87th Congress
2d Session

COMMITTEE PRINT

BACKGROUND FACTS ON THE FINANCING OF THE HEALTH CARE OF THE AGED

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

EXCERPTS
FROM THE REPORT OF THE
DIVISION OF PROGRAM RESEARCH,
SOCIAL SECURITY ADMINISTRATION
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

MAY 24, 1962

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
84130° WASHINGTON : 1962

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington 25, D.C. - Price 20 cents

SPECIAL COMMITTEE ON AGING

PAT McNAMARA, Michigan, *Chairman*

GEORGE A. SMATHERS, Florida
CLAIR ENGLE, California
HARRISON A. WILLIAMS, JR., New Jersey
OREN E. LONG, Hawaii
MAURINE B. NEUBERGER, Oregon
WAYNE MORSE, Oregon
ALAN BIBLE, Nevada
JOSEPH S. CLARK, Pennsylvania
FRANK CHURCH, Idaho
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
EDWARD V. LONG, Missouri
BENJAMIN A. SMITH II, Massachusetts

EVERETT McKINLEY DIRKSEN, Illinois
BARRY GOLDWATER, Arizona
FRANK CARLSON, Kansas
WALLACE F. BENNETT, Utah
PRESCOTT BUSH, Connecticut
JACOB K. JAVITS, New York
WINSTON L. PROUTY, Vermont

WILLIAM G. REIDY, *Staff Director*

LETTER OF TRANSMITTAL

MAY 24, 1962.

To Members of the Special Committee on Aging:

A report, "The Health Care of the Aged," recently issued by the Department of Health, Education, and Welfare, has enabled us to update and expand our two reports prepared last year for the use of the Special Committee on Aging. These earlier reports were "Health and Economic Conditions of the American Aged—A Chart Book" and "Basic Facts on the Health and Economic Status of Older Americans."

The present staff report consists of excerpts from the Department's comprehensive summary of the reference data and background facts related to the financing problem of the health care of the aged. In excerpting these data, we have concentrated on facts most relevant to the health and economic conditions of older people, the subject of our two earlier committee prints. We have excluded the section of the Department's report which deals with "Public Programs and Philanthropic Arrangements for Medical Care," primarily because a forthcoming staff report will be devoted to an analysis of the Kerr-Mills programs.

Obviously, the condensation submitted herewith cannot serve the same purpose as the complete and thoughtful analysis in the report prepared by the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare. It should be useful, however, for those who do not have access to the Department's report or who need a briefer reference volume.

We would like to express our appreciation to the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare, for making this staff report possible, and particularly for its cooperation in providing the charts used in the report.

PAT MCNAMARA,
Chairman, Special Committee on Aging.

CONTENTS

	Page
Letter of transmittal	III
Summary	1
Chapter 1. Number and characteristics of the aged	11
Characteristics of persons 65 and over	11
Age and employment	13
The aged eligible for OASI benefits	14
Chapter 2. Health conditions of the aged	17
Chronic conditions and limitation of activity	17
Days of disability	17
Summary	18
Chapter 3. Use of health services by the aged	19
Physicians' services	19
Utilization of general hospitals	19
Factors affecting time spent in general hospitals	20
Utilization in last year of life	21
Nursing homes and other long-stay institutions	22
Nursing services	23
Drugs	23
Dental care	24
Chapter 4. Health expenditures	25
Total medical costs	25
Medical costs and income	27
Hospital costs	28
Impact of hospitalization on total medical costs	30
Chapter 5. Resources and budget needs	33
Money income	33
Income and retirement	33
Income and family situation	35
Other financial resources	38
Homeownership	40
Noncash income	40
Measures of need	41
Budget needs of retired and younger worker families	41
Tax provisions favoring the aged	42
Federal tax savings	42
State and local tax provisions	42
Chapter 6. Private health insurance	43
Availability of health insurance to the aged	43
Group coverage before retirement	43
Group coverage after retirement	43
Policy conversion	44
Initial nongroup enrollment	44
Restrictions because of age	44
Restrictions because of ill health	45
Renewal guarantees	45
Promotion of sales to the aged	46
Low benefit ratio on individual insurance	46
Paid-up-at-retirement policies	47
The extent of health insurance protection for the aged	47
Reasons why aged persons do not have insurance	49
Chapter 7. Methods of paying for medical care	51
Using own resources	51
Help from others	52
Medical need and public assistance	53
The role of hospital insurance	53
Length of stay and portion of bill covered	53
Amount of insurance and amount of hospital utilization	55
Chapters 8 through 10. Excluded in their entirety.	

Page

Chapter 11. Trends in selected health services and costs 57
Trends in health care costs 57
Overall health costs and prospects 58

TEXT TABLES

1. Age and sex: Number and distribution of persons 65 and over in the United States, 1950 and 1960 11
2. Marital status and living arrangements: Distribution of persons 65 and over, by sex and age, for the United States, March 1961 12
3. Work experience: Distribution of persons 65 and over by sex, 1950 and 1960 13
4. Persons aged 65 and over in the United States with money income: Estimated number and distribution of persons by type of money income, June 1961 14
5. Aged population receiving OASDI and OAA benefits: Number and percent of aged population, June 30, 1961 15
6. Aged population and eligibility for OASI: Estimated number of persons by age, 1964, 1970, and 1980 16
7. Chronic conditions and limitation of activity: Percent distribution of persons by age, July 1959–June 1960 17
8. Restricted-activity and bed-disability days: Number per person per year by age and family income, July 1959–June 1960 18
9. Physician visits: Number per person per year by age and family income, July 1957 to June 1959 19
10. Hospital utilization: Annual rates in short-stay hospitals by age, July 1958 to June 1960 20
11. Hospital discharges: Percent distribution of patients discharged annually from short-stay hospitals by age and length of stay, July 1958 to June 1960 20
12. Hospital utilization: Annual rates in short-stay hospitals by age and family income, July 1958 to June 1960 21
13. Utilization of long-stay institutions: Annual rates for aged OASI beneficiaries by type of institution, 1957 23
14. Persons receiving care at home: Rates per 1,000 population by age and type of care, July 1958 to June 1959 23
15. Drug expenditures: Amount by private individuals, by age, 12-month period, 1957–58 24
16. Per capita medical expenditures: Amount by private individuals by age and type of service, 12-month period, 1957–58 26
17. Out-of-pocket medical costs: Distribution of families by percent of income spent, 1957–58 27
18. Charges for hospital services: Average per patient by age, Michigan hospitals, 1958 29
19. Hospital costs: Distribution of costs of hospital care for hospitalized aged OASI beneficiaries by marital status and insurance status, 1957 30
20. Hospitalization and total medical costs: Distribution of total medical costs for the year incurred by aged OASI beneficiaries with a general hospital stay, by marital status and insurance status, 1957 31
21. Money income of men aged 65 and over: Annual amount and percent distribution by work experience and source of income, 1960 33
22. Money income of families: Distribution by amount for families with head aged 65 and over, by source of income, and number of earners, 1960 34
23. Money income of persons 65 and over: Distribution by amount and sex, 1960 35
24. Money income of families and persons living alone or lodging: Distribution by amount and age, 1960 36
25. Money income of persons living alone or lodging: Annual amount and percent distribution by amount of income, age, and sex, 1960 37
26. Value of liquid assets: Distribution of spending units by size of holdings and age of head, early 1960 38
27. Total assets: Distribution of spending units with head 65 and over according to type by value of assets, 1960 38

Page

28. Savings and health insurance: Distribution of couples with head aged 65 and over and other persons aged 65 and over according to savings and insurance coverage by money income, 1959 39
29. Budget costs: Relative costs for retired persons and members of city worker's family by category, 1959 41
30. Blue Cross and Blue Shield plans: Age limits on initial nongroup enrollment, end of 1961 45
31. Insurance coverage of aged persons: Percent of aged persons with hospital insurance by income, July to December 1959 48
32. Reasons for no hospitalization insurance: Percent of aged OASI beneficiaries who did not have insurance, 1957 50
33. Old-age assistance: Distribution of cases opened by reasons for opening, by OASDI status, 25 States, January–June 1961 53
34. Insurance coverage of hospital costs: Distribution of short-stay hospital discharges according to proportion of bills paid by insurance, by age and length of stay, July 1958–June 1960 54
35. Insurance coverage of hospital costs of OASI beneficiaries: Distribution of aged beneficiaries in general hospitals according to proportion of costs paid by insurance, by marital status and hospital ownership, 1957 55
36. Insurance status and hospitalization in public institutions: Distribution of aged OASI beneficiaries in general hospitals by hospital ownership and insurance status, 1957 56
37. Consumer Price Index: Percent increase by category and for selected medical care items, 1950 to 1961 and 1940 to 1961 57

SUMMARY

New developments in medicine and the better living conditions attendant upon our growing productivity now keep more and more people alive beyond the biblical span of three score and ten. At the same time, there is a tendency to retire the worker from active employment at a progressively younger age—leaving him more years to get along on reduced income.

OASDI and related income-maintenance programs developed over the last quarter century assure continued basic self-support for most persons after they reach age 65. Years of prosperity and advancing wage levels bring to many persons in later life some security in owned homes and other savings accumulated during the working years. But for nearly all, the burden of health costs casts a heavy shadow over the prospects of retirement.

Persons 65 and over now total over 17 million, and their number is growing faster than the rest of the population. Today out of every 11 persons, 1 has passed his 65th birthday. By 1980, the proportion may well be more than 1 out of 10 and the number 25 million. Because women tend to outlive men, the aged population includes a disproportionate share of widows. Indeed, the 65 and over group has almost as many widows as married men. Close to half of the widows are past 75. It is in the oldest age groups that illness costs become especially high, and it is usually the widows who have the least financial resources.

The majority of the aged maintain independent living arrangements: About 7 in 10 live alone or with a spouse or one other relative; little more than half a million in all live in institutions. While independent living brings its own satisfactions, it usually means living on a rather restricted budget, and often with no one at home to help out during illness.

Few at age 65 can count on continuing to earn their living for the remaining years of life. In mid-1961, fewer than 1 in 4 of those 65 and over had any income from employment, even counting wives whose husbands worked. Furthermore, most of those who worked were not working full time, merely supplementing payments under a public program. More than 9 in 10 aged persons now receive income from some public program, whereas only 1 in 20 is still working and drawing no income from a public program.

Public programs obviously are limited in what they pay. On the average, the aged person has to get along on only half as much income as the younger person in a family of the same size. While the older person's total needs are less than those of the younger person, they are far from 50 percent less.

Today 9 out of 10 workers are accumulating credits towards retirement benefits under the OASDI program. Persons currently drawing benefits, or eligible to do so if they choose to retire, already number three-fourths of those 65 or older and eventually should include

almost every one. (The few not included will for the most part come under one of the other public retirement and income-support programs.)

Although OASI benefits to retired workers have been rising, the current average monthly payment of $76, or even the current maximum of $125 for a retired worker or $187 for an aged couple, is not likely to make for comfortable living without additional resources, particularly when serious illness strikes.

Medical bills for the aged person come high, judged both in terms of the dollar total and in the light of his limited resources. Older persons pay out more for medical care than young persons, and these payments take a larger share of their small income—and the share would be even greater if all the elderly got and paid for the care they needed.

How much care do the aged need? Persons 65 and over are twice as likely as younger persons to suffer a chronic condition, and six times as likely to have one restricting or limiting activity. By age 75 every fourth person (not in an institution) is totally unable to carry on normal activity—work or keep house. The average old person is incapacitated 5 weeks of the year by illness or injury, with two of these weeks spent in bed.

Aged persons as a group see doctors and get medical attention more than younger persons, but many, particularly those with low income, go without care that could bring relief. From 40 to 50 percent of those who have arthritis and rheumatism, or hernias, or who have trouble seeing or hearing, for example, and 1 out of 7 with a heart condition, are not currently under medical care. It is the aged in families with low incomes who are more likely to have incapacities and illnesses, but it is those in families with high incomes who see the doctor more often.

Hospital care for anyone poses a special problem because of the large and usually unexpected bills, making it difficult to plan ahead of time. It is especially difficult for the aged. The aged person has a 1 in 6 chance of going to a hospital in a given year, somewhat higher odds than for the person under 65. Also, once he is admitted, the aged person can count on staying an average of 2 weeks, as opposed to 1 week for younger patients. Thus, he can expect a hospital bill twice that of his younger fellow patient. What makes the situation still worse is that less of the older person's bill will be met by insurance.

Among the aged, as among the rest of the population, it is those most in need of health insurance who are least likely to have it: the chronically ill, the ones not working, and those with low income. Such persons generally either find the costs of insurance beyond their means, or are considered too poor a risk for the commercial insurer. Some who have protection find the policy canceled when they most need it—when they develop expensive long-drawn-out "conditions," or when they reach the older age brackets, although currently more noncancelable policies are being written.

Sometimes the aged person himself discontinues the protection he had before retirement, because he no longer has the advantage of the lower group rate and must pay more on an individual basis—and usually for less adequate benefits. In addition the share paid by the employer is often stopped altogether, leaving much higher premium costs at the time income is sharply cut.

