47.3	11.5
Hospital care	100	8.3	91.7	75.5	16.2
Physicians' services	100	53.9	46.1	42.1	4.0
Other professional services	100	90.1	9.9	7.1	2.8
Drugs and drug sundries	100	92.5	7.5	3.7	3.8
Nursing-home care	100	56.1	43.9	25.7	18.2
Other health services	100	72.4	27.6	21.4	6.2

The $5.4 billion expenditures by public programs consist of Medicare (59 percent), public assistance vendor medical payments (20 percent), veterans hospital and medical care (10 percent), other public hospital and medical care (9 percent), and other (2 percent). Only 11.5 percent of the total is now derived from State and local funds, down from 17 percent.

Although the Federal Medicare program has replaced a large segment of private spending for health care, 41 percent [2] remains as a personal responsibility to be met out of Social Security benefits, other income, and assets, and by relatives and friends, and by their private insurance.

II. WHAT COSTS MEAN IN PERSONAL TERMS

However significant and imposing the national statistics are, they must be translated into individual terms, if we are to understand the grave medical cost problems facing millions of older Americans today.

The most striking attribute of such costs is their uneven distribution.

The amount of hospital care required annually varies from none for 87 percent to two or more stays for some of the elderly. Older persons with $10,000 or more income were heavier than average users of hospitals. Those with two or three hospital episodes required more than two or three times as many days of care as those hospitalized only once.[3]

[2] See footnote 1 on p. 13.
[3] Source: NCHS Series 10, No. 50, p. 5, "Persons Hospitalized" June-July 1966.

Visits to doctors also vary by age, sex, and by physical condition, as well as by city and by income. The per capita visits rise with age. This is one reason why aged females average more doctor visits than males. Only 27–30 percent of the population aged 65 and over goes through a year without seeing a doctor—7 percent see a doctor 13 or more times a year, or more than once a month.

Thus, costs can range from nothing to $400 or more, just for doctor visits outside the hospital.

Prescribed drug usage varies widely; those with chronic illnesses require more than the average number of prescriptions, so their costs can be sizable. This is one of the gaps in Medicare; it is one of the large segments of expenditures under Medicaid. And it is the largest area of per capita private expenditure by the aged.

A. Medicare: The Benefits, the Gaps

As Table 1 showed, Medicare pays a large portion of the hospital bills of the aged. The deductible of the first $44 of the hospital bill and the coinsurance in the later days of hospital and extended care facility stay do not affect many aged people in the course of a year. Under Part B of Medicare, however, enrollees not only pay a $48 annual premium but the first $50 of the insured services and 20 percent of the remainder of the charges. When a person sees a doctor, quite often other charges, such as for laboratory work, prescriptions, X-rays, and so forth, are also incurred. Some or all of these charges represent gaps in Medicare coverage.[4]

Still another kind of gap exists in Medicare which might be called a "communication gap" though some observers react with such disbelief that it might be labeled a "credibility gap" instead.

Only about half of the physicians caring for Medicare patients accept assignments of the benefits. "Assignment of benefit" means that the aged person has instructed the Medicare fiscal intermediary to pay his doctor directly ("assign his benefits" to the doctor). When a doctor accepts assignment, he binds himself not to send a separate and additional bill directly to the old person; he collects 20 percent of the bill from the beneficiary and 80 percent from the Trust Fund via the fiscal intermediary. Surgeons, whose bills are usually larger than those of other physicians, are more and more showing a willingness to accept assignment rather than to struggle to collect from the beneficiary who may only be able to pay after receiving the claims payment himself.

Here is how a comparison of a surgeon's bill can work with and without assignment:

[4] The absence of prescription drug coverage is discussed in Part III. Coverage of mental illness under medicare is subject to special limitations on days of care (190 days in a lifetime) and on out-of-hospital treatment (50 percent coinsurance and a limit of $250 annually as well as the $50 deductible). While 68 percent of all mental hospitals with 74 percent of all mental beds, participate in Medicare, the proportions vary by region of the country and by sponsorship. The problem was described in some detail by Dr. Robert W. Gibson, representing the American Psychiatric Association and the National Association of Psychiatric Private Hospitals at U.S. Senate hearings on the Social Security Amendments in 1967:

"Under the supplementary medical insurance benefits for the aged, outpatient treatment may be paid for after a $50 deductible, with the patient paying 20 percent, and with no top limit. But, in the case of psychiatric treatment, the patient must pay 50 percent after the deductible, and there is a top limit of $250. This limitation seriously curtails outpatient psychiatric treatment for the aged patient. Many elderly patients can be successfully treated on an outpatient basis. *If such treatment is denied because of financial limitation, the inevitable result will be hospitalization. Such unwarranted hospitalization may not serve the best interests of the patient, and will most certainly add to the cost of the hospital insurance program.*"

Case: A CATARACT OPERATION WITH OPHTHALMOLOGIST'S BILL AMOUNTING TO $700

WITH ASSIGNMENT

Fiscal intermediary finds $700 exceeds usual and customary by $150:	
Intermediary pays 80% of $550	$440
Patient pays 20% of $550	110
Total paid	550

WITHOUT ASSIGNMENT

Doctor sends bill to patient who pays $700 to doctor and sends bill to fiscal intermediary:	
Intermediary pays patient	$440
Patient has to pay balance	260
Total paid	700

Prior to Medicare, physicians often showed an understanding of their patients' economic circumstances and did not raise the fees they had been charging old patients for years on end. With Medicare, fees have been "adjusted" upward so that it is not too unusual to have the aged family spending as much out of pocket as before the program began, or even more, especially if the $48 in Part B premiums is counted among their expenses, as it should be.

The disadvantages of nonassignment are fivefold: (1) the aged person must pay the doctor's charges, whatever their level, without such deterrents as are imposed by having the fiscal intermediary screen for reasonableness and relationship to other doctors' charges; (2) the aged must themselves complete forms, submit claims, pay the bill, etc.; (3) the higher charges soon become the accepted level of charges and are subsequently paid by the fiscal intermediary; (4) the dollar cost of the coinsurance of 20 percent mounts; and (5) workers pay more social security taxes as demands on the trust fund rise.

Certain types of health care—notably long-term nursing care for chronic illness, as distinct from posthospital extended care—are almost exclusively the domain of the aged. In a 1964 survey, only 12 percent of the residents of nursing and personal care homes were under age 65. Forty-eight percent were females aged 75 and over. More than 50 percent were men and women in their eighties.

In Michigan, under Medicaid, nursing homes cost $420 a month on the average, or $5,040 a year. How can elderly people by definition long since separated from the labor market and entitled in the main to the minimal social security cash benefits afford the cost of nursing-home care? The average extended-care facility under Medicare [5] costs more than $500 a month.

Not surprisingly, the per enrollee benefit payments under Parts A and B of Medicare vary widely by State.

That the spread is as wide as it is, is as much related to the relative availability and use made of hospital and physician services as it is a reflection of geographic differentials in costs. For hospitals, the lower wage scales of the Southern States enter into the cost differentials.

[5] "Staff Data Relating to Medicaid-Medicare Study," July 1, 1969, Committee Print, U.S. Senate Committee on Finance.

Per Medicare enrollee, Part A benefit payments in fiscal 1967 ranged from $66 in Mississippi to $191 in Nevada. The national average was $134.

Part B payments varied from $23 in Alabama and $24 in Alaska, Kentucky, Mississippi, and South Carolina to $72 in California. The national average was $38 in fiscal 1967.

Differences of this magnitude cannot be explained solely in terms of charges per unit of service. Because of higher charges, more people in California meet the deductible, and thus a greater proportion of their cost is covered by Medicare than in the Southern States.

Some idea of the Medicare limitations can be obtained from the size of payments that must be made for old-age-assistance recipients after Medicare charges have been met. (Non-OAA recipients, of course, pay such charges from their own pockets.)

In one State, New Hampshire, welfare paid the following average amounts on Medicare bills:

Inpatient services	$59.75
Outpatient services	5.89
Home health agency services	47.88
Physicians' services	15.40

Thus, far more than the averages shown could easily be uninsured by Medicare for an individual beneficiary after his Medicare benefits were exhausted.

B. Medicaid: Uneven Protection and Uncertainty

Medicaid programs are designed individually by each State using certain minimal Federal criteria and guidelines. The majority of the 50 States have such programs and these provide the five basic services required; namely, inpatient hospital care, outpatient hospital care, skilled nursing home care, physicians' services, and laboratory and X-ray services.

Among the 40 States and three other locations 27 provide the five basic services to medically needy persons; 16 limit the benefits to the categorically needy.

Prescribed drugs and home health services are made available in 36 States, with 23 of the 36 paying for them for both categories of needy. Thus over half the States do nothing to help the low-income aged with drugs. Lesser numbers of States furnish dental services, appliances, and types of treatment not included as physicians' services. The medically needy aged citizen living in California or Connecticut, Minnesota, New York, or North Dakota is eligible for 19 or 20 kinds of services while his counterpart in Alabama or Tennessee, Alaska, or Indiana has not been eligible for any title 19 services.

Forty-one percent of the people eligible for Medicaid are at least 65 years old. Because Medicare absorbs much of the hospital costs and a share of physicians' costs, only 45 cents of each Medicaid dollar is spent on the elderly. Much of this expenditure is for nursing home care and drugs; these services are either limited or not included under Medicare.

The lack of coverage of many needed services that poor, ill people should have and the fragmentation in the delivery of the services that are provided are both disturbing. All too often, when a question

of funding comes up, cuts are made in Medicaid at the expense of the clients, not the providers.

Medicaid could be a useful vehicle for improving the delivery system for care of people were it not riddled with contradictory policies in its implementation.

III. CAN PRIVATE HEALTH INSURANCE HELP?

The Division of Research and Statistics of the Social Security Administration periodically reports on the extent of private insurance purchased by or on behalf of the U.S. population. According to this source about half the aged population has supplemented its Medicare coverage with some form of private protection. The private policies are financed by the aged themselves or result from employee benefit provisions continued after retirement. Like private insurance generally, these policies vary widely in the scope of benefits (table II) and in the cost of premiums.

TABLE II.—PRIVATE HEALTH INSURANCE ENROLLMENT AS OF DECEMBER 31, 1967: NUMBER OF PERSONS AGED 65 AND OVER WITH SOME COVERAGE OF SPECIFIED SERVICES OR EXPENSE

[In thousands]

Type of plan	Hospital care	Physician service: Surgical services	Physician service: In-hospital visits	Physician service: X-ray and laboratory examinations [1]	Physician service: Office and home visits [2]	Dental care	Prescribed drugs (out-of-hospital) [3]	Private-duty nursing	Visiting-nurse service [4]	Nursing-home care
Blue Cross-Blue Shield	5,410	4,413	4,081	[5] 1,925	1,208	----------	496	825	1,010	2,600
Blue Cross	5,241	275	218	266	105	----------	([6])	([6])	([6])	([6])
Blue Shield	169	4,138	3,863	[5] 1,659	1,103	----------	([6])	([6])	([6])	([6])
Insurance companies:										
Group policies	2,072	1,735	1,116	1,050	1,050	40	1,050	1,050	1,050	100
Individual policies	2,238	1,754	612	100	100	----------	100	100	100	----------
Unadjusted total	4,310	3,489	1,728	1,150	1,150	40	1,150	1,150	1,150	100
Less duplication [7]	263	210	83	----------	----------	----------	----------	----------	----------	----------
Net total	4,047	3,279	1,645	1,150	1,150	40	1,150	1,150	1,150	100
Independent plans	430	505	500	515	[8] 450	43	211	270	335	210
Community	110	170	170	175	170	3	25	85	175	70
Employer-employee-union	315	325	320	330	270	9	185	185	160	140
Private group clinic	5	10	10	10	10	10	1	----------	----------	----------
Dental society	----------	----------	----------	----------	----------	21	----------	----------	----------	----------
Gross total	9,887	8,197	6,226	3,590	2,808	83	1,857	2,245	2,495	2,910
Less duplication [9]	([9])	([9])	([9])	36	28	----------	19	22	25	29
Net number of different persons	[10] 9,085	[10] 7,568	[10] 5,905	3,554	2,780	83	1,838	2,223	2,470	2,881
Percent of population aged 65 and over [11]	47.8	39.8	31.1	18.7	14.6	.4	9.7	11.7	13.0	15.2

[1] In physicians' offices, clinics, or health centers. Excludes those covered only in hospital outpatient departments or those covered only in accidents or fracture cases or when services are followed by surgery.

[2] Number covered for all conditions. Excludes those eligible for care only after hospitalization.

[3] Excludes those covered for drugs only after hospitalization.

[4] Assumes that all persons covered for private-duty nursing are also covered for visiting-nurse service.

[5] Approximately 0.8 million additional persons are covered for X-ray examinations only.

[6] Not estimated separately; in many cases coverage is jointly written.

[7] As estimated by HIAA for first three services; considered insignificant for the other services and hence shown as zero.

[8] About 15 percent of this number not covered for home calls.

[9] Duplication for hospital care, surgical services, and in-hospital medical visits not calculated by ORS since the HIAA estimate of net number of persons covered is used.

[10] HIAA estimates.

[11] Based on Bureau of the Census estimate of 18,994,000 as of Jan. 1, 1968.

Source: Reed, Louis S., and Carr, Willine, Social Security Bulletin 32, February 1969, p. 6.

While 47.8 percent of the population aged 65 and over has some coverage for hospital care (where Medicare and Medicaid leave little for the individual to pay in ordinary circumstances), much lower proportions of the elderly have other kinds of private insurance protection.

Only 15 percent had obtained insurance for home and office care from physicians; only 10 percent had insurance for out of hospital drugs. Fewer than 83,000 aged had any dental insurance.

Many of the policies the aged hold are designed to pay the two deductibles and the Part B coinsurance of Medicare and not a great deal else. Some apply only to hospitalized illness in the traditional Blue Cross-Blue Shield posture.

The Blue Cross Association recently reported [6] that prior to Medicare there were 5.6 million people aged 65 and over among 57 million Blue Cross members or about 10 percent of their enrollment. They also reported that by the end of 1967 some 5.2 million aged had enrolled for their coverage which complements Medicare. Statistics prepared by BCA on just under 2 million such enrollees in 28 Blue Cross plans showed that a total of 233 per 1,000 aged enrollees used the benefit in 1967. There was almost no need for full-pay days (days beyond the Medicare benefit of 90 days)—only 5 days per 1,000 enrollees. The deductible and co-pay benefit applied to 167 days per 1,000 enrolles. Since Medicare is used at a rate of at least 3,100 days per 1,000 beneficiaries, the Blue Cross benefits are not heavily used except for meeting the initial deductible of $40 of the hospital bill (now $44).