No more than half the aged today have any protection against hospital costs—the most common form of health insurance. According to the National Health Survey, just about half the elderly patients discharged from a short-stay hospital had no part of the hospital bill paid by insurance. Such insurance as was available was more likely than not to cover only short stays. Insurance took care of as much as three-fourths of the bill for 6 out of 10 stays under a month, and fewer than 5 out of 10 lasting a month or more.

Although the average elderly patient leaves the hospital within 2 weeks, nearly 1 in 10 remains a month or longer. The longer his hospitalization lasts the more likely is the aged person to need help in paying for his care. Among OASI beneficiaries in a general hospital 3 out of 4 of those staying as long as 2 months, and 1 out of 2 of those hospitalized for shorter periods could not assume responsibility for all of their own medical costs.

The burden of paying for hospital care is even greater when one takes account of those who do not leave the hospital alive. Terminal illnesses often are especially expensive and those at the older ages, most likely to die, are least likely to have any insurance. Often they leave a legacy of debt with a heavy burden on surviving widows.

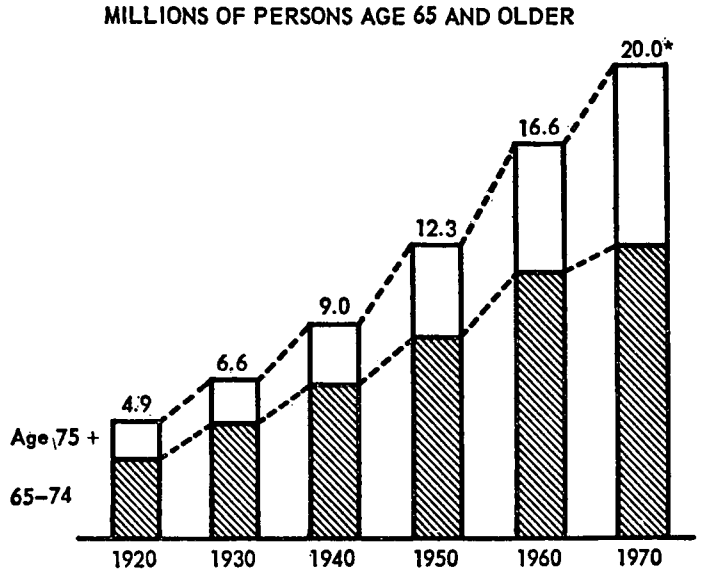
No one can foresee just when he will enter the hospital—although 9 out of 10 persons who reach age 65 are sure to go at least once in their remaining lifetime. But all the evidence indicates that the year one does have to go will be characterized by unusually high medical bills of all kinds. In 1957–58, for example, hospital care costs, excluding those paid out of public funds, averaged $49 per person 65 or older. For those who actually had a hospital illness, however, costs were seven times this much. Their doctors' fees for inhospital visits were twice as great as the average total bill for all doctors' visits in the year—in or out of hospital.

Aged OASI beneficiaries in general hospitals during 1957 had total medical bills for the year five times as high as those with no hospital illness—not counting the costs of persons unable to report them—often because some care was given without charge or paid for directly by a public or private agency. For beneficiaries who went to a hospital, the hospital charges alone represented close to half the total medical bills for the year. They were two to three times as large, on the average, as the total medical costs for the year for beneficiaries who did not have a hospital illness.

84130°—62——2

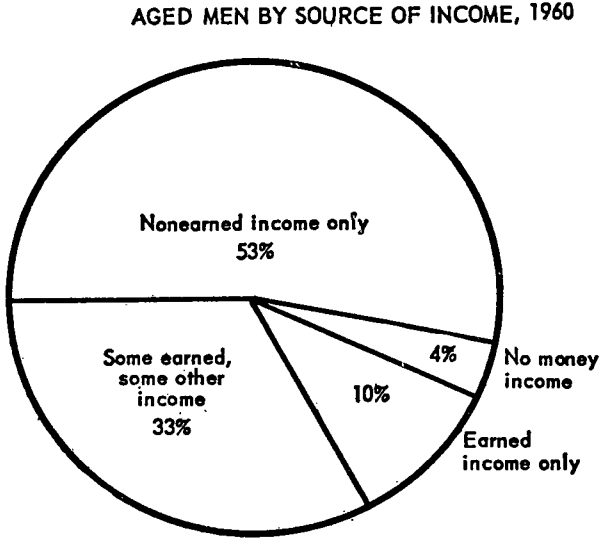
HEALTH PROBLEMS OF THE AGED

1. More and more people live to increasingly older ages.

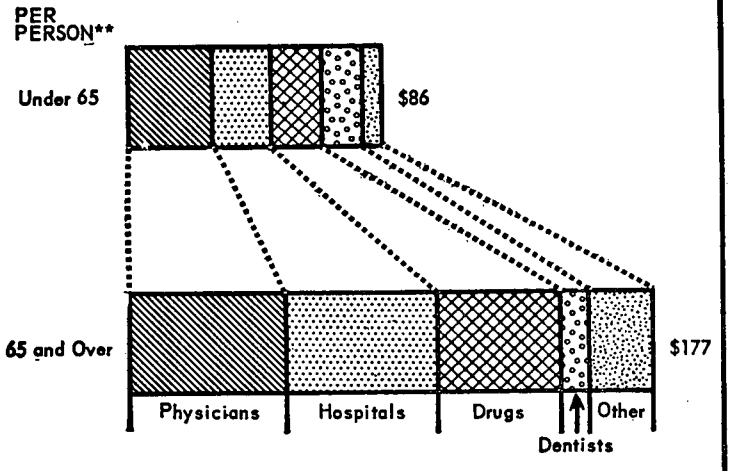


*Projected

2. Few men over 65 are still working; most depend in part on public programs.

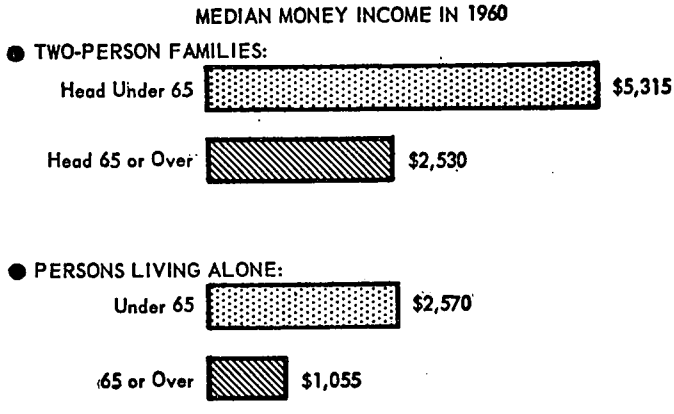


3. Average medical expenses in a year are at least twice as high in old age.



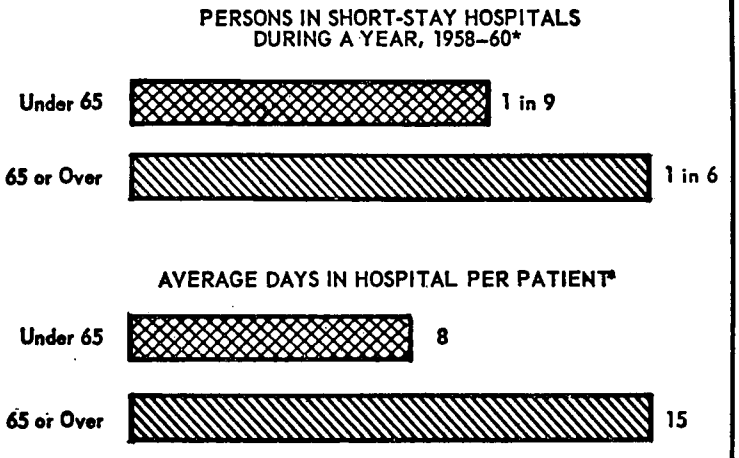
**In 1957–58; excludes private expenditure for nursing home care and all care at public expense.

4. With most of them retired, income of the aged average much lower than the rest of the population.



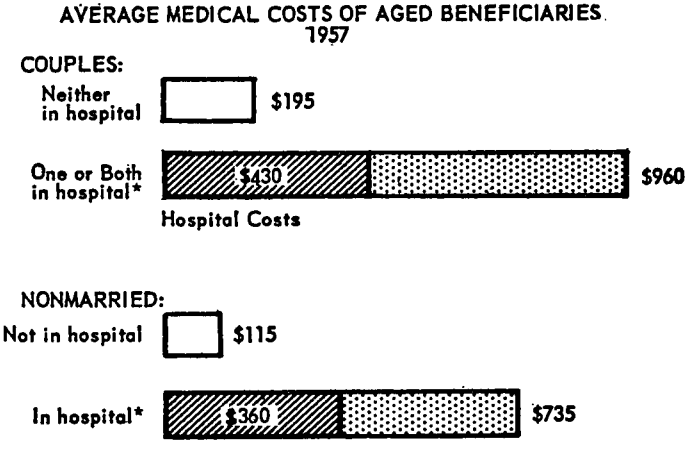
HEALTH PROBLEMS OF THE AGED

5. Old people go to the hospital more often and stay longer than younger persons.



*Adjusted to allow for decedents.

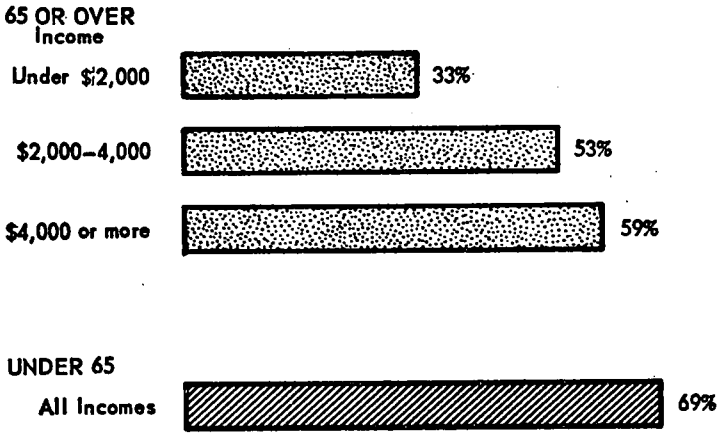
6. Hospital stays bring extra large total medical bills for the year.



*General hospital; excludes persons in chronic-care institution only.

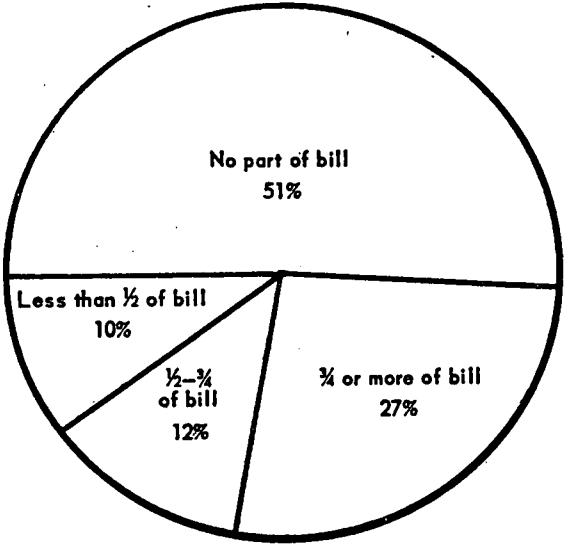
7. Only half of the aged have any insurance for medical bills.

HOSPITAL INSURANCE, 1959



8. For a majority of the hospital stays of the aged, insurance pays less than half of the bill.

PORTION OF HOSPITAL COSTS MET BY INSURANCE FOR EPISODES IN SHORT-STAY HOSPITALS, 1958–60



At December 1961 prices an elderly couple with one or both members receiving hospital care could expect their combined total medical bills for the year to total about $1,160. For the elderly person without a spouse, a hospital stay might mean average medical bills for the year of about $895. With half the aged couples having less than $2,500 income and more than half the other aged persons less than $1,000 it is obvious that most of them would be hard put to pay such a bill and still have enough left for groceries and housing—unless they had the benefit of health insurance, could count on getting free care, or received help from relatives. Indeed, more than two-fifths of the beneficiary couples and roughly three-fifths of the nonmarried beneficiaries who were in a general hospital in 1957 did not meet all the year's medical costs out of their own income, assets, or health insurance.

Except for an owned home, few of the aged have assets in substantial amounts. Those who do are more likely to be the relatively small number who already have the advantage of higher income. Sometimes the aged person with low income and some savings must choose between using them for everyday needs, or doing without some essentials so as to leave savings intact for a medical emergency.

How, then, do the aged manage when ill? Some seek help from relatives and, failing that, from public assistance. Some borrow money. A small number can manage on their own, especially if they have insurance. Some, as is true of all low-income groups, probably never get the care they need. Relatives provided help with medical bills for every seventh OASI beneficiary couple and every fourth nonmarried beneficiary who went to a hospital. Many beneficiaries who "paid their own bills" could do so only because relatives had either taken them into their own home or contributed in cash to their living expenses. Typically, the relatives to whom old people must turn for help already have families and children to take care of, or are themselves old enough to be facing their own problems of retirement.

Some aged persons with medical problems ask for public assistance—either to meet the emergency itself, or for regular living needs after using their resources to pay for the medical care. In the first half of 1961, just about every third person approved for old-age assistance needed it directly or indirectly as a result of health difficulties. Among recipients getting the assistance to supplement OASI benefits—generally those with the greatest economic resources of their own—the proportion obtaining assistance on account of medical needs was as high as 2 in 5. Currently about half the aged going on the OAA rolls are OASI beneficiaries.