Other insurance policies provide straight dollar indemnities for each day in the hospital, sometimes increasing the amounts at the 21st and 90th days.

Usually incompletely, other cash indemnity plans cover ambulatory care and include prescriptions, eye examinations, physical examinations, etc., that are excluded from Medicare.

Prepaid group practice plans have worked out ways of dovetailing benefits so that their Medicare members can continue to receive routine physical examinations, eye examinations, prescribed drugs, and other services not included in Medicare's benefits.

Overall, however, it is apparent that many of the same reasons why voluntary health insurance could not provide the kind of protection the aged needed still hold.

Premiums for adequate benefits are beyond the means of many; the complementary coverage purchased is more often than not limited so that benefits are paid only when the Medicare patient is in the hospital. It is true that a number of the collectively bargained health plans have provided for benefits indefinitely, for pensioned union members and their spouses, but other older people have felt that the premium they are obliged to pay for Part B Medicare benefits was as much as they could spend. The sum of $8 monthly or $96 annually for a couple, in addition to the deductibles and coinsurance the beneficiary must meet, and the expenses for drugs, etc., takes all their modest budget can manage.

[6] "Blue Cross Reports," December 1968, pp. 7-8.

PART TWO

HOW MEDICAL COST INFLATION INTENSIFIES THE PROBLEM

Health care expenditures per aged person in fiscal 1967 averaged two and three quarters times those of people under age 65. (Chart F.) It becomes clear, then, that inflationary tendencies in the health field will have intense impact upon care provided for the elderly, and that public and private sources of this support are certain to be strained during periods of dramatic cost increases. When medical care is excluded from the general price index, medical care prices rose two and a quarter times as fast as other prices in the period since 1957–59.

I. EXTENT OF TODAY'S HEALTH CARE INFLATION

During the period 1960–65, when prices generally were rising less rapidly than at any time since 1946, the Consumer Price Index for daily service charges of hospitals also slowed down—from an annual 8.3-percent rise to a 6.3-percent rise.

In that year—marked by the beginning of Medicare in July—medical care prices rose nearly twice as fast as the annual rate for the 1960–65 period.
But the deceleration stopped abruptly in 1966.

In 1967 the index for hospital charges rose by 19.1 percent and in 1968 by 13.2 percent.

Physicians' fees rose 7.1 percent in 1967 and 5.6 percent in 1968. In the 3-year period ending December 1968, hospital daily charges have risen 52 percent and physicians' fees 21 percent. Overall, medical care services had risen 25 percent.

FIVE SPECIAL PROCEDURES

The Social Security Administration arranged with the Bureau of Labor Statistics in the summer of 1965 to collect prices for three surgical procedures (cholecystectomy, prostatectomy, and fractured neck of femur) and two in-hospital medical services (myocardial infarction and cerebral hemorrhage) that are common among older persons, though not necessarily limited to them. Prices are collected for these five procedures but are not incorporated in the regular sample of the CPI. It was believed that fees for such services might be sensitive to the new Medicare program and hence would provide baseline data to assess the impact of the program on physicians' fees.[1]

These five special procedures are the reason for hospitalization for many elderly people. The average increase of 21 percent found for doctors' charges generally for the 36 months ending December 1968, compared closely with increases of 17 to 21 percent for the five procedures.

[1] As reported in Research and Statistics Note No. 6, 1969, Social Security Administration, Office of Research and Statistics.

Inflation of medical care services and supplies not covered by Medicare affect the elderly on fixed income directly and completely. The 25 percent increase in such items and services can bring real hardship.

DRUG COSTS FOR THE ELDERLY—HAVE THEY RISEN?

While the CPI for drugs and prescriptions shows little change between December 1965 and December 1968, there is a real question whether the surrogate items priced for this index are representative of the kinds of drug therapies the elderly require.[2]

RISING MEDICAL COSTS: IS MEDICARE RESPONSIBLE?

An Estimate of the "Inflationary Flames".—A high level appraisal of rising medical costs was provided on December 31, 1968, when Secretary of Health, Education, and Welfare Wilbur Cohen decided that he would not raise the monthly premium aid by 19 million Americans enrolled in Part B of Medicare.

Secretary Cohen had been advised by the Social Security Administration's Chief Actuary to raise the premium from $8 a month ($4 from Federal sources, $4 from each beneficiary) to $4.40 from each, or $8.80 a month, total. Among the reasons given by the Secretary for his decision were the following:

—The Actuary's estimates of future need were based on estimates that physicians' fees will rise about 5 percent in calendar year 1969 over 1968 and 1½ percent in 1970 over 1969 and that medical utilization under the program will increase about 2 percent in 1969 and 1½ percent in 1970. Thus, the $8.80 premium level was suggested, even though $9 would have been preferable.[3]

—But, said Secretary Cohen: "Any increased premium based on an assumption of as much as 4½ percent increase in physicians' fees is likely to act as a further inflationary factor. Any such estimate is likely to be viewed as a minimum prediction of increase—one which the Federal Government has approved. No one can say with any reasonable degree of certainty what the effect of the proposed increase would be on other parts of the $40 billion medical care industry. Thus, any increase under Medicare also may be reflected in an increase in Medicaid costs and in the premiums that people have to pay for private insurance. Insofar as it is humanly possible I want to avoid further fanning the flames of inflation throughout our entire medical care system."

[2] "*The Drug Users*," one of the reports issued by a HEW Task Force on Prescription Drugs, reports: Although only three of the 14 products in the CPI list are available solely under brand names, and are therefore immune from price competition by chemical equivalents, about three-fourths or more of the most widely used drugs are available only under brand name. Two of the 14 drugs listed in the CPI "market basket"—penicillin and tetracycline—have shown substantial price decreases, largely the result of intense competition from generic-name products, while the other 12 products have shown little or no price change. Finally, the CPI index is so designed that it does not reflect the impact of new and costly products which may be introduced on the market and replace older and less expensive drugs.

The CPI is thus not relevant to the changes which have been occurring in the average price of all prescriptions purchased by patients.

The irrelevancy is indicated by changes shown by three independent indices—the "Lilly Digest Index," the "National Prescription Audit," and the "American Druggist Index"—which demonstrate that the average prescription price has been increasing at the rate of about 2 percent per year during the past decade.

[3] The Actuary's estimate thus included a 10-percent rise in the 2-year period; the extra 20 cents was evidently a margin of safety in the estimate.

—The Secretary also noted that Medicare was enacted during a period of relative stability in the relationship between physicians' fees and prices for other items and wages. During 1965–67, however, the annual increase in physicians' fees was 7 percent, compared to average hourly wage increases of 4.3 percent and a cost of living increase of 2.8 percent. He pointed out:

"A very marked imbalance has developed between the rate at which the physicians' fees have been escalating and the rates at which other indicators have been moving during these years."

—Even more significantly, said the Secretary: "total physician net incomes have increased even faster than the increase in fees for particular services. Based on data from 'Medical Economics,' median physicians' incomes increased 11 percent in 1966 over 1965 and 8 percent in 1967 over 1966. Physicians have not been economically disadvantaged by Medicare."

—Secretary Cohen said he did not believe it is necessary for utilization to increase 2 percent in 1969 and 1½ percent more during 1970. He added:

"I especially urge physicians, patients, families and friends to cooperate in eliminating unnecessary utilization of physicians' services, and I am asking the carriers and intermediaries in their professional review of claims to exercise special diligence during this period."

Medicare and inflation.—As the Secretary's comments make clear, Medicare can generate powerful inflationary forces in the health care market, but, in the Advisory Committee's opinion, and more positively, it can also be a force against runaway costs. The following excerpts from the first annual report of the Health Insurance Benefits Advisory Council of the U.S. Department of Health, Education, and Welfare give a balanced view of what may be possible in either direction:

"In its deliberations, and in drawing up its recommendations, the Council has tried to keep before it two major sets of facts about Medicare.

"On the one hand, this is an insurance program. It finances, for older people, the purchase of services from the providers of health care, most of whom also supply services to all other age groups in the population. As a consequence, Medicare by itself cannot exercise a dominant influence over costs and standards in the health care field. At the same time in exercising its obligations to beneficiaries in the provision of high-quality medical care and its obligation to taxpayers in securing care at reasonable costs, Medicare can, in a limited but important way, indirectly affect the standards and costs of health care for the population at large.

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"While all third-party payers should have an important role to play in seeking and applying cost restraints, this is particularly true of Medicare. The scope and coverage of the program are so large that what Medicare does may set a pattern for many other third-party payment programs.

"One of the reasons that third parties have an important role to play in controlling cost is that most of the forces of typical marketplace situations which act to control costs for nonhealth services cannot perform effectively in the health field. Cost

reimbursement to hospitals offers no built-in incentives to cost restraint. Charge reimbursement to doctors, as well, does not provide the protections against increasing charges that are present in many other economic areas.

"The Council, in common with other parties, is concerned that medical care expenditures and Medicare funds in particular should be spent most effectively in order to maximize the benefits received for the funds expended. The Council is very much aware that there are limits to the time during which medical cost can continue to rise as rapidly as in recent years without creating serious issues of the priority of allocation of further resources to medical care rather than to housing in the inner city, to education or to the multitude of other demands not now fully satisfied. The ways that Medicare sets the amount it will pay for covered services may have very important effects on the entire health care industry.

"*The escalation of physicians' charges.*—The medical insurance program (Part B) is designed to reimburse the beneficiary, or pay on his behalf, reasonable charges incurred for physicians' services, and certain other medical services, subject to applicable deductible and coinsurance amounts.

"The law does not contemplate that reimbursement of physicians will be based on a fee schedule. Nor was it expected that an individual's income would determine the amount of the payment to be made. It is also clear, however, that Congress did not contemplate reimbursement of physicians without controls of any kind over the costs of the program or without limit to the liabilities it assumed. The law thus provides that only reasonable charges shall be reimbursed. To implement this reasonable charge limitation, the law calls for individual determinations or reasonable charges for specific services by the Medicare carrier which may not exceed the amount the carrier customarily pays under its own program under comparable situations and which take into account:

"(1) the customary charges of the physician, and (2) the prevailing charges in the community. The concept of customary charges incorporates the idea that physician's fees to Medicare beneficiaries for a given service should be no higher than his charges to other patients for the same service. As the program has developed, it has become clear that effective administration of this concept requires recognition of the idea that the physician's charges should not be higher than those that have been applicable in his practice for some time—in short, that customary fees should be those that have in fact been established by custom. The concept of prevailing charges incorporates the idea that a particular physician's fees to a Medicare beneficiary for a specific service should not be out of line with the level of fees generally charged in the locality.

"The statute, therefore, is based upon the view that reasonable charges by physicians and other persons under the program include only those which stay within the bounds marked out by the criteria of customary, prevailing, and comparability.

"Enforcement of these concepts, under the Medicare program, is in the hands of the insurance carriers, operating within the regulations and under the supervision of the Social Security Administration. They are required to assure that the charges determined to be reasonable for Medicare meet the customary and prevailing criteria. Comparison of individual charges with a profile of charges derived both from their Medicare records and the records relating to their own policyholders and subscribers, and with other data on physicians' charges are the primary means of determining that the Medicare reimbursement conforms to the statutory requirements."

II. THE QUESTION OF CONTROLS UNDER MEDICARE OR MEDICAID

The Advisory Committee has grave doubts as to whether, in the absence of a free market as is true in the health field, the concept of allowing the providers to control their own reimbursement is susceptible to the imposition of controls. The terms "prevailing" and "customary" are imprecise and hardly made less so by setting the computer to record the 82d percentile. Limits on frequency of allowing individual physicians to raise a fee merely shift to the patient the amount denied and postpone for a period the day when the higher fee is recognized as the particular doctor's customary one.

The Committee has followed the efforts to find incentives that will induce hospitals to operate more economically. It is not difficult to recognize the truth of the situation—that there is little reason to control costs if your largest customer will pay costs, however unjustified they actually are. Neither carrots nor clubs are effective for long in such inflationary settings.

We are also somewhat discouraged at the reports received from Canada that prior budgeting has not met with any great success as a way of containing costs. Nevertheless, we urge some U.S. experiments along these lines.

Noting the interest of the Administration in the prospective influence of the voluntary sector of third-party purchasers on cost, one of the largest private purchasers—the United Auto Workers—has been frustrated in its efforts to maintain standards in the nursing homes it uses. Furthermore, a 20-percent escalation in premiums has occurred in this large nationwide program since the concept of variable fees was adopted.

We note that standards for quality of care for physicians' services outside the hospital can be developed. New York City has done this and it must be done elsewhere.

We must be innovative and active in seeking ways to keep the cost to all—the aged, the remainder of the population, and public and private insurance programs—within bounds.

III. THE QUESTION OF "CHEATING" UNDER MEDICARE AND MEDICAID

As the foregoing discussion suggests, there are serious voids in present-day cost controls under Medicare, and much more must also be done in the setting of standards for services rendered. The same is also true of Medicaid.[4]

There needs to be a reexamination of the use of fiscal agents and intermediaries in these programs from the point of view of their capability and willingness to promptly supply the data necessary to police the providers. There is a real or potential conflict of interest in expecting intermediaries to control utilization and costs in the public interest.

As long as such voids exist, there is always the opportunity for the kind of overcharging and other forms of cheating which are now the subject of intensive investigations by congressional units. Close attention to all such practices is vital, and it is overdue. Profiteering on programs meant to improve health care—and to make it available to people who might otherwise be denied such care—is a moral outrage, as well as an inflationary force in an already volatile market.

It should be remembered, however, that in terms of the sheer dollars-and-cents impact upon individual elderly consumers of medical products and services, overcharging and outright nondelivery of billed services may not be as significant as other factors.

Under Medicare, physicians' charges come to approximately 25 percent of all charges. In fiscal 1968, this meant that $1,291 million were involved; it is too early to say how much of that sum has been absorbed by fraudulent or questionable practices.

Clearly, investigation in this area must continue. But hard analysis must also be provided on matters that in the long run are of more far-reaching importance to individual patients and the health industry itself.

Such matters mentioned here and elsewhere in this report, include:

—Overutilization of expensive and inappropriate facilities.[5]

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[4] It is equally true of other Federal programs that purchase services, including CHAMPUS (Civilian Health and Medical Program of the Uniformed Services); only because they serve other age groups than the aged are they elided here.