The kinds of medical services and the amount of care provided through public assistance vary greatly from State to State. Some State public assistance programs pay for relatively comprehensive services, others meet emergency medical needs only. In January 1962, vendor payments for medical care under old-age assistance averaged $13.62 per recipient; the range was from a low of 24 cents to a high of $61.29 per recipient per month.

The 1960 Amendments to the Social Security Act increased the Federal matching funds for vendor payments under old-age assistance. They also provided Federal matching grants for a new program of medical assistance to aged persons not eligible for old-age assistance but whose income and resources are insufficient to meet the cost of

needed medical care. As of March 1962, medical assistance for the aged programs were in effect in 23 States, Puerto Rico, the Virgin Islands, and Guam. The services provided under these new programs also vary widely. Currently, about five-sixths of all expenditures under the MAA program are being made in two States, States that transferred to MAA most of the nursing care cases on their OAA rolls. Liberalization of the Federal contribution in the federally aided assistance programs has often meant more improvement in States already doing a better-than-average job than in those where standards and available funds were low.

Many aged persons get medical care at public expense or at reduced rates. Probably close to 30 percent of total public expenditures for patient care in hospitals goes for treatment of the aged, who comprise only 9 percent of the population.

Hospital care, more costly and more often emergency in character, may be more likely to be obtained without charge than other types of service. In any case, aged persons with no health insurance and in need of hospitalization are more likely to go to a public hospital than patients with health insurance. Public hospitals more commonly than private institutions must tailor their charges to ability to pay, including taking as a public charge those who cannot pay at all.

Total public and private expenditures for medical care for aged persons are estimated to have been about $5 billion in 1960, or approximately 1 dollar out of every 5 spent for personal medical care services. Only 1 person in 11 is aged 65 or over. Public programs are now responsible for more than 1 dollar in every 4 spent for medical care for persons aged 65 and over. Thus much of the burden of medical care of the aged population already falls on the community at large. One may well question, however, whether the cost of this burden is prorated among all our citizens in the most efficient and equitable fashion.

Over the past decade, prices of all goods have gone up, but not as much as has income of the population. Real income, as measured in purchasing power, has improved for most Americans. On the other hand, medical care prices, and especially the cost of hospital care, have risen more than other prices, and by and large have outstripped gains in income. This has been a serious problem for all low-income groups; and particularly so for persons currently age 65 and over—many of whom receive retirement benefits based on low lifetime earnings.

A part of the increase in the cost of hospital and medical care has resulted from improvements in the earnings and conditions of work of hospital employees who have been among the relatively lowest paid groups and are of the last to move from a 12- to 8-hour working day. Changes in medical technology, such as the increasing use of specialized equipment and expensive drugs and antibiotics, while increasing the power of medicine, have also made it more costly.

Wage and salary levels of hospital employees have now largely caught up with those in other service industries and will probably increase in the future at more or less the same rate as general wage levels. We have certainly not reached the end of changes in medical science and technology. New breakthroughs in knowledge which can be expected from the large investments now being made in medical research may further increase the unit cost of medical care or they may drastically reduce prolonged illness and the cost of medical services.

The organization of medical services is also in process of change. The hospital is assuming a new importance as the center for medical care in a community, at the same time that more effective use of home health services and skilled nursing home or other arrangements is making it possible to transfer many long-term patients out of the hospital, to their benefit as well as that of the community. The further development of a wide range of community and social services can have a significant effect on medical care problems.

By and large, in planning for the next decade, it seems reasonable to assume that the overall cost of medical care will increase at about the same rate as our total national output. Whatever the future costs may be, the question of how the benefits of modern medicine can best be assured to all who need them will be one of the most important challenges to our social ingenuity.

CHAPTER 1. NUMBER AND CHARACTERISTICS OF THE AGED

The United States has a rapidly growing total population and an even more rapidly expanding population 65 years and older. Advances in medical technology, improvements in living standards, and other factors have increased life expectancy at birth to an overall average of 70 years. Those who live to be 65 can look forward to reaching on the average age 79 or 80. This lengthening lifespan, accompanied by a lowering of the age at which workers voluntarily or involuntarily withdraw from the labor force, brings with it its own special problems. A growing number survive to face the illnesses and infirmities of age, but many do not have the income to pay for the care they need and which modern medicine has to offer. For most of our aged, basic self-support in retirement is largely assured by old-age, survivors, and disability insurance and related income-maintenance programs developed over the last quarter century except for the burden of medical care costs in retirement.

Persons aged 65 and over now number about 17¼ million, or more than 9 percent of the population of the United States, and in less than another decade, it is expected they will exceed 20 million, and by 1980, 25 million. During the 1950's the proportion of persons aged 65 and over in the population increased 35 percent (table 1), or from 1 in 12 to 1 in 11, and by 1980, they may well make up more than 1 in 10 of the total.

CHARACTERISTICS OF PERSONS 65 AND OVER

The growth in the aged population has been accompanied by a change in its composition. There has been an increase in the relative numbers of women and, also, of persons in the 85 and over age group. These are trends which will continue.

TABLE 1.—*Age and sex: Number and distribution of persons 65 and over in the United States,*[1] *1950 and 1960*

	Age						
	Total	65 to 69	70 to 74	75 to 79		80 to 84	85 and over
Number (thousands):							
Total, 1960	16,560	6,258	4,739	3,054		1,580	929
Male	7,503	2,931	2,185	1,360		665	362
Female	9,057	3,327	2,554	1,694		915	567
Total, 1950	12,295	5,013	3,419		[2] 3,284		578
Male	5,813	2,431	1,633		1,511		238
Female	6,482	2,582	1,786		1,773		340
Percent distribution:							
Total, 1960	100.0	37.8	28.6	18.4		9.5	5.6
Total, 1950	100.0	40.8	27.8		26.7		4.7
Percent female of total:							
1960	54.7	53.2	53.9	55.5		57.9	61.0
1950	52.7	51.5	52.2		54.0		58.8
Percent increase, 1950 to 1960:							
Total	34.7	24.8	38.6		41.1		60.7
Male	29.1	20.6	33.8		34.0		52.1
Female	39.7	28.9	43.0		47.2		66.8

[1] Includes Alaska and Hawaii in 1950 as well as 1960. [2] Breakdown not available for 1950.

Source: Bureau of the Census, *United States Census of Population: 1960, General Population Characteristics, United States Summary* (Final Report PC (1)-1B), August 1961.

With 2½ million who have passed their 80th birthday, and well over 900,000 who have passed their 85th, it might be expected that substantial numbers would be in institutions such as chronic care hospitals, nursing homes, and homes for the aged. The decennial census, however, shows that only 615,000, or less than 4 percent of all persons 65 and over, were in institutions in 1960. Persons not in institutions, and not living with a spouse, divide almost equally between those who live with relatives and those who live alone or with nonrelatives (table 2). In all, about 7 in 10 aged persons live alone or in two-person families.[1]

TABLE 2.—*Marital status and living arrangements: Distribution of persons 65 and over, by sex and age, for the United States, March 1961*

Status	Total 65 and over	Male			Female		
		Total	65 to 74	75 and over	Total	65 to 74	75 and over
Total, 65 and over	100.0	44.8	29.8	15.0	55.2	35.0	20.2
Married, spouse present	50.9	31.2	23.0	8.3	19.7	15.5	4.1
Other, by marital status:							
Widowed	38.6	9.1	3.8	5.3	29.5	15.5	14.0
Separated	2.1	1.1	.8	.4	1.0	.8	.2
Divorced	1.5	.6	.4	.2	.9	.6	.3
Never married	6.8	7.7	1.8	.8	4.1	2.6	1.6
Other, by living arrangements:							
In families	23.1	6.0	2.6	3.3	17.2	8.8	8.4
Family head (spouse not present)	8.2	2.0	1.2	.8	6.2	3.7	2.5
Relative of head (other than wife)	14.9	4.0	1.4	2.5	11.0	5.1	5.9
Living alone or lodging	22.3	6.1	3.5	2.7	16.2	9.6	6.6
In institutions	3.7	1.5	.7	.7	2.2	1.1	1.1

Source: Bureau of the Census, *Current Population Reports; Population Characteristics*, Series P-20, No. 114. "Marital and Family Status: March 1961," Jan. 31, 1962; and preliminary count of institutional inmates from the 1960 Census of Population.

[1] Data for March 1959 (from Bureau of the Census, *Current Population Reports: Population Characteristics*, "Marital and Family Census: March 1961," Series P-20, No. 112, Dec. 29, 1961) show 61 percent of all family members aged 65 and over were in two-person families.

AGE AND EMPLOYMEMT

While more and more persons live to age 65, relatively fewer of them can count on continuing to earn their own living—or having husbands who do (table 3).

TABLE 3.—*Work experience: Distribution of persons 65 and over by sex, 1950 and 1960*

[Noninstitutional population of the United States]

Work experience	Men		Women	
	1960	1950	1960	1950
Total	100.0	100.0	100.0	100.0
Did not work during year	56.9	50.7	84.2	88.2
Worked during year	43.1	49.3	15.8	11.8
At part-time jobs	16.5	11.6	8.2	5.6
1 to 26 weeks	6.7	4.5	3.1	1.9
27 to 49 weeks	3.1	3.2	1.9	1.3
50 to 52 weeks	6.7	3.9	3.2	2.4
At full-time jobs	26.6	37.7	7.6	6.2
1 to 26 weeks	5.1	4.5	1.8	1.4
27 to 49 weeks	4.6	7.4	1.5	1.3
50 to 52 weeks	16.9	25.8	4.3	3.5

Source: Bureau of the Census, *Current Population Reports: Labor Force*, Series P-50, No. 35, "Work Experience of the Population in 1950," Oct. 26, 1951; and Carl Rosenfeld, "Work Experience of the Population in 1960," *Monthly Labor Review*, December 1961.

In June 1961 fewer than 1 in 5 aged persons had any paid employment—about 3 in 10 of the men and 1 in 10 of the women. (Another 1 in 10 aged women were married to workers.) Various public income-support and retirement programs—notably old-age, survivors, and disability insurance—have been developed to replace part of the income lost when earnings cease. A substantial majority of those with earnings were in fact retired, working as they could to supplement benefits. Only about 1 in every 20 persons 65 years or older has earnings and has no income from any public program (table 4). Private pension plans, whose coverage has expanded rapidly since they first became a prime objective of collective bargaining in 1950, are another important source of support for a relatively small number of retired workers many of whom draw benefits under a public program also.

TABLE 4.—*Persons aged 65 and over in the United States with money income: Estimated number and distribution of persons by type of money income, June 1961* [1]

Type of money income	Number (in thousands)			Percent of total		
	Total	Men	Women	Total	Men	Women
Total population aged 65 and over	17,130	7,760	9,370	100.0	100.0	100.0
Employment, total [2]	4,100	2,290	1,810	23.9	29.5	19.3
Employment and no income from public programs	910	630	280	5.3	8.1	3.0
Employment and social insurance benefits	2,610	1,230	1,380	15.2	15.9	14.7
Employment and payments under other public programs	580	430	150	3.4	5.5	1.6
Social insurance (retirement and survivor) benefits, total [3 4]	12,430	5,940	6,490	72.6	76.5	69.3
Benefits and no earnings or veterans' or public assistance payments	7,950	3,660	4,290	46.4	47.2	45.8
Benefits and veterans' payments	1,090	710	380	6.4	9.1	4.1
Benefits and public assistance	780	340	440	4.6	4.4	4.7
Veterans' pension or compensation, total [4]	1,890	1,110	780	11.0	14.3	8.3
Veterans' payment and no earnings or social insurance [5]	310	30	280	1.8	.4	3.0
Public assistance, total [6]	2,400	820	1,580	14.0	10.6	16.9
Public assistance and no earnings or payments under other public programs	1,510	420	1,090	8.8	5.4	11.6
No income from employment or public programs	1,390	310	1,080	8.1	4.0	11.5

[1] The 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands.
[2] Includes 3,200,000 earners and an estimated 900,000 nonworking wives of earners. The figures on earners differ from those published by the Bureau of Labor Statistics, not only because of the inclusion of Puerto Rico and the Virgin Islands but, more important, because they take account o ithe larger-than-expected number of persons aged 65 and over reported in the Decennial Census and not yet reflected in the population totals shown in the Monthly Reports on the Labor Force.
[3] Includes persons with income from one or more of the following sources: old-age, survivors, and disability insurance, railroad retirement, and Government employee retirement as follows:

Type of money income	Number (in thousands)			Percent of total		
	Total	Men	Women	Total	Men	Women
Old-age, survivors, and diability insurance	11,260	5,389	5,880	65.7	69.4	62.8
Railroad retirement	640	320	320	3.7	4.1	3.4
Government employee retirement	1,040	520	520	6.1	6.7	5.5

Excludes persons with benefits under unemployment or temporary disability insurance or workmen's compensation programs.
[4] Includes estimated number of beneficiaries' wives not in direct receipt of benefits.
[5] Includes a small number receiving supplementary public assistance.
[6] Old-age assistance recipients and persons aged 65 and over receiving aid to the blind or to the permanently and totally disabled, including a relatively small number receiving vendor payments for medical care but no direct cash payment under either old-age assistance or medical assistance for the aged.