[5] Many studies indicate needless hospitalization. For example, a survey in Rochester, N.Y., recently showed that 14 to 18 percent of hospital beds were usually occupied by patients who did not require that level of care. They would have been more appropriately served by less expensive long-term care, home care, out-patient care, or even no care at all. A recent study showed that in New York City the average length of hospital stay of those 65 and over with specific surgical diagnoses increased by 3 to 4 days in the immediate post-Medicare period. Much of the increase occurred between admission and surgery rather than in the postoperative stay.

—The lack of adequate and informative standards for services performed.[6]
—Uneven impact of the deductibles and coinsurance upon those most in need of help and least able to pay.
—The dangers arising from fragmented treatment including failure to coordinate drug prescribing for a patient.

There is some danger that the current investigations of fraud and near-fraud in Medicaid and Medicare may lead to a defeatist or negative attitude toward each program. There is also a danger that such emphasis may well thwart efforts to deal with more fundamental deficiencies in each program.

Reform is needed, but it should be thoroughgoing and it should be positive. This Nation has declared that high-quality medical care is the right of every American. We should be innovative and positive in making changes; we should be as insistent upon upgrading quality as we are insistent that wrongdoing be recognized and punished.

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[6] The case for setting quality standards was vigorously expressed by Dr. Martin Cherkasky, administrator of the Montefiore Hospital in New York City, during 1968 hearings before the Senate Subcommittee on Executive Reorganization. Here is an excerpt:

"Equally disturbing and certainly more dangerous is the total lack of quality standards for physicians treating Medicare patients. Here Congress should act and act quickly. For example, provisions for payment could require that major surgery only be paid for if carried out in an institution fully accredited by the Joint Commission on Accreditation and carried out by a surgeon who is either Board qualified or Board eligible.

"In other words, major surgery should not be paid for by the Government except in unavoidable circumstances unless the surgeon has evidence of the qualifications he should have.

"And, you know, Senator, this is not an insistence upon standards which are meaningless. Cancer of the cervix is a very dangerous and deadly illness. When early cancer of the cervix is operated on by qualified Board-certified gynecologists, there is 80 percent cure rate. When it is operated on, as it often is, by people who don't have these qualifications, there is a 50 percent cure rate. The difference between insisting upon qualifications and no qualifications is the difference between 50 and 80. We are talking about human lives, not about money or anything else.

"Where a Medicare patient has a major medical problem, a consultation with a qualified specialist should be required."

PART THREE

SPECIAL NEEDS OF THE ELDERLY AND THEIR EFFECT UPON MEDICAL COSTS

I. EXTENT OF DISABILITY

As we get older, those of us who survive have increasing need for medical care. Evidence of our increasingly disabled state is not hard to find. For example, 34 percent of the population 45–64 has no chronic conditions, while only 20 percent of the population 65–74 has none, and less than 13 percent of the population 75 and over responds that they do not have one or more chronic conditions.[1]

Among those 45–64, only 3 percent are unable to carry on a usual major activity, such as working, or keeping house. In the 75 and over age group, the figure is 24 percent so disabled that they cannot work or keep house. Bed disability days as well as days of restricted activity increase as age rises.

Per person per year, those 45–64 spend 7.2 days in bed; those 75 and over, 19.4 days. Days on which activity was restricted were twice as high for the oldest group as for the age group 45–64 and three times as high as for the population as a whole. The age group 65–74 was intermediate.

PHYSICIANS' SERVICES

Other kinds of evidence of poorer health include an expanding volume of doctor visits and hospital care as age advances; only in exposure to surgical intervention is there a decline in the rates. Doctor visits outside the hospital rise from an average of five annually for the 45–64 year group to 7.2 for those 75 and over. There is an increase in the proportion of doctor visits to the home—a fourth of all visits for those over age 75 are to the patients' residence [2]—which has cost implications since doctor charges are generally higher for home visits.

HOSPITALIZATION

Hospital admissions and discharges also rise as age increases, as the following tabulation [2] shows:

	Discharges per 1,000	Days per 1,000	Average length of stay
All ages	128.3	1,065	8.3
45 to 64	147.9	1,627	11.0
65 to 74	181.3	2,284	12.6
75 and over	195.6	2,484	12.7

[1] All the data in this section are derived from NCHS series 10 No. 32, *Age Patterns in Medical Care Illness and Disability*. July 1963–June 1965.

[2] NHS data vary slightly depending on the year in which the data are gathered. These figures are for July 1963–June 1965.

More time spent in the hospital connotes larger hospital and doctor bills as a concomitant of aging. As a result, the portion of any medical bills not met by Medicare benefits would also be larger for the oldest ages since the 20-percent coinsurance would be applied to a larger base.

II. LONG-TERM CARE

By definition, a long-term care hospital is one in which the length of stay exceeds 30 days on the average. Such beds are in short supply in the United States except for those in mental hospitals. Tables III IV indicates the national and regional averages in bed supply and demonstrate once more the uneveness of the distribution of facilities. The New England region (region I) has one long-term bed per 1,000 population of all ages and in addition has 2.2 extended-care-facility beds. The only other region coming close to this supply is the Pacific Coast region (region IX), where extended-care facilities are relatively abundant.

The right side of the table relates the bed supply to the population 65 and over. For short stay beds, the figures are relatively meaningless (since the aged compete with the younger population) but for long stay and extended care facilities, the aged occupy 90–95 percent. So the variation in supply from 11.1 to 33.8 per 1,000 means there will be problems in obtaining care in many places.

Nursing home care for the aged cost the Nation $1.2 billion in fiscal year 1967. A little more than half of this amount came from private resources.

With Medicare and the Federal share of title 19 paying for ECF care for 6 months of the 12 months of 1967, the Federal tax dollar paid for 26 percent of the total; State and local funds financed 18 percent. The public share will be rising as Medicare pays more throughout each year and more extended-care facilities and skilled nursing homes are constructed. Quite apart from inflation, to meet desirable standards established for acceptable care, costs will rise with expanded employment of better trained nursing personnel.

TABLE III

PHS regions	Beds per 1,000 civilian population			Beds per 1,000 Medicare Part A beneficiaries		
	Short stay	Long stay	ECF	Short stay	Long stay	ECF
United States	4.0	0.2	1.7	41.0	2.2	17.6
I	4.0	1.0	2.2	36.6	8.8	20.0
II	4.1	.2	1.5	39.1	2.2	14.5
III	3.5	.1	.9	42.8	1.4	11.1
IV	3.6	(1)	1.5	37.6	.4	15.7
V	4.2	.2	1.5	44.3	2.1	15.4
VI	5.2	.1	1.5	43.8	.9	12.3
VII	3.9	.1	1.6	44.0	.6	17.3
VIII	4.1	.2	2.5	46.7	1.7	28.8
IX	3.3	.3	3.0	37.5	3.4	33.8

[1] Less than 0.05.

Source: Based on data from Social Security Administration and Bureau of the Census, prepared by Community Profile Data Center, Public Health Service.

THE NURSING HOME POPULATION [3]

Who are the people in nursing homes and personal care homes with nursing? By and large they are old—the median age is nearly 80—and unwell: 85 percent have two or more chronic conditions or impairments; nearly 25 percent have at least five such conditions. Only 10 percent have a living spouse; the balance are widows, 63 percent, divorced, separated, or never married. Nearly six in 10 were not living with their family or even a relative prior to admission to the home.