Source: Lenore A. Epstein, "Sources and Size of Money Income of the Aged," *Social Security Bulletin*, January 1962.

THE AGED ELIGIBLE FOR OASI BENEFITS

Retirement and survivor benefits under the OASDI program were paid to more than two-thirds of all persons aged 65 and over in mid-1961. Including the 1.1 million insured workers (with 270,000 dependents) eligible for benefits but not receiving them because of employment, the proportion eligible was close to 75 percent.

By State the proportion of aged persons actually receiving OASI benefits in mid-1961 ranged from three-fourths in Rhode Island to less than half in Louisiana and the territories (table 5). In 24 of the 50 States, at least two-thirds of all aged persons were on the OASDI rolls. Of the 13 States with the lowest rates, 10 were in the South; of the 13 with the highest rates, 9 were in the Northeast. The differences reflect, in large part, the fact that farmers and some farm laborers, domestics and urban self-employed were not covered until 1955.

TABLE 5.—*Aged population receiving OASDI and OAA benefits: Number and percent of aged population, June 30, 1961*

State of residence [1]	Total number		Percent of aged population		
	OASDI	OAA	OASDI	OAA	OASDI or OAA or both
Total	11,256,125	2,296,190	65.7	13.4	74.9
Alabama	149,941	99,881	56.2	37.4	84.2
Alaska	3,326	1,420	57.3	23.7	72.3
Arizona	57,784	14,136	59.6	14.6	69.6
Arkansas	115,814	56,414	58.8	28.6	82.1
California	911,147	253,937	63.7	17.8	72.6
Colorado	94,898	51,270	58.6	29.3	75.7
Connecticut	182,838	13,871	73.1	5.5	76.1
Delaware	25,364	1,205	68.6	3.3	71.0
District of Columbia	37,158	3,045	53.1	4.4	56.0
Florida	375,772	70,100	62.4	11.6	69.7
Georgia	159,260	95,325	53.6	32.1	79.5
Hawaii	20,332	1,439	67.8	4.8	71.4
Idaho	41,858	7,253	69.8	12.1	77.8
Illinois	672,656	70,259	67.3	7.0	72.3
Indiana	327,065	26,157	72.4	5.8	76.7
Iowa	221,542	33,480	66.9	10.1	73.9
Kansas	157,126	27,531	64.4	11.3	72.7
Kentucky	189,106	55,727	63.9	18.8	78.7
Louisiana	118,673	126,040	47.9	50.8	82.9
Maine	78,561	11,072	73.4	10.3	79.7
Maryland	145,665	9,615	62.5	4.1	65.6
Massachusetts	405,306	62,766	69.9	10.8	75.0
Michigan	486,718	56,494	73.9	8.6	79.5
Minnesota	238,578	45,627	65.7	12.6	74.3
Mississippi	106,900	81,132	55.7	42.3	85.7
Missouri	320,785	113,361	62.7	22.1	77.3
Montana	44,999	6,484	67.2	9.7	73.6
Nebraska	109,814	14,377	65.8	8.6	72.2
Nevada	11,577	2,535	60.9	13.3	67.1
New Hampshire	50,497	4,834	74.3	7.1	78.6
New Jersey	418,353	18,952	72.1	3.3	74.2
New Mexico	28,936	11,061	53.6	20.5	70.3
New York	1,219,081	61,297	70.3	3.5	72.5
North Carolina	209,457	47,593	65.5	14.9	77.7
North Dakota	39,762	7,075	67.4	12.0	76.4
Ohio	621,809	89,814	68.0	9.8	74.5
Oklahoma	137,520	88,161	54.4	34.8	80.0
Oregon	137,691	16,469	72.9	8.7	78.3
Pennsylvania	807,802	49,977	70.2	4.3	73.2
Rhode Island	69,017	6,615	75.8	7.3	79.9
South Carolina	90,741	30,928	59.3	20.2	77.9
South Dakota	48,687	8,479	66.7	11.6	75.4
Tennessee	187,444	53,995	59.5	17.1	74.5
Texas	426,550	220,594	55.2	28.5	76.4
Utah	40,682	7,516	65.6	12.1	74.4
Vermont	30,825	5,611	70.1	12.8	78.3
Virginia	186,605	14,459	63.3	4.9	67.6
Washington	196,302	46,930	68.9	16.5	78.6
West Virginia	119,716	18,678	69.2	10.8	78.8
Wisconsin	298,321	33,542	72.4	8.1	77.8
Wyoming	17,292	3,105	64.0	11.5	71.0
Puerto Rico	61,714	37,926	49.0	30.1	79.0
Virgin Islands	738	527	32.8	26.4	59.1
Guam	20	99	1.8	9.9	11.7

[1] Distribution by State estimated for OASDI beneficiaries.

Source: Bureau of Family Services and Bureau of Old-Age and Survivors Insurance, Social Security Administration.

Over 9 out of 10 of all those now reaching age 65 in the United States are eligible to draw benefits if they (or their husbands) retire. By the start of 1964, the proportion of aged persons who would have protection should exceed 80 percent, with 14.4 million, of the 17.9 million aged persons in the population, eligible under the OASDI program (table 6). By 1970 it is expected that all but 15 percent of those 65 and over will be eligible for OASI benefits and by 1980, all but 11 percent. In the long run 95 percent of the entire group 65 years and over will be eligible.

TABLE 6.—*Aged population and eligibility for OASI: Estimated number of persons by age, 1964, 1970, and 1980*

[In millions]

Age	Jan. 1, 1964	July 1, 1970	July 1, 1980
Total population:			
Total 65 years and over	17.9	20.2	25.3
68 years and over	13.7	15.8	19.8
70 years and over	11.2	13.1	16.4
72 years and over	9.1	10.7	13.5
Total 62 years and over	22.4	25.5	31.4
Total eligible for OASI:			
Total 65 years and over	14.4	17.1	22.6
68 years and over	10.5	13.2	17.6
70 years and over	8.6	10.7	14.4
72 years and over	6.7	8.8	12.0
Total 62 years and over	18.2	21.5	27.9

Source: 1970 and 1980—Chief Actuary, Social Security Administration; 1964—Actuarial Branch, Division of Program Analysis, Bureau of Old-Age and Survivors Insurance, Social Security Administration.

CHAPTER 2. HEALTH CONDITIONS OF THE AGED

Not only is the number of persons 65 and over growing rapidly, but those most likely to need medical care and least likely to have the resources to finance such care are increasing at an even more rapid rate.

The successes of modern medicine in preventing epidemics and curing or controlling diseases such as pneumonia, tuberculosis, and other once fatal infectious diseases have made it possible for an increasing proportion of the population to reach the age when they are more vulnerable to arthritis, rheumatism, heart disease, cancer, and other chronic illnesses. This development along with the high incidence of crippling accidents among the aged has brought the chronic conditions of old age to the fore as their major health threat.

CHRONIC CONDITIONS AND LIMITATION OF ACTIVITY

Older persons are twice as likely as younger persons to have one or more chronic conditions (table 7).

TABLE 7.—*Chronic conditions and limitation of activity: Percent distribution of persons by age, July 1959–June 1960*

[Noninstitutional population of the United States]

Age	Total	With no chronic conditions	With one or more chronic conditions		
			Not limited	Limited	
				Partially	Completely
65 and over, total	100.0	22.5	34.1	28.2	15.2
Under 65, total	100.0	62.3	30.2	6.4	1.0
75 and over	100.0	16.1	28.2	31.7	24.0
65 to 74	100.0	25.8	37.2	26.3	10.6
55 to 64	100.0	35.0	41.9	18.5	4.5
45 to 54	100.0	42.5	43.7	12.2	1.6
Under 45	100.0	69.0	26.6	4.0	0.5

Source: Public Health Service, U.S. National Health Survey, *Duration of Limitation of Activity Due to Chronic Conditions, United States, July 1959–June 1960* (Publication No. 584-B31), January 1962.

Not all chronic conditions are necessarily disabling although such conditions often require medical care.

DAYS OF DISABILITY

Persons 65 and over reported an average of 38 days (more than 2½ times as many days as younger persons) during the year when their usual activities were restricted because of illness or injury. On 14 of these days, the aged person was confined to bed all or most of the time as compared with 5 days for the younger person. Also, according to the same survey data, the lower the family income, the greater the number of days of restricted activity or confinement to bed (table 8).

TABLE 8.—*Restricted-activity and bed-disability days: Number per person per year by age and family income, July 1959–June 1960*

[Noninstitutional population of the United States]

Family income	Restricted-activity days		Bed-disability days	
	65 and over	Under 65	65 and over	Under 65
Total	37.8	14.2	13.6	5.3
Under $2,000	48.2	21.7	16.2	7.8
$2,000 to $3,999	32.0	15.1	11.5	5.7
$4,000 to $6,999	30.9	12.8	11.3	5.0
$7,000 and over	33.4	11.9	13.5	4.4

Source: Public Health Service, U.S. National Survey, *Disability Days, United States, July 1959–June 1960* (Publication No. 584-B29), September 1961.

SUMMARY

The data on health conditions of the aged from the National Health Survey indicate clearly the extent to which aged persons are more prone to illness and disability than younger persons. These data are based on household interviews and exclude persons in nursing homes, homes for the aged, and long-stay hospitals as well as persons whose illness resulted in death during the survey year. The health situation of older persons, therefore, is actually more unfavorable than these data indicate.

Another factor in the possible underestimation of the severity of chronic conditions of the aged may well be the inaccuracy or underreporting resulting from self-evaluation in the household interview. Methodological studies by the National Health Survey have shown that chronic conditions as diagnosed by the physician do not necessarily match the conditions as reported by the respondent in the household interview. Other studies have also shown that some types of chronic conditions are actually underreported in the household interview.

CHAPTER 3. USE OF HEALTH SERVICES BY THE AGED

Precise measures of the needs of the aged for medical care are not available. However, the fact that the aged are more prone to illness and disability has been well documented. Evidence of their special needs is the higher rate of utilization of health services as compared with that of younger persons. They use a greater volume of physicians' services. They are admitted to hospitals more frequently and stay longer. They are heavy users of nursing homes and other long-stay institutions. They receive considerably more care at home, part of which is provided by nurses. They need and use more drugs. However, they do use less dental services than younger persons.

PHYSICIANS' SERVICES

Aged persons interviewed in household surveys averaged 6.8 physician visits per year—2 more visits than persons of younger ages—and would have used more had those who died in the survey year been included. One of the limiting factors in persons of any age getting all the care they need is the ability to pay. Persons with lower family incomes visit doctors less frequently than those with higher incomes, notwithstanding the fact that the former group has a higher rate of disability and a higher prevalence of chronic illness (table 9).

TABLE 9.—*Physician visits:* [1] *Number per person per year by age and family income, July 1957 to June 1959*

[Noninstitutional population of the United States]

Family income	Age	
	65 and over	Under 65
Total [2]	6.8	4.8
Under $2,000	6.5	4.0
$2,000 to $3,999	6.6	4.4
$4,000 to $6,999	6.9	5.0
$7,000 and over	8.7	5.6

[1] Includes consultation by telephone or in person, at the office, hospital clinic or home visit but does not include services to hospital inpatients.
[2] Includes a small number not reporting income.

Source: Public Health Service, U.S. National Health Survey, *Volume of Physician Visits, United States, July 1957–June 1959* (Publication 584-B19), August 1960.

UTILIZATION OF GENERAL HOSPITALS

The use of hospitals varies by sex, income, and insurance status. Results of the National Health Survey for the 2-year period ending June 1960 show that hospital stays of persons 65 and over discharged alive averaged approximately 15 days, and that there were almost 15 discharges per 100 hospitalized. For younger persons, the average stay was about half as long as that of older persons and there were only

11 discharges per 100 persons. For every 100 aged persons (whether or not hospitalized) the survey shows a total of 218 days of hospital care—more than 2½ times the average for younger persons (table 10).

TABLE 10.—*Hospital utilization:* [1] *Annual rates in short-stay hospitals by age, July 1958 to June 1960*

[Noninstitutional population of the United States]

Age	Discharges per 100 persons	Average length of stay	Hospital days per 100 persons
65 and over, total	14.6	14.9	217.6
Under 65, total	11.2	7.6	85.0
75 and over	15.4	15.8	243.5
65 to 74	14.1	14.4	204.1
55 to 64	12.2	12.2	148.7
45 to 54	11.1	11.5	128.0
Under 45	9.0	6.3	70.1

[1] Living at time of interview.

Source: Public Health Service, U.S. National Health Survey, *Hospital Discharges and Length of Stay: Short-Stay Hospitals, 1958–60* (Publication No. 584-B32). (In press.)

Averages do tend to obscure the actual length of time that persons aged 65 and over are in hospitals. For example, 19 percent of the hospitalized stayed from 15 to 30 days per year, and an additional 9 percent stayed more than 31 days, for the 2-year period ending June 1960 (table 11).

TABLE 11.—*Hospital discharges: Percent distribution of patients discharged annually from short-stay hospitals by age and length of stay, July 1958 to June 1960*

[Noninstitutional population of the United States]

Length of stay	Age	
	65 and over	Under 65
Total	100.0	100.0
1 day	4.1	11.8
2 to 5 days	22.6	49.9
6 to 14 days	44.1	28.9
15 to 30 days	19.4	6.6
31 days or more	8.7	2.6
Unknown	1.1	0.2

Source: Public Health Service, U.S. National Health Survey, *Hospital Discharges and Length of Stay: Short-Stay Hospitals, 1958–60* (Publication No. 584-B32). (In press.)