The leading conditions and impairments afflicting the residents of these institutions in descending order are (1) vascular lesions affecting the central nervous system, (2) diseases of the heart, (3) arthritis and rheumatism, (4) chronic brain syndrome, and (5) hearing impairments. Together just these five conditions are found 1,249 times in each 1,000 residents, because the residents have more than one condition.

Not surprisingly the residents may spend years in the home. The median stay is about 18 months, the mean stay at least 3 years. Some 17 percent had been in residence 5 or more years.

Only scattered information came to the Advisory Committee's attention regarding monthly charges for care in nursing homes. We are of the opinion that charges have risen sharply from the level indicated by the NHS survey in May–June 1964.

At that time the average monthly charge in a proprietary home was $205, but 48 percent of the residents were paying more than this and 15 percent were spending $300 a month or $10 a day. A $10-a-day charge had become a relatively low charge by 1969.

An indicator of widespread variations in availability of extended-care facilities is given in this table of ECFS now participating in the Medicare program.

TABLE IV.—REGIONAL DISTRIBUTION OF EXTENDED-CARE FACILITIES AND BEDS, PERCENT INCREASE, AND RATIO TO BENEFICIARY POPULATION, JULY 1968

Geographic division	Facilities		Beds		Ratio of beds to 1,000 Medicare enrollees, July 1968
	July 1968	Percent increase since July 1967	July 1968	Percent increase since July 1967	
Total	4,702	+13.0	329,621	+13.2	16.9
United States	4,696	+13.0	329,353	+13.2	17.2
New England	378	+3.3	25,195	+8.7	20.1
Middle Atlantic	562	+16.6	52,131	+14.1	13.5
East North Central	738	+12.7	54,474	+11.0	14.5
West North Central	437	+17.5	23,132	+11.2	12.2
South Atlantic	479	+15.4	36,815	+15.5	14.0
East South Central	226	+22.8	14,456	+27.0	11.8
West South Central	470	+11.1	30,173	+18.1	17.4
Mountain	281	+7.3	16,384	+.5	25.4
Pacific	125	+13.1	76,593	+14.3	33.9
Other areas	6	0	268	−35.3	1.7

Source: "Health Insurance for the Aged: Number of Participating Health Facilities, July 1968." R. S. Health Insurance Statistics, HI-14, June 20, 1969, p. 11; Office of Research and Statistics, Social Security Administration, D/HEW.

[3] Data in this section are from NCHS series 12, Nos. 8, 9, 10, and 12 where the findings from the May-June 1964 survey are set forth.

III. OUTLAYS FOR OUT-OF-HOSPITAL DRUGS

"There are many elderly men and women who have some income and some savings—who may even have sufficient Medicare or other insurance to protect them against the bulk of hospital and medical costs of a brief illness—but who cannot pay for the out-of-hospital drugs and other costs of a long-continuing chronic illness without seeing their financial assets eroded or totally dissipated."—HEW Task Force on Prescription Drugs, final report, February 7, 1969.

Drug costs rise sharply with age (Chart F). Like other medical needs, both the quantity used and the cost per acquisition is likely to be above the averages for younger persons. The situation is illustrated by the following table:

	Number of drug acquisitions	Average cost per purchase	Yearly average cost per person
Age group:			
All ages	4.7	$3.60	$21.00
Under 15	2.8	2.60	10.40
15 to 24	2.7	3.40	12.50
25 to 44	4.2	3.70	20.00
45 to 64	6.6	4.10	31.80
65+	11.4	4.00	50.20

Source: NCHS series 10 No. 33 "Cost and Acquisition of Prescribed and Nonprescribed Medicines, United States' July 1964–June 1965, PHS Publication No. 1,000, 1966.

Averages, however, tell only a small part of the story of drug use and costs among the elderly. The HEW Task Force report makes it clear that the costs fall heavily upon those likely to be already under heavy financial pressures.

Highlights from the report

—Per capita expenditure for the elderly with severe disabilities was nearly three times greater than that for those with none.

—A 1968 estimate indicates that 20 percent of the elderly have no drug expenses, while the costs will be less than $50 for 41.5 percent, between $50 and $99 for 19 percent, between $100 and $249 for 15.5 percent, and $250 or more for 4 percent.

(*NOTE: Half of all older people living alone or with nonrelatives, during 1967, had annual incomes of less than $1,480; one in four had as little as $1,000 or less.*)

—The average number of acquisitions for elderly women was nearly 50 percent more than for the men, and the per capita expenditure for elderly women was more than one-third higher than that for elderly men.

(*NOTE: Six of ten of all widows and other aged women living alone have incomes below the poverty line.*)

—For the elderly with one or more chronic conditions, the annual costs of prescribed medicines was $48.80; for those with conditions which limit major activity completely, costs averaged $78.80. Prescription expenses of those of the elderly with severe chronic conditions—*about 15 percent of all elderly persons*—were over six times as great as the expenses of younger people.

—Only 10 percent of the 65+ population had private health insurance for out-of-hospital prescription drugs at the end of 1966. Where such coverage is purchased, it is financially helpful only in so-called "catastrophic illnesses." It is generally included only in major medical policies involving deductibles of $100, $250, or $500 which the aged must pay himself.

—Income tax deductions provide relief for only an estimated 8 percent of drug expenditures of the elderly, and such relief benefits only those elderly individuals who receive enough income to income tax payments.

After surveying such data and studying the patterns of drug use among the elderly—for "therapeutic," "diagnostic," or "maintenance" purposes—the HEW Task Force concluded that the disproportionately high expenditures among the elderly, combined with a widespread inability to pay for such drugs "may well be reflected in needless sickness and disability, unemployability, and *costly hospitalization which could have been prevented by adequate out-of-hospital treatment.*" [Emphasis added.]

Futhermore, declared the Task Force, the problem is destined to become increasingly serious as unit prices of prescriptions increase, and the armamentarium of useful drugs expands.

This Advisory Committee emphatically agrees with the Task Force conclusion that "there is a need for an out-of-hospital drug insurance program under Medicare."

This Advisory Committee also must point out, however, that while such action is vital for a significant number of high-risk elderly individuals, it will not materially reduce the overall medical expenditures facing the great majority of the elderly.

IV. DENTAL CARE

National Health Survey data[4] show that over half of the 65+ group have not seen a dentist in more than 5 years, and that even in high- or middle-income groups the average number of visits to the dentist is no higher than among those with less adequate income.

One explanation for the limited demand for dental visits may be that the older population—after decades of inadequate care in the past—includes a large number of persons who are toothless.

Among those 65 and over, between 50 and 60 percent have lost all their teeth; the proportion increases as age advances.

Another reason may be that many older persons regard visits to the dentist as unnecessary once they have made the sizable outlay necessary to acquire dentures.

There is little doubt, however, that neglect plays a large role. And, as a result of earlier neglect, 42 percent of the visits to dentists that those age 65 and over do make are for denture work, compared to 11 percent for the population under 65. This finding only emphasizes that those who still have all or some of their teeth are not taking adequate care of them, Further evidence to support this thesis was provided by a recent survey of dental services carried out by the Council on Dental Health and the Council on Hospital Dental Serv-

[4] Series 10, No. 29

ice of the American Dental Association with the cooperation of the American Nursing Home Association. Forty-four percent of the nursing homes surveyed indicated that none of their patients had received any dental are. More than 63 percent of the homes for the aged (those without nursing care) reported that none of their patients received dental treatment.

"Although dental care is needed by a significant percentage of these people, there was no demand for care," reported the American Dental Association, which also concluded: "* * * the attitudes and motivation of older persons toward dentistry need to be examined."

Conditioned as we in this Nation are to dental care neglect among the elderly, we give too little heed to what may be a growing demand for dental services for individuals in the upper age groups. This demand could be a natural component of the current insistence on high-quality medical care for all, and it is a health demand which should be met.

Such prepayment of dental care as there is, holds little promise for those whose teeth have been neglected over the years.

PART FOUR

DEFICIENCIES IN DELIVERY OF SERVICES

As the preceding chapter suggests, Medicare and Medicaid helped create inflationary pressures by raising new demands for medical services that were unavailable or in short supply.

Thus, deficiencies in the delivery system for health care services played a direct role in creating dollars and cents problems now encountered by elderly people who need medical care.

Less apparent, but certainly of considerable impact, are other difficulties caused by faulty organization or nonexistence of services.

Tables and statistics can tell only part of the story here. Perhaps several examples can make the following point:

The elderly, along with other age groups, suffer, not only in terms of inconvenience, but also in terms of direct dollar outlays because of irrational or outmoded delivery systems for medical care and services.

EXAMPLES

Multi-Problems Cause Multi-Stops: Ill, elderly persons usually have more than one ailment at a time. If they cannot get "one stop" service for examinations or treatment, they become prime victims of a health care system recently described by Social Security Commissioner Robert Ball [1] as "largely decentralized, largely uncoordinated, and largely voluntary." Surgeon General William H. Stewart calls it a nonsystem.

One poignant example, provided during a hearing by the U.S. Senate Special Committee on Aging, is repeated here because it offers a classic study of an aged man who, even with financial resources for treatment, paid a heavy price for having multiple health problems. It is a story of a patient who:

> * * * had a serious eye problem—actually two diseases: glaucoma and keratitis—for which he received care at a nearby medical center, in the department of ophthalmology. His personal doctor, a good internist, however, had diagnosed a mild diabetes, and for this periodic visits were necessary to an office 8 miles away. Painful corns and bunions, impairing the ability to walk, were not within the speciality of the personal doctor, so these required periodic visits to a podiatrist at an office 6 miles in another direction. Dental care, in an effort to save the few remaining teeth, so that dentures would fit more firmly and food could be more properly chewed, required numerous visits to a dentist at still another location.

[1] In speech Jan 9, 1969, before the New York Regional Health Care Cost Conference.

Then a bladder problem developed and prostatic disease was suspected. At about the same period, the patient showed lethargy and confusion, suggesting a mild cerebrovascular accident. The personal doctor made a home call and the decision was to hospitalize. A bed was not immediately available—except in a small proprietary hospital which the family refused—and it was not till 10 days later that he could be admitted to a good voluntary general hospital 15 miles away. After X-rays, cystoscopy, and other examinations there, his treatment was stabilized. In the workup, it was discovered that a drug the ophthalmologist had been prescribing for many months was causing serious side effects, which had been missed by the internist since these two specialists had never communicated with each other. The patient was then admitted to a sanatorium, selected for its closeness to the family home, so that visits from the patient's children would be possible daily.

This was one of the "better" nursing homes—it was certainly expensive enough at $32 a day paid by Medicare—but this was evidently not costly enough to support a proper staff. After a few days, because of lack of proper surveillance, this aged patient was found roaming on the street. When this happened a second time, the commercial proprietor decided to discharge the patient as "too difficult to care for." It took 5 weeks of nursing care at home, with daily problems of incontinence of urine and feces, before a bed in another nursing home became available.

The latter facility proved to be better managed and the patient improved. After only 2 weeks, however, he was getting up from a chair one day, when he fell and fractured his left hip. This required an orthopedic surgeon, readmission to the hospital, and preparation for a major operation. But then complications to the diabetes set in, because of the traumatic shock of the fracture. A delay of over 24 hours in reporting a critical laboratory test nearly cost the patient's life at this time. Had the hospital been adequately staffed, this delay would not have occurred. A skillful operation, with a pinning of the broken bone, was done. Special-duty nurses costing $111 per day—over and above the Medicare coverage of the hospital bill—had to be hired because of the shortage of regular hospital nurses.

I have not recounted the other details of multiple-drug prescriptions, special services of an appliance shop to adjust the bed at home, the physical therapy required for a knee injury, and much more. This patient was my widowed father, who lived with my wife and me for 9 years after his retirement from 51 years of medical practice. My abbreviated account of his medical care problems applies only to the last year, or it would be much longer. Accounts like this could be told thousands of times over, each day in the United States, and would doubtless be more complex and disturbing for a family less well informed about the jungle of medical care delivery. * * *

The witness before the committee was a professor of public health and a doctor of medicine.

Even with Medicare, even with sympathetic and knowledgeable guidance, the patient in this case encountered expensive, disturbing obstacles to swift and appropriate treatment. For the low-income

elderly, the problems can be even more intense, so much so that the health problems may reach the crisis stage before help is sought, thus increasing the dollar expenditures paid from public or private sources.

Among the problems faced in poverty areas: [2]

—There is a dearth of health personnel in neighborhood settings, and unavailability of transportation to health resources.

—Physicians' services are often not available on nights and weekends.

—Hospital emergency services become more and more the only resource available, and often the quality of care suffers because of fragmented attention.[3]

Uneven distribution of physicians.—Many urban and rural areas are so bereft of physicians that the elderly must either do without their services or make tiring journeys for treatment or tests, such as eye or foot examinations. One response to this problem has been establishment of Office of Economic Opportunity neighborhood health centers in poverty areas. For those slightly above the poverty level, even the help of an OEO center may not be available.

As the following table makes clear, physician availability varies widely in the United States.

PHYSICIAN AVAILABILITY BY REGION, DECEMBER 1967

PHS region	Total physicians [1]	Number per 100,000 population
Region I	17,896	159.0
Region II	60,747	163.8
Region III	23,275	108.8
Region IV	21,114	93.4
Region V	44,497	113.9
Region VI	17,143	107.8
Region VII	18,881	95.9
Region VIII	5,732	122.4
Region IX	39,897	148.8
United States	249,182	125.5

[1] Excludes physicians in Federal service and those whose major professional activity is other than patient care.

Source: Based on data from American Medical Association, prepared by Community Profile Data Center, PHS.

Uneven distribution of facilities.—Enrollment in Medicare does not guarantee that an older person will necessarily receive the most appropriate kind of treatment. Hospital beds, for the most part, are in good supply. But wide variations exist in the availability of extended-care facilities and other forms of long-term care. It is a sad but prevalent truism in many parts of the United States that large numbers of elderly patients, including those on Medicare, stay on in expensive hospital beds longer than they need because of shortages of nuring home accommodations and absence of home health programs.

Central urban areas are especially hard hit and as a result elderly patients may be sent to nursing homes in distant suburbs or even farther out to rural areas. In such cases, nursing home care may be lower in cost than in the cities, but the effect upon the patient—who is quite often thus isolated from family and friends—can be disastrous.

[2] Summarized from statement to the Senate Committee on Aging by Dr. Frank Furstenberg, medical director of the Sinai Hospital of Baltimore.

[3] A social worker for a citywide health service project in New York City reported to the committee that, "Different medications and courses of treatment are prescribed by individual doctors," as elderly patients receive fragmented care at clinics, hospitals, or emergency rooms.