FACTORS AFFECTING TIME SPENT IN GENERAL HOSPITALS

Data from the National Health Survey, based on live discharges, show no discernible relationship between discharge rates and income. However, there is an association between length of stay and income—the lower the family income, the longer the hospital stay (table 12). It cannot be assumed, however, that aged persons in the lower income groups (under $4,000) are currently getting all the hospital care they need since a greater portion of them have chronic and disabling illnesses (table 8).

TABLE 12.—*Hospital utilization: Annual rates in short-stay hospitals by age and family income, July 1958 to June 1960*

[Noninstitutional population of the United States]

Family income	Discharges per 100 persons		Average length of stay	
	65 and over	Under 65	65 and over	Under 65
Total [1]	14.6	11.2	14.9	7.6
Under $2,000	14.3	10.5	15.7	9.6
$2,000 to $3,999	14.8	11.7	15.0	7.4
$4,000 to $6,999	13.2	11.2	13.6	7.1
$7,000 and over	16.9	10.6	14.6	6.9

[1] Includes a small number not reporting income.

Source: Public Health Service, U.S. National Health Survey, *Hospital Discharges and Length of Stay: Short-Stay Hospitals, 1958-60* (Publication No. 584-B32). (In press.)

Various studies have shown that persons having insurance protecting them against the costs of hospitalization are more likely to enter a hospital than those with no insurance protection. The 1957 OASI beneficiary survey found 14 per 100 aged insured beneficiaries (and their spouses aged 65 and over) had been in a hospital during the year as against 9 per 100 uninsured. However, because the length of stay was often longer for the uninsured patient (17 days for insured; 26 days for noninsured), the total days of care received in the year was almost as much for the uninsured person as among the insured. These data suggest that persons without insurance may tend to postpone entering a hospital until the need is critical and that they then require longer care for recovery.

There is further evidence from the National Health Survey of the association between health insurance and recourse to hospital care. The interim data showed that elderly persons with insurance were hospitalized each year at a rate over 1½ times that for the uninsured. At age 75 and over, the differences in the proportions hospitalized of the insured and uninsured are even greater, as shown below:

Age	Percent of persons 65 and over hospitalized	
	Insured	Not insured
65 and over, total	13.7	8.2
65 to 74	12.9	8.7
75 and over	16.3	7.6

UTILIZATION IN LAST YEAR OF LIFE

The National Health Survey data on hospital utilization exclude the 12-month period prior to the household interview of the persons who died in that period. Since the mortality rate of the 65 and over age group is high, household surveys considerably understate the hospital utilization of aged persons.

On the basis of a survey in the Middle Atlantic States, it is estimated that the inclusion of hospitalization received by decedents during the survey year results in increases of one-fourth to one-third in the total volume of hospitalization reported for persons 65 and over.

Since the death rate for persons under 65 is substantially lower, the adjustment in hospital utilization for decedents in this age group is estimated to be considerably less than for older persons.[2] On this basis it may be estimated that aged persons are now receiving about 270–285 days of hospital care per 100 persons per year, as contrasted with about 90 days for persons under 65. In similar fashion, the number of aged persons likely to enter a hospital over the period of a year is estimated at 1 in 6—taking account of the experience of those who will die during the course of the year as well as those who survive, and allowing for those who go to the hospital more than once. As would be expected this 1 in 6 represents a somewhat higher incidence of hospitalization than the number of hospital discharges per 100 persons computed solely on the basis of the experience of aged persons alive at the end of a 12-month period (table 10).

The 1957 survey of OASI beneficiaries also gives some indication of the heavy volume of hospitalization which may characterize a person's last illness. Data for a small number of persons who died leaving a spouse drawing a retired worker's benefit (nonmarried beneficiaries dying during the survey year were not included) show that three times as many had one or both members hospitalized during the year as among those where both partners survived the year.

NURSING HOMES AND OTHER LONG-STAY INSTITUTIONS

In addition to their high rate of utilization of general hospitals, aged persons are the primary users of nursing homes and chronic disease hospitals. A substantial portion of the patients in mental hospitals and tuberculosis sanatoriums are also elderly.

A 1953–54 survey of nursing homes in 13 States found the average age of patients was 80 years.

The National Institute of Mental Health reports that 1 in every 3 beds in public mental hospitals is occupied by a person 65 or older and that one-fourth of the patients admitted for the first time to such hospitals are aged 65 and over. Of this group, more than half (55 percent) were 75 or over.[3] The Public Health Service estimates that 20 percent of all patients in tuberculosis hospitals are aged 65 and over.

The 1957 survey of OASI beneficiaries found that there was one beneficiary aged 65 and over receiving care in a long-stay institution for every five beneficiaries (and their spouses aged 65 and over) in a general hospital. However, the aggregate number of days was close to 2 days in a long-stay institution for every 1 day in a general hospital (table 13).

---

[2] Data from the U.S. National Health Survey (*Hospitalization in the Last Year of Life*, Public Health Service Publication No. 584–D3, June 1961) suggest that at the time of the study in 1957, including the experience of persons dying during the survey year would increase by about 40 percent the earlier estimates of days of hospital care used by aged persons, and by about 10 percent the utilization rate for persons under 65, derived solely from the experience of survivors. However, current National Health Survey statistics for hospital utilization of the population alive at time of interview are already higher than heretofore as a consequence of improved collection procedures. Thus the rates obtained from the current National Health Survey data need be increased by a smaller amount to allow for days used by decedents, namely by no more than a fourth to a third in the case of the aged and only about one-sixteenth in the case of the younger population.

[3] Elias S. Cohen, *Mental Illness Among Older Americans*, prepared for the U.S. Senate, Special Committee on Aging (Committee Print, 87th Cong., 1st sess.), Sept. 8, 1961.

TABLE 13.—*Utilization of long-stay institutions: Annual rates for aged OASI beneficiaries by type of institution, 1957*

Type of institution	Per 1,000 beneficiaries [1]		Average length of stay in days
	Number in institutions	Aggregate days	
Total	23.1	4,482	194
Nursing homes	13.2	2,759	209
Mental institutions	3.5	972	277
Tuberculosis sanatoriums	3.2	526	164
Other	3.2	225	70

[1] Includes aged beneficiaries and their spouses aged 65 and over.

Source: "Aged Beneficiaries of Old-Age and Survivors Insurance: Highlights on Health Insurance and Hospital Utilization, 1957 Survey," *Social Security Bulletin*, December 1958.

NURSING SERVICES

Specific data are not available on the volume of special nursing care in the hospital or home received by aged persons in comparison with those of younger ages.

Data from the National Health Survey on the volume of personal care in the home show that the proportion of elderly people under constant or part-time care at home is far greater than among the rest of the population. Persons 65 and over are 15 times as apt to receive personal care at home than younger persons (table 14).

TABLE 14.—*Persons receiving care at home: Rates per 1,000 population by age and type of care, July 1958 to June 1959*

[Noninstitutional population of the United States.

Age	Rates per 1,000 population		
	Total	Constant	Part time
65 and over, total	44.3	24.8	19.5
Under 65, total	3.0	1.8	1.2
75 and over	87.7	52.7	35.0
65 to 74	21.9	10.4	11.5
55 to 64	9.6	5.9	3.7
45 to 54	4.0	2.2	1.8
Under 45	2.0	1.2	.8

Source: Public Health Service, U.S. National Health Survey, *Persons Receiving Care at Home, United States, July 1958-June 1959* (Publication No. 584-B28), October 1961.

DRUGS

Many elderly people having chronic illnesses are constantly in need of one or more drugs. The volume of drugs used by the aged may be measured by expenditures for this purpose. Average annual expenditures of aged persons for medicines (prescribed and unprescribed) are well over twice those of the entire population (table 15).

TABLE 15.—*Drug expenditures: Amount by private individuals, by age, 12-month period, 1957–58*

Age	Amount
Total	$19
0 to 5	14
6 to 17	9
18 to 34	13
35 to 54	22
55 to 64	31
65 and over	42

Source: Health Information Foundation, *Family Expenditure Patterns for Personal Services, 1953 and 1958* (Research Series, No. 14), p. 14.

DENTAL CARE

Dental care is the one health service of which the aged have less than the rest of the population. Data from the National Health Survey show that persons over 65 average 0.8 dental visits per capita per year compared with 1.5 for the entire population. There are 0.5 visits for aged persons in families of under $2,000 income compared with 1.1 in families of over $7,000 income, but in each income group the aged have fewer dental visits than those of younger ages.

CHAPTER 4. HEALTH EXPENDITURES

Another measure of the medical needs of the aged is how much it costs to provide the care they receive. Expenditures by private individuals indicate the direct impact upon the aged themselves—or on the relatives and other persons who help assume some of the responsibility for payment. It is possible also to take cognizance of the care provided at public expense to those who cannot afford to pay. There then still remain some further costs not accounted for—namely, the value of services provided by doctors and other individuals at free or reduced rates as their personal recognition of a special problem.

Older persons not only spend more on medical care than younger persons, but these expenditures represent a larger share of their family's money income. The lower income of retired families is only partially offset by lessened needs of the aged for some items such as food, clothing, and transportation. Their outlays for medical care, on the other hand, average higher and would be higher still if they got all the care they needed and were themselves to pay for all they received.

TOTAL MEDICAL COSTS

Combined public and private expenditures for medical care for aged persons in 1960 are estimated at about $5 billion, out of a total of $24.5 billion for medical care for the entire population. Thus approximately 1 dollar out of every 5 of the Nation's bill for personal medical care services is currently going for the care of someone age 65 or older, whereas only 1 person in 11 falls in this age group. Like other low-income groups the aged receive some of their care at public expense. Of the public funds expended for civilian patient care probably close to $1½ out of every $5 today goes to pay for an aged patient.

The major portion of the aggregate outlay for personal health services for persons 65 and over represents expenditures by private individuals. In 1960, 72 percent of the total was spent by aged persons themselves or by relatives or friends on their behalf. More than one-fourth of the expenditures were made by public agencies. A very small share of the total represented care provided by philanthropic agencies. The latter proportion would be larger if it included the value of services provided without charge to the aged by private physicians. The estimated aggregates for 1960 are as follows:

Source of funds	*Total (millions)*
Total	$5, 045
Private persons	3, 615
Public agencies	1, 330
Private philanthropy	100

Leaving aside care provided out of the public purse, average private expenditures for medical care (counting costs met by insurance as

well as bills paid directly by individuals), are at least twice as much for a person 65 or more as for one younger—e.g., $177 versus $86 in 1957–58, according to the Health Information Foundation. These calculations take no account of the heavy costs of terminal illness for persons who were living alone at time of death—an omission of particular significance for the aged. If allowance is made for the costs incurred in their last illness by persons living apart from relatives, as well as for payments by individuals for medical care of inmates of nursing homes and other institutions, private medical expenditures probably would have averaged $187 per person in 1957–58 rather than the $177 shown in table 16.

TABLE 16.—*Per capita medical expenditures: Amount by private individuals by age and type of service, 12-month period, 1957–58*

Type of service	Per person 65 and over		Per person under 65	
	Amount	Percent	Amount	Percent
Total [1]	$177	100	$86	100
Physicians	55	31	29	34
Hospitals	49	28	19	22
Drugs	42	24	18	21
Dentists	10	6	14	16
Other [2]	21	12	6	7

[1] Excludes expenditure for nursing home care.
[2] Special nurses in hospital or at home, optometrists and other health personnel, eyeglasses and other appliances, ambulance fees, nonhospital diagnostic procedures.

Source: Health Information Foundation, *Family Expenditure Patterns for Personal Health Services, 1953 and 1958* (Research Series, No. 14).

Not only is the expenditure for the older person's care greater than for a younger person but it differs also in the way it is distributed among the various types of service. In line with the utilization data presented earlier, the one item for which the older person spends less on an annual basis is dental care. His higher expenditures for doctor and hospital care and drugs, however, far outweigh his lower dental costs. It is much more common, too, for older persons to have an "unusual" year in the sense of above-average expenses.

According to the Health Information Foundation the proportion of individuals in each age group who experienced "gross expenditures" of $200 or more for health services in a 12-month period in 1957–58 was as follows:

	Percent
All ages	13
0–17	5
18–54	15
55–64	17
65 and over	22

"Gross expenditures" as used here do not include the costs of free care. They cannot indicate how many aged persons not reporting as much as $200 in actual expenditures may have received at least that amount of care as gift or charity, or did not apply for what they could not afford.

MEDICAL COSTS AND INCOME

Studies over the years have shown consistently that the amount of medical care (measured in dollar costs) a family obtains is influenced by the size of its income, and that the low-income family—though it spends less than one with high income—nevertheless assigns more of its current funds for the purpose. Older families, of course, are subject to the double jeopardy of low income and high medical need. With the large majority of the aged having little better than $1 in disposable income per person for every $2 in a younger family of the same size, it is obvious that their higher medical needs—needs which become increasingly greater with advancing age—can take a heavy toll of their meager resources, the more so because like other low-income families they often are without the benefit of health insurance to help foot the bill.

The Health Information Foundation reported families with income under $2,000, many of whom are the aged, having out-of-pocket expenses for health services in 1957–58 (including health insurance premiums) amounting to 13 percent of their total income for the year. For families at all ages and all income levels the out-of-pocket cost came to no more than 5½ percent of aggregate income. Among families at all income levels with an aged head, 1 in 6 used at least 20 percent of money income for the year for health care, whereas only 1 in 20 families with head under 65 used so much income for this purpose (table 17).

TABLE 17.—*Out-of-pocket medical costs:* [1] *Distribution of families by percent of income spent, 1957–58*

[In percent]

Percent of family income [2]	Family head 65 and over	Family head under 65
All families	100	100
No outlay	6	1
Under 5 percent	38	55
5 to 9 percent	20	27
10 to 19 percent	20	12
20 to 49 percent	12	4
50 percent or more	4	1
Aggregate outlay as percent of aggregate family income	7	5

[1] The family's actual cash outlay during the 12-month survey year for personal health services and the voluntary prepayment for such services. Includes medical bills as yet unpaid, that were incurred during the survey year.

[2] Gross family income (i.e., before deduction for taxes) from business, profession, or farm, from wages and salaries, and from all other sources such as interest, rents, and pensions. Excluded are income in goods and services, the value of free rent, and other noncash benefits.

Source: Health Information Foundation, National Opinion Research Center, unpublished data.

A study of hospital and medical expenses of Michigan residents in 1958 found aged families with less than $3,000 income—a group including nearly 3 out of 4 of all aged families in the sample—averaging out-of-pocket expenses of $242, about one-seventh of their average income of $1,700. The families incurred a sizable amount of expense in addition, for which a welfare or other agency paid, raising the gross medical expense to the equivalent of nearly one-fifth of family income. By contrast the Michigan families headed by a person under

65 averaged medical costs representing only 5 percent of income for the medical bills they paid themselves, or 6 percent if costs paid by others are included.

HOSPITAL COSTS

The large bills which come without much warning and must be paid all at once make a hospitalized illness the kind of emergency for which it is difficult to budget. Other medical costs also tend to be much larger when there is a period of hospitalization or nursing home care. For the aged person, who uses about three times as much hospital care a year, on the average, as the younger person, the specter of heavy expenses attendant on hospitalization looms particularly large. Not only are the odds greater that he will enter a hospital, but when he does he is likely to be faced with a bigger bill than is common for the younger patient.

The average gross medical expenditure for an aged person in 1957–58 included $49 for hospital care, 28 cents out of every dollar spent for medical care. For persons under 65, hospital costs claimed 22 cents out of every dollar spent. The larger share of the older person's outlay going for hospital care is a particular burden because no more than half the aged have any insurance covering hospital bills, compared with about 7 out of 10 persons under 65. (These gross expenditure figures include costs met out of health insurance but not the costs of care coming out of public funds.)

As a measure of individual need, expenditures averaged over the total population have their limitations. This is particularly true for hospital care: The overall average greatly understates the burden of cost when the need does arise. As opposed to the average private expenditure for hospital care per person of only $49 for a 12-month period, aged persons who actually went to a hospital had total costs of $352—more than twice the bill for patients of all ages combined. On top of this a hospital admission for an aged person entailed an additional doctor's fee of $101 for inhospital care or a surgeon's fee of $160, rather than the average per person payment of $55 for all physicians' services in the year—in or out of hospital—as shown in table 15.

Similarly, elderly patients in Michigan general hospitals in 1958 ran up bills averaging about $400—counting all hospital charges regardless of who footed the bill, an individual or a welfare agency. For some conditions common to the elderly the costs were much higher. For example, hospitalization for fractures of the hip, to which aged persons are prone, resulted in an average bill of about $700. For patients under 65 (other than newborn infants) the average bill was little more than half that of the aged person. The longer stay of the latter would be expected to result in higher total costs for the hospital room. In addition his laboratory, drug, and other ancillary costs are also greater than the younger patient's, as the figures in table 18 illustrate.

Information on the impact of hospital costs on aged persons is available also from the 1957 survey of OASI beneficiaries. Although limited to persons receiving OASI benefits, in several respects the

data are more complete than those of other studies cited. First, they obtained detail not only on general hospitals, but on episodes in chronic-care institutions and nursing homes as well. Furthermore, they make it possible to study the total medical costs—including those not directly associated with the hospitalization. And finally they have been analyzed for married couples separately from other aged beneficiaries, an analysis particularly meaningful in considering ability to pay. It is the combined resources of husband and wife that will be tapped in the event either becomes ill.

TABLE 18.—*Charges for hospital services: Average per patient by age, Michigan hospitals, 1958*

Selected hospital services	Age of patient	
	65 and over	Under 65
Total hospital bill [1]	$399	$217
Accommodation charges	228	117
Ancillary services	171	100
Laboratory	38	22
Drugs, dressings, supplies, oxygen	69	35
X-ray	23	12
EKG and BMR	6	2
Other	35	29

[1] All types of hospitals combined.

Source: *Basic Facts on the Health and Economic Status of Older Americans: A Staff Report to the Special Committee on Aging,* U.S. Senate (Committee Print, 87th Cong., 1st sess.), June 2, 1961, p. 8.

Among married couples,[4] every fifth had one or both spouses in a hospital sometime during the survey year and just about 1 in 7 of the nonmarried beneficiaries were in a hospital also. Almost all the married patients (96 percent) were in a general hospital (including short-stay special hospitals), but about 1 out of 5 of the nonmarried beneficiaries reported as hospitalized were treated in a chronic-care institution or nursing home.

Roughly a fourth of the hospitalized beneficiaries could not report in detail cost of their hospital care, because they did not know how much had been paid by others, they had not yet received the bill, or they knew only the combined total for hospital and doctor. As used here, costs include all incurred expenses regardless of how or by whom they were paid. About half of those not reporting costs had been treated in a public hospital where presumably limited ability to pay was a factor in admission. Of those who did report costs, half the couples with a general hospital stay incurred hospital charges of $250 or more, and half the nonmarried had charges of at least $200 (table 19). The average cost, however, was much higher—a total of $430 per couple and $360 per nonmarried beneficiary.

[4] As used here and throughout this report, the survey data for married couples apply to aged beneficiaries and their spouses, whether or not entitled to benefits. In some instances the spouses were under age 65.

TABLE 19.—*Hospital costs: Distribution of costs of hospital care for hospitalized aged OASI beneficiaries by marital status and insurance status, 1957*

Cost of hospital care [1]	Married couples [1]				Nonmarried beneficiaries			
	All hospitals [2]	General hospitals [4]			All hospitals [2]	General hospitals [4]		
		Total	With no hospital insurance [5]	With hospital insurance [5]		Total	With no hospital insurance	With hospital insurance
Total hospitalized	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Costs reported	72.5	73.9	65.3	80.3	70.4	70.0	55.4	84.2
Less than $100	13.6	14.2	16.2	12.7	16.8	20.4	20.8	20.1
$100 to $199	16.5	17.7	17.9	17.5	12.3	15.2	13.8	16.5
$200 to $299	10.5	10.9	9.8	11.8	6.9	8.1	6.9	9.4
$300 to $399	6.0	6.0	4.0	7.4	6.9	7.4	4.6	10.1
$400 to $499	5.7	6.2	5.2	7.0	3.6	3.7	1.5	5.8
$500 to $999	11.7	11.7	8.1	14.4	11.1	11.1	5.4	16.5
$1,000 to $1,499	3.8	3.7	2.3	4.8	5.1	2.2	.8	3.6
$1,500 to $1,999	2.4	2.0	1.7	2.2	4.2	1.1	.8	1.4
$2,000 to $2,499	1.0	.7	----	1.3	2.4	.4	----	.7
$2,500 or more	1.2	.7	----	1.3	1.2	.4	.8	----
Costs not reported [6]	27.5	26.1	34.7	19.7	29.6	30.0	44.6	15.8
Nongovernmental hospitals	15.1	15.4	17.3	14.0	14.7	15.9	19.2	12.9
State, county, and city hospitals	10.3	9.0	14.5	4.8	12.3	10.4	19.2	2.2
Federal hospitals	2.2	2.0	3.5	.9	3.0	3.7	6.9	.7

[1] Aged beneficiary and spouse, whether or not entitled to benefits (spouse may be under 65).
[2] Hospital costs do not include fees of surgeon or inhospital physician. For married couples, includes hospital costs of the hospitalized member. If both were hospitalized, data tabulated represents the combined costs for both members.
[3] Includes chronic-care institutions and nursing homes.
[4] Includes short-stay special hospitals.
[5] For the hospitalized person. If both spouses were hospitalized, but only one insured, the couple is classified in the "with insurance" category.
[6] In many cases, includes some "free" care; i.e., no bills rendered to anyone, or vendor paid directly by public assistance or other agency.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration, 1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.

IMPACT OF HOSPITALIZATION ON TOTAL MEDICAL COSTS

Although 1 in 6 aged persons enters a hospital during a given year (counting those who died during the year), all must be prepared for the eventuality. It has been estimated that 9 out of 10 persons who reach age 65 will be in a hospital at least once in their remaining lifetime, and as many as 2 out of 3 will be in more than once. No one can foretell just when his turn will come, but all the evidence indicates that the year it does will find him experiencing considerably higher total medical costs than before. Thus, among OASI beneficiary couples with neither member hospitalized in 1957, median total medical costs for the year were $150 (excluding those unable to report costs). For couples having one or both members hospitalized in either a short or long-stay hospital median total medical costs for the year were $700—nearly five times as high. Corresponding median costs for the year for nonmarried beneficiaries were $600 for those with a hospital illness ($500 if only general hospitals are considered) and $80 for those without.

Of the beneficiaries hospitalized in a general hospital and able to report all their costs, 1 out of 3 couples and 1 out of 5 nonmarried beneficiaries incurred at least $1,000 in total medical bills during the year (table 20). The average total medical bill for the year for those with a general hospital stay amounted to $960 for the couples, and $735 for the nonmarried. The hospital care costs alone represented about 45 percent and 49 percent, respectively, of these total costs for the year. If medical costs could be computed for all beneficiaries with a hospital illness, including those who did not pay their own way, the hospital expense might represent an even larger share of the year's total medical costs because hospital care is probably obtained free or at reduced rates more often than out-of-hospital services.

TABLE 20.—*Hospitalization and total medical costs: Distribution of total medical costs for the year incurred by aged OASI beneficiaries with a general hospital stay, by marital status and insurance status, 1957*

Total medical costs incurred [2]	Married couples [1]			Nonmarried beneficiaries		
	Total	With no hospital insurance [3]	With hospital insurance [3]	Total	With no hospital insurance	With hospital insurance
Total hospitalized [4]	100.0	100.0	100.0	100.0	100.0	100.0
Costs reported	81.3	75.1	86.0	71.5	61.5	81.3
Less than $100	1.2	2.3	.4	2.2	3.1	1.4
$100 to $199	3.7	4.6	3.1	11.5	10.0	12.9
$200 to $299	5.7	5.2	6.1	9.3	11.5	7.2
$300 to $399	8.0	6.9	8.7	7.0	6.2	7.9
$400 to $499	9.5	8.7	10.0	7.0	4.6	9.4
$500 to $999	25.1	24.3	25.8	18.9	15.4	22.3
$1,000 to $1,499	13.9	12.1	15.3	8.5	4.6	12.2
$1,500 to $1,999	6.7	4.0	8.7	3.7	4.6	2.9
$2,000 to $2,499	3.2	4.0	2.6	1.5	----	2.9
$2,500 or more	4.2	2.9	5.2	1.9	1.5	2.2
Costs not reported [5]	18.7	24.9	14.0	28.5	38.5	18.7
Nongovernmental hospitals	10.2	10.4	10.0	14.4	13.1	15.8
State, county, and city hospitals	6.2	11.0	2.6	10.0	18.5	2.2
Federal hospitals	2.0	3.5	.9	3.7	6.9	.7
2 stays involving 2 kinds of kinds of ownership	.2	----	.4	----	----	----

[1] Aged beneficiary and spouse whether or not entitled to benefits (spouse may be under 65).
[2] For the survey year. For married beneficiaries, represents total medical costs for the couple.
[3] For the hospitalized person. If both spouses were hospitalized, but only one insured, the couple is classified in the "with insurance category."
[4] In general hospital, including short-stay special hospital.
[5] In many cases, includes some "free" care, i.e., no bills rendered to anyone, or vendor paid directly by public assistance or other agency.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration, 1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.

A beneficiary in a hospital sometime during the year was likely to find the hospital costs alone came to more than twice the medical costs of all kinds for the whole year by a beneficiary with no hospitalized illness, as the following figures illustrate: [5]

	Average medical costs incurred in 1957	
	Total	Hospital costs
Couples:		
One or both in general hospital	$960	$430
Neither in general hospital	195	----
Nonmarried beneficiaries:		
In general hospital	735	360
Not in general hospital	115	----

With the general climb in prices of medical care items since 1957, particularly marked in the case of hospital accommodations, aged persons having a hospital illness would face costs totaling considerably higher today. For instance, half the beneficiary couples with either or both members in a hospital at today's prices would be likely to incur total medical bills for the year of at least $825 rather than the $700 which represented median incurred costs under similar conditions in 1957. Total medical bills for the year at December 1961 prices would average about $1,160, of which hospital costs alone would represent 49 percent as opposed to the 45 percent of 4 years earlier.