SUMMARY: THE NEED FOR ALTERNATIVES TO HOSPITALIZATION

Clearly, since hospital charges are the fastest rising component of medical costs today, any strategy directed at reducing those costs should be aimed at offering less costly alternatives wherever possible.

The Social Security Administration—before and since the Medicare program began—has recognized this fact, at least in expressions of official intent. But, in a recent analysis[4] of existing and potential resources, SSA reached the following major conclusions:

1. In many communities the less costly alternatives to inpatient hospital care, such as hospital and other outpatient services, home health services, extended-care facilities, and nursing homes are often in short supply.
2. In some communities, there is often an excess in supply—resulting in wasteful duplication of certain services and facilities, including some very expensive hospital services that involve heavy stand-by costs. Health facility planning is not now performed adequately.
3. Services, especially costly hospital services, are sometimes utilized unnecessarily; i.e., they are not medically necessary.
4. Many private health insurance plans produce undesirable incentives to use the most expensive methods of care.
5. Many possible hospital management improvements have not been adopted.
6. The growth of group practice has been retarded by legal bars and restrictive attitudes.
7. Productivity in the provision of medical care has not been defined and measured.
8. Insufficient attention is given to financing preventive care and health education.
9. There are insufficient financial incentives to restrain mounting hospital costs while maintaining high-quality medical care.

Similar conclusions were reached in an annual report issued in June 1969 by the Health Insurance Benefits Advisory Council. HIBAC, discussing utilization of health services under Medicare, made the following points:

—Use of health services for the aged increased significantly under Medicare, but utilization rates vary widely from State to State and area to area, in a pattern which confirms the view that utilization of a particular service depends to a significant degree on its availability.

—In the case of hospitals, the variations in use, payments, and in hospital admission rates appear to be, in part, associated with the number of available hospital beds per 1,000 population.

—"However," the report, added, "such factors as the availability of physicians in a community, their staff privileges and the geographical proximity of other health services and local customs on use of extended-care facilities and home health agencies (their use varies widely) must also contribute to these variations in both the hospital and medical insurance programs."

[4] "Annual Report on Medicare," pp. 16 and 43.

—Home health agencies, in particular, offer uneven coverage. Scattered among 25 States are 99 counties with populations over 40,000 without a home health agency; in Rhode Island the "start of care" rate per 1,000 beneficiaries was 34.3 at the end of June 30, compared to 3.2 in Mississippi and 3.3 in North Carolina; and there are wide variations in the range of services offered.

Each organizational deficiency listed above, together with others described in this section, causes financial, social, and moral problems not only for governmental agencies, but also for elderly individuals. Until the problems of persons needing direction, understanding, and treatment, rather than delay, confusion, or indifference are resolved, the economic problems of the elderly will be needlessly intensified.

PART FIVE

CONSIDERATIONS FOR FORMULATION OF PUBLIC POLICY

The Advisory Committee believes that a comprehensive, compulsory health insurance program[1] for all age groups—a program with built-in cost controls, standards for quality care, incentives for prepaid group practice, and other badly needed reforms—offers the best hope this Nation has for living up to the oft expressed declaration that good health care is the right of every man, woman, and child who lives in this land.

As a vital prerequisite for establishment of a national health insurance program, and while there exists a dual system of financing through social insurance and by general revenues, public and private efforts should immediately be made to deal with demonstrated deficiencies in Medicare, because:

1. Health-care problems of the elderly are still widespread, and they remain urgent.
2. Three years of experience under Medicare have provided invaluable lessons in the operation of a major public health insurance program. The time has come to heed those lessons.
3. Current investigations into profiteering under Medicaid and Medicare have helped focus attention upon the need for cost controls and establishment of uniform standards of care. Such reforms can have a beneficial effect upon the entire health industry and can combat medical cost inflation.
4. Success in improving Medicare will lead to more general acceptance of steps necessary to provide higher quality health care to our entire population.
5. The lack of sufficient consumer representation in Medicare and its almost total absence from State advisory committees for Medicaid is deplorable.

It is not the function of this Advisory Committee to offer a detailed program for action, but it can offer some general recommendations:

- **The Advisory Committee believes Part B of title 18 should be recast, to bring it under the social security payroll tax and do away with premium payments by the aged. This rearrangement would then make possible several simplifications of benefit administration, including:**
  - **(1) Permitting capitation payments to group practice plans providing hospital and physician services.**
  - **(2) Fostering use of home health services without reference to coinsurance.**

[1] Approximately 160 million Americans have some form of health insurance but such coverage pays for only about one-third of all consumer expenditures for health care. Medicare pays less than 50 percent of the medical costs of the elderly.

- **The Advisory Committee believes Medicare benefits should be extended—**
  - **(1) To include other services and supplies not now covered, and especially those drugs that are important for the treatment of the chronic diseases that commonly affect the aged. Eventually all prescribed drugs should be included.**
  - **(2) To eliminate the deductible and coinsurance features of both Parts A and B.**
  - **(3) To do away with the 3-pint deductible for blood and the 3-days-in-the-hospital requirements for admission to an extended-care facility, and the lifetime limitation on the mental hospital benefit.**
  - **(4) To include preventive and diagnostic services more fully, and eye and foot care.**
- **No matter how much money we pump into Medicaid, a mechanism that simply pays bills is not the answer to a problem that calls for improving the delivery system.**
- **Nursing homes must be brought into the mainstream of medical care by truly being adjuncts of nonprofit hospitals. Standards for nursing home care must be constantly raised.**
- **Every encouragement should be given to the expansion of prepaid group practice, a demonstrably more economical and efficient method of using our health resources. In addition to the higher quality and more comprehensive health care provided by such means, the team approach to delivering medical care would permit essential supportive services for the aged in relation to their social and financial problems. For example, the elderly need a place to turn for information on supplementary insurance.**
- **Another kind of social service would recognize problems connected with discharge from hospital. As a condition of participation in Medicare, every hospital should have a discharge planning committee.**
- **The Advisory Committee considers that Medicare has established itself in the daily lives of millions of Americans; physicians should no longer be permitted to refuse to recognize it by not taking assignment of benefits.**
- **The Advisory Committee believes that physicians' fees cannot remain subject to the whims of individual providers of service, if Medicare and Medicaid are to be fiscally predictable and gross abuses are to be stopped. The same is true of hospital costs.**
- **The Advisory Committee believes that standards for physicians' qualifications should be promulgated by Medicare to require that qualified surgeons alone be allowed to perform operations.**
- **The Advisory Committee hopes to see greater emphasis on prior budgeting and controls of costs for hospitals, extended-care facilities, home health agencies, and on more meaningful utilization review than is often the case.**
- **There should be more consumer participation in the decision-making processes under Medicare and Medicaid.**

Since the Advisory Committee anticipates a universal program of health insurance, programs of public medical care based on a means test would disappear. In the interim, while reliance must be placed on Medicaid to help with the problems of the younger poor, there must be far more coordination of the two programs than presently exists.

Each can thus benefit from the activities of the other in areas of cost control, quality control, sanctions against abuses of the programs, etc. These coordinated activities will smooth the transition to a program of high quality care for all Americans.

Submitted by the Advisory Committee:

AGNES W. BREWSTER.
S. J. AXELROD, M.D.
MELVIN A. GLASSER.
BERT SEIDMAN.

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