[5] Based on those able to report costs. Hospitalization here implies a stay in a general hospital—including short-stay special hospitals. A small number of beneficiaries, mostly nonmarried, who spent no time in a general hospital but did have a stay in chronic-care institutions are excluded entirely. Adding in their costs would raise the average total costs for the year for beneficiaries not in a general hospital from $195 to $205 for the couples and from $115 to $145 for the nonmarried.

CHAPTER 5. RESOURCES AND BUDGET NEEDS

While persons 65 and over have medical costs at least twice as large as younger persons, they have, on the average, only about half as much income. This discrepancy is not offset to any great extent by differences in needs for other goods and services. To be sure, aged persons are more likely than the younger persons to own a mortgage-free home and other assets, but relatively few, particularly among those with the lowest income, have enough cash savings or assets to finance a major illness.

MONEY INCOME

Income and retirement

Retirement from employment usually brings a sharp drop in income. For example, in 1960 aged men who did not work at all had only a third as much income as aged men with full-time jobs all year, and less than half as much as those who had full-time jobs during part of the year. Looked at in another way, those who had no earnings had on an average not much more than half as much as the men who did have earnings as well as other income (table 21).

TABLE 21.—*Money income of men aged 65 and over: Annual amount and percent distribution by work experience and source of income, 1960*

[Noninstitutional population of the United States]

Characteristic	Percentage distribution	Percent with income	Income recipients		
			Median income	Percent with—	
				$1 to $1,499 or less	$4,000 and over
Total	100.0	96.4	$1,698	45.1	17.2
Work experience: [1]					
Did not work in 1960	56.8	94.7	1,363	57.2	5.1
Worked during 1960—					
At part-time jobs:					
49 weeks or less	9.8	99.6	1,560	48.3	9.1
50 to 52 weeks	6.7	99.1	1,779	43.9	17.1
At full-time jobs:					
49 weeks or less	9.7	99.0	2,930	20.8	34.1
50 to 52 weeks	16.8	97.6	4,115	18.5	51.0
Source of income: [1]					
No income	3.6				
Nonearned income only	53.1	100.0	1,324	59.7	4.3
Some earnings—					
And other income	33.4	100.0	2,482	27.4	29.5
No other income	9.9	100.0	3,604	26.8	46.0

[1] The data on income by source and by work experience differ slightly because the former were obtained in March 1961 and the latter in February 1961. Not all reports on income could be matched with those on work experience.

Source: Bureau of the Census, *Current Population Reports*; *Consumer Income*, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," Jan. 17, 1962.

Although women look to their husbands for some or all of their support, more than three-fifths of the women past 65 years of age must depend on themselves or on benefit rights earned by their de-

ceased husbands. In 1960, nearly a fourth of all older women reported no cash income while the remaining ones had a median income of only $820, in some cases supplementing their husband's income and in other cases the income was the sole source of their support. As in the case of men, the large number of women who reported no earnings from employment had roughly half as much income as the small number who did have some earnings.

As would be expected, the association of income and extent of employment reflects itself in the income of families. In 1960, of the families with head 65 or older, a third reported no earnings and had a median income of only $1,920. Only 10 percent of the families reported all their income from earnings, and they averaged $4,570 for the year (table 22).

TABLE 22.—*Money income of families: Distribution by amount for families with head aged 65 and over, by source of income, and number of earners, 1960*

[Noninstitutional population of the United States]

Money income class	Total	No earnings [1]	Some earnings			
			And other income	No other income	1 earner	2 or more earners
Total	100.0	100.0	100.0	100.0	100.0	100.0
Under $2,000	31.4	53.6	19.8	18.7	23.3	13.1
Under $1,000	9.2	15.4	5.0	10.9	7.2	3.5
$1,000 to $1,499	10.3	16.4	7.3	5.6	8.0	5.5
$1,500 to $1,999	11.9	21.8	7.5	2.2	8.1	4.1
$2,000 to $3,999	32.4	37.0	31.1	24.8	34.6	22.6
$2,000 to $2,499	11.6	18.8	8.5	4.9	10.1	4.0
$2,500 to $2,999	8.8	9.4	9.0	5.3	9.4	7.1
$3,000 to $3,999	12.0	8.8	13.6	14.6	15.1	11.5
$4,000 and over	36.1	9.3	49.2	56.6	42.1	64.2
$4,000 to $4,999	8.4	3.8	10.8	10.9	11.5	9.8
$5,000 to $6,999	11.3	2.6	16.0	15.6	15.6	16.7
$7,000 to $9,999	8.5	1.4	11.4	17.0	8.6	19.0
$10,000 and over	7.9	1.5	11.0	13.1	6.4	18.7
Median income	$2,897	$1,916	$3,925	$4,571	$3,423	$5,519
Percent distribution	100.0	35.8	54.4	9.9	40.9	23.4

[1] Includes a small group with no income.

Source: Bureau of the Census, *Current Population Reports: Consumer Income*, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," Jan. 17, 1962, and related unpublished data.

For aged persons living apart from relatives (23 percent of the aged population), three-fourths reported no earnings and had about half as much income as those with earnings.

Since most persons 65 and over have no earned income, and public maintenance programs are limited in what they pay, it is not surprising that most older persons must get along on relatively low incomes. Counted as individuals, more than half (53 percent of those not in institutions) had less than $1,000 in 1960 and 3 in every 4 had less than $2,000 (table 23). How "low" this is depends on the need for income and also how it compares in amount with the income of others in the population.

TABLE 23.—*Money income of persons 65 and over: Distribution by amount and sex, 1960*

[Noninstitutional population of the United States]

Money income class	Total [1]	Men	Women
Total	100.0	100 0	100.0
Less than $1,000	52.6	27.1	73.9
Zero	14.5	3.6	23.6
$1 to $499	11.7	5.5	16.8
$500 to $999	26.4	18.0	33.5
$1,000 to $1,999	23.7	32.0	16.8
$1,000 to $1,499	15.3	20.1	11.2
$1,500 to $1,999	8.4	11.9	5.6
$2,000 to $2,999	10.2	17.3	4.2
$3,000 to $4,999	7.2	11.8	3.4
$5,000 or more	6.3	11.8	1.7
Median income, all persons	$950	$1,620	$640
Income recipients	1,150	1,698	821
Year-round, full-time workers	3,630	4,115	2,838

[1] The distributions for men and women were combined using population figures estimated in the Division of Program Research by updating the decennial census counts after adjustment to exclude institutional inmates.

Source: Bureau of the Census, *Current Population Reports; Consumer Income*, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," Jan. 17, 1962, and related unpublished data.

Income and family situation

For two-person families, which represent nearly three-fourths of all older families, the median income in 1960 was less than half as large when the family head was aged 65 or over—$2,530—as when he was under age 65—$5,314 (table 24).

TABLE 24.—*Money income of families and persons living alone or lodging: Distribution by amount and age, 1960*

[Noninstitutional population of the United States]

Money income class	All families		Families containing specified number of members								Persons living alone or lodging	
			Two		Three		Four		Five or more			
	Head 65 and over	Head under 65	Head 65 and over	Head under 65	Head 65 and over	Head under 65	Head 65 and over	Head under 65	Head 65 and over	Head under 65	65 and over	Under 65
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Under $2,000	31.4	10.2	35.7	16.0	20.3	9.0	17.6	6.5	17.9	8.9	79.4	41.2
Under $1,000	9.2	4.4	10.0	7.0	8.0	3.7	7.2	2.8	3.6	3.9	47.7	26.2
$1,000 to $1,499	10.3	2.8	11.5	4.4	6.8	2.3	5.2	1.8	9.4	2.4	21.3	9.3
$1,500 to $1,999	11.9	3.0	14.2	4.6	5.5	3.0	5.2	1.9	4.9	2.6	10.4	5.7
$2,000 to $3,999	32.4	16.5	35.5	18.8	28.2	16.6	15.7	14.5	20.0	15.8	14.1	27.4
$2,000 to $2,499	11.6	3.5	13.7	4.1	5.9	3.5	7.1	3.1	4.0	3.2	6.2	7.8
$2,500 to $2,999	8.8	3.5	9.8	4.2	6.6	3.7	2.9	2.6	8.0	3.4	3.2	6.6
$3,000 to $3,999	12.0	9.5	12.0	10.5	15.7	9.4	5.7	8.8	8.0	9.2	4.7	13.0
$4,000 and over	36.1	73.3	28.8	65.1	51.6	74.6	66.6	79.1	62.0	75.3	6.4	31.4
$4,000 to $4,999	8.4	10.8	7.9	11.2	12.2	11.5	8.6	10.5	4.9	10.3	2.4	12.8
$5,000 to $6,999	11.3	25.4	9.4	22.8	15.9	25.3	16.6	27.6	19.2	26.2	4.0	18.6
$7,000 to $9,999	8.5	21.8	5.9	18.7	14.8	22.5	18.6	24.5	17.4	21.8		
$10,000 and over	7.9	15.3	5.6	12.4	8.7	15.3	22.8	16.5	20.5	17.0		
Median income	$2,897	$5,905	$2,530	$5,314	$4,122	$5,930	$6,100	$6,300	$5,727	$6,074	$1,053	$2,571
Mean size	2.5	3.9	2.0	2.0	3.0	3.0	4.0	4.0	6.4	6.2	1.0	1.0
Percent distribution	100.0	100.0	72.9	26.4	16.4	21.6	5.1	22.9	5.6	29.1	----------	----------

Source: Bureau of the Census, *Current Population Reports:* Consumer Income, Series P-60, No. 37, "Income of Families and Persons in the United States: 1960," Jan. 17, 1962, and related unpublished data.

For persons living alone or lodging with nonrelatives, the economic disadvantage of the aged is even more marked (table 25). This is because only about one-fourth of the former, as compared with more than five-sixths of younger persons in a similar situation had any earnings in 1960.

TABLE 25.—*Money income of persons living alone or lodging: Annual amount and percent distribution by amount of income, age, and sex, 1960*

[Noninstitutional population of the United States]

Income and age	Total	Men	Women
Median money income:			
65 and over	$1,053	$1,313	$960
Under 65	$2,571	$3,371	$2,152
Percent with income of—			
Under $1,500:			
65 and over	69.0	59.2	72.9
Under 65	35.5	28.7	40.9
$4,000 and over:			
65 and over	6.4	9.8	5.0
Under 65	31.4	42.7	22.7
Percent distribution by sex:			
65 and over	100.0	27.5	72.5
Under 65	100.0	44.0	56.0

Source: Bureau of the Census, *Current Population Reports: Consumer Income*, Series P–60, No. 37, "Income of Families and Persons in the United States: 1960," Jan. 17, 1962, and related unpublished data.

The very large disparity in income for two-person families doubtless reflects the relatively large proportion of older two-person families in which neither member worked during 1960. Three-person families, often including an adult child living at home, are more likely to have at least one regularly employed member. Their median income was only about 30 percent less than that of younger families. For even larger families, which are very few in number, there was no significant difference in the average income, presumably because many of these families with an aged head contained several adults, including younger ones, in the productive ages. Regardless of the size of family, the proportion with less than $2,000 in 1960 was at least twice as large when the family head was over 65 as when he was younger.

In assessing income figures, allowance must be made for the fact that some types of income, such as realized capital gains and lump-sum insurance payments, are not included in the income definition used in the survey. The Bureau of the Census report calls attention also to the fact that understatements of income in field surveys tend to be more serious for nonearned than for earned income. It concludes, however, that even after allowance for these factors, available evidence suggests that a substantial proportion of older nonearner families still had incomes totaling less than $2,000 in 1960.[6]

Aged persons living in the homes of relatives (who "disappear" in any analysis of family income) typically have little or no income of their own. In 1960 more than half the aged men and four-fifths of the aged women in this situation had less than $1,000 cash income. Two-fifths of these older persons were living in the home of married couples, usually their married children likely to have dependent children also. A special analysis for March 1959 shows that of the aged persons who lived in the home of relatives and who had less than $1,000 income of their own in 1958, about one-third were members of families whose total money income was below $3,000. Half were in families with less than $5,000.

[6] U.S. Bureau of the Census, *Current Population Reports: Consumer Income*, Series P–60, No. 37, "Income of Families and Persons in the United States: 1960," Jan. 17, 1962, p. 11.

OTHER FINANCIAL RESOURCES

Older persons are somewhat more likely than younger persons to have some savings, but in general those with the smallest incomes are the least likely to have other resources to fall back on. Moreover, most of the savings of the aged are tied up in their homes or in life insurance, rather than in a form readily convertible to cash (table 26).

TABLE 26.—*Value of liquid assets: Distribution of spending units by size of holdings and age of head, early 1960*

[Noninstitutional population of the United States]

Value of liquid assets	Age of head			
	65 and over	45 to 64	35 to 44	Under 35
Total	100	100	100	100
Do not own	30	22	20	26
Own:				
$1 to $199	6	11	18	14
$200 to $999	14	22	26	
$1,000 to $1,999	10	13	14	17
$2,000 to $4,999	18	15	12	
$5,000 and over	22	17	10	2
Median value:				
All spending units	$1,000	$800	$700	$400
Holders only	$3,000	$1,100	$900	$700

Source: University of Michigan, Institute for Social Research, Survey Research Center, *1960 Survey of Consumer Finances* (1961).

It is noteworthy, also, that, in a special study of low-income families, about two-thirds of the older spending units who reported less than $500 liquid assets, had not had $500 within the previous 5 years.[7]

Relatively few of the aged hold any marketable securities (table 27), and those who do usually are the ones who have other liquid assets also.

TABLE 27.—*Total assets: Distribution of spending units with head 65 and over according to type by value of assets, 1960*

Value of assets	Total assets	Liquid assets	Corporate stock	Equity in home	Other real estate	Unincorporated business
Do not own	13	30	86	36	79	97
Own	87	70	14	64	21	3
Less than $1,000	8	20	2	1	3	1
$1,000 to $4,999	15	29	3	14	5	1
$5,000 to $9,999	22	10	2	18	3	(1)
$10,000 to $24,999	23	8	2	26	6	(1)
$25,000 and over	18	4	3	4	3	(1)
Not ascertained	2	(1)	1	(1)	1	(1)
Total	100	100	100	100	100	100
Median, all spending units	$8,000	$1,000	0	$4,700	0	0
Median, holders only	$9,400	$3,000	$7,500	$9,700	$8,300	(2)

[1] No cases reported or less than ½ of 1 percent.
[2] Too few cases.

NOTE.—Details may not add to totals because of rounding. There were 425 cases in the sample.

Source: University of Michigan, Institute for Social Research, Survey Research Center, *1960 Survey of Consumer Finances* (1961).

[7] Morgan, James, and David, Martin, "The Aged and Their Economic Position—Some Highlights of a Survey Taken Early in 1960," in *Retirement Income of the Aging, Hearings before the Special Committee on Aging*, U.S. Senate, (87th Cong., 1st sess.), 1961, app. IV.

Having savings, as might be expected, is related to income. The 1959 Survey of Consumer Finances, conducted for the Federal Reserve Board, found that among spending units with head 65 and over:

When income was less than $3,000 (70 percent of the total)—
47 percent had less than $200 in liquid assets, and
44 percent had liquid assets of $500 or more.
When income was $3,000 to $5,000—
21 percent had less than $200 in liquid assets, and
70 percent had liquid assets of $500 or more.

Reports on the value of the various types of assets make it clear that in amount as well as frequency of ownership, the home is far more important than any other asset. Even with the equity in the home included, more than one-third have total assets of less than $5,000; only two-fifths have $10,000 or more.

While some older people have substantial resources in the bank or in Government bonds, the great majority do not (table 28). About 70 percent of the couples with head aged 65 or over and 85 percent of the other persons 65 years or over had less than $5,000 in savings. Almost three-fifths of these couples and almost three-fourths of the other aged persons with less than $5,000 savings had no health insurance.

TABLE 28.—*Savings and health insurance: Distribution of couples with head aged 65 and over and other persons aged 65 and over according to savings and insurance coverage by money income, 1959*

[Noninstitutional population of the United States]

Money income class	Total	Less than $5,000 in savings		$5,000 or more in savings
		No health insurance	Health insurance	
COUPLES WITH HEAD 65 AND OVER				
Total	100	42	29	29
Under $2,000	100	68	20	12
$2,000 to $2,999	100	42	34	24
$3,000 to $4,999	100	28	44	28
$5,000 to $7,499	100	14	45	41
$7,500 and over	100	7	16	77
OTHER PERSONS 65 AND OVER				
Total	100	62	23	15
Under $1,000	100	73	16	11
$1,000 to $1,999	100	59	23	18
$2,000 to $2,999	100	44	28	28
$3,000 and over	100	11	69	20

Source: University of Michigan, Institute for Social Research, Survey Research Center, unpublished data.

This, as other studies, shows that the lower their income the less likely are the aged to have either substantial savings or any health insurance. Indeed, of those in the lowest income group (under $2,000 for couples, under $1,000 for others, including more than one-third of the couples and more than half the other aged) almost 90 percent had less than $5,000 savings with nearly four-fifths of them having no health insurance at all.

Life insurance is a fairly common form of saving, although less so among the aged than among younger families. The policies of the

aged have a relatively low face value, and some of them have no cash surrender value. The proceeds are therefore more likely to be used for burial costs or some of the bills outstanding after a terminal illness, than to meet costs of current medical care.

Among OASI beneficiaries studied in the fall of 1957, 71 percent of the married couples and half of the other aged beneficiaries carried some life insurance. The median face value was $1,850 for the policies carried by couples and less than half as much for nonmarried beneficiaries. More than two-thirds of all the beneficiaries either held policies with a face value of less than $1,000 per person, or had no insurance at all.

HOMEOWNERSHIP

Equity in a home is the most common "saving" of the aged and represents the major portion of their net worth. Like other forms of saving, the advantage of homeownership is more common among those with higher incomes.

In early 1960, almost two-thirds of the nonfarm families headed by a person 65 and over owned their homes, with more than four-fifths of the homes clear of mortgage debt.

Among OASI beneficiaries studied in 1957, about 2 out of 3 of those married and 1 out of 3 of the nonmarried, owned a nonfarm home. Most of these homes were mortgage free, but the equity was relatively modest: the median amount was about $8,000 for couples and widows and about $6,000 for single retired workers. Nearly 8 out of 10 of the beneficiary couples with income of $5,000 or more, but fewer than 2 out of 3 with less than $1,200, owned their homes.

While homeownership, particularly mortgage free, can mean lower out-of-pocket costs, still it does not mean living without significant housing costs. Data from the 1957 beneficiary survey indicate that urban couples keeping house alone in a paid-up home averaged only about 30 percent less for taxes, upkeep, and utilities than the average outlay for rent and utilities by couples renting their living quarters.

NONCASH INCOME

Many aged persons have noncash resources which enable them to enjoy better living than their money resources alone could make possible. Such "nonmoney" income, however, does not necessarily release an equivalent number of dollars for purchasing goods and services, such as health care.

According to the 1957 survey of OASI beneficiaries, 4 out of 5 couples and 3 out of 5 nonmarried beneficiaries had some noncash income of one or more of the following types: An owned home or rent-free housing, food home grown or obtained without cost, or medical care for which the beneficiary did not pay. Others received some support from the children or relatives with whom they lived.

Evaluation of these noncash resources requires so many arbitrary decisions that it is rather seldom attempted. Survey Research Center staff members, however, did estimate for their analysis of income distribution and factors affecting low-income families, not only the imputed rental income earned on the net equity in owner-occupied homes, and the value of free medical care, but even the value of food and housing contributed by relatives in the same household and the

money saved by growing food and doing home repairs. They report that adding such nonmoney components of income increases the income averages for couples and other persons aged 65 and over by only $300 or $400. It reduces the proportion with less than $2,000 in 1959 from 46 percent to 35 percent for units consisting of aged couples or nonmarried males; from 89 percent to 79 percent for aged women.

MEASURES OF NEED

Questions are raised from time to time as to the relative income needs of aged persons and of younger families. It is suggested that the actual incomes received by aged persons are not as low as they appear to be relative to those of younger persons, in view of the lesser budgetary needs of the aged.

Budget needs of retired and younger worker families

The budget for a city worker's family of four persons and the budget for a retired couple, released by the Bureau of Labor Statistics in 1960, use the same methodology; both represent a "modest but adequate" level of living. Since the city worker's family budget applies to a family of four persons, the budget amounts cannot be compared directly with those for an elderly couple. Nor would it be entirely fair to place both budgets on a per capita basis. In order to compare the two budgets, an adult-equivalent relationship was used; specifically the amounts in the elderly couple's budget were divided by 2, those in the 4-person family budget by 3½, treating the 13-year-old boy as an adult, the 8-year-old girl as half an adult. The relationship between the per adult cost for elderly couples and for a young worker's family is shown in table 29 for six cities in different regions of the country.

TABLE 29.—*Budget costs: Relative costs for retired persons and members of city worker's family by category, 1959*

Item	Relative costs [1]					
	Atlanta	Boston	Chicago	Los Angeles	St. Louis	Washington, D.C.
Estimated total cost [2]	84	92	90	87	87	87
Cost of goods and services	98	108	105	102	103	103
Food and beverages	89	90	89	90	90	90
Housing	119	145	135	129	130	131
Rent, heat, utilities	118	145	135	128	131	131
Housefurnishings	86	89	89	87	87	86
Household operation and communications	191	210	200	219	189	195
Clothing	68	68	69	68	68	68
Medical care	156	172	176	151	160	156
Transportation	58	61	60	58	61	59
Other goods and services	102	108	106	106	105	107

[1] Ratio of per capita cost of retired elderly couple's budget to per adult equivalent cost of city worker's family budget, in which the boy 13 is treated as an adult; the girl 8 as half an adult.

[2] Includes life insurance, occupational expenses, and personal taxes for the worker's family. The budget for a retired couple makes no allowance for life insurance nor Federal income taxes.

Source: "The Interim City Worker's Family Budget," *Monthly Labor Review*, August 1960, and "The BLS Interim Budget for a Retired Couple," *Monthly Labor Review*, November 1960.

With some variations from one city to another the amounts of money required for medical care of aged persons in reasonably good health were 50 to 75 percent higher than the comparable (per adult equivalent) amounts for younger families. Housing costs were also significantly higher for the older persons, as might be expected with the smaller size household. Food costs were somewhat lower, the costs of clothing and transportation substantially lower. The cost of all the goods and services budgeted for an aged person was very close to or slightly above the per adult equivalent cost of all goods and services for the members of a younger family. However, when account is taken of the personal taxes, life insurance, and occupational expenses that would be paid by the younger families, the total costs incurred by an aged person are between 84 and 92 percent of the per adult equivalent cost for a member of a young worker's family.

While the BLS budgets relate to families and elderly couples living in large cities or their suburbs, there is no reason to think that the *relationship* between the costs for older and for younger families would be markedly different in small cities or in rural areas.

TAX PROVISIONS FAVORING THE AGED

Federal tax provisions recognize the special problems encountered by older persons. It is apparent, however, that as with savings, homeownership and similar resources of the aged, the more favorable their income situation, the greater the advantage.

Federal tax savings

The Treasury Department estimates that during the 1961–62 fiscal year, persons aged 65 and over will have a total tax savings of $742 million as a result of three special tax provisions of the Federal income tax. Of the total tax benefit, the double exemption for persons aged 65 and over accounts for $482 million in tax savings, the retirement income credit accounts for $120 million in tax savings, and the special medical expense deduction, over and above the deduction available to all age groups, accounts for $140 million.

State and local tax provisions

No overall appraisal is available of the extent to which State and local taxes affect the aged. Of the 35 States that levy personal income taxes, 17 allow additional deductions for the aged. Some have favored treatment for older homeowners in respect to real estate taxes.

CHAPTER 6. PRIVATE HEALTH INSURANCE

AVAILABILITY OF HEALTH INSURANCE TO THE AGED

The extent and quality of health insurance coverage of the aged is influenced by many factors: on the one hand, by their ability to pay full cost premiums which are likely to be high because of their morbidity rates; and on the other hand, the opportunities they have either to carry over into retirement the insurance they had while employed or to purchase insurance after reaching age 65.

Group coverage before retirement

To the extent that the aged are gainfully employed, they have much the same opportunities as other active workers to obtain health insurance on a group basis. But only a small proportion have full-time employment and many of these are apparently in jobs for which health insurance is not available on a group basis through their work. The 1958 HIF–NORC study found that 93 percent of the uninsured individuals 65 and over in the labor force reported health insurance coverage was not offered through their work.

Group coverage after retirement

During the last 5 or 10 years, many employers and jointly managed union-management welfare funds have developed various types of plans to include retired employees under their group health insurance program. Benefits may be the same as for active employees or they may be curtailed in various respects. The cost sharing arrangements as between the employer and employee may be the same as for active employees or different.

No comprehensive data are available as to the extent to which health insurance has been made available to retired employees. However, the Bureau of Labor Statistics did make a study of the provisions of 300 collectively bargained health and insurance plans in 1959 each with more than 1,000 workers. It showed that provisions for continuing hospital care insurance after retirement have been steadily increasing under collectively bargained plans, averaging about 1 to 2 percentage points a year from 1955 to 1959. Of the surveyed employees about 42 percent were in firms that provided hospital protection both before and after retirement. Major negotiations, since 1959, in the steel, aluminum, and meatpacking industries for extending hospital insurance after retirement have brought this coverage figure up to an estimated 53 percent.

There are a number of important limitations on extension of hospital care protection to retired workers through employee-benefit plans even through the large, collectively bargained plans. First, even when such benefits are incorporated in a plan, they may refer only to future pensioners, not to those already retired. Second, in most instances, to continue receiving hospital expense protection workers must have had at least 5 to 15 years of service or of participation

in a hospital expense plan. Third, because of the relatively high costs involved in providing elderly persons with hospital care protection, many plans extending such protection reduce the benefit provisions after retirement in a variety of ways—such as placing monetary or time limits on benefits. This particular limitation was true of 41 percent of the plans with hospital benefits for retired workers, covering 27 percent of the employees. Fourth, many plans require workers after retirement to bear a larger share of the costs. According to the BLS study, 3 out of 4 employees in plans where preretirement hospital benefits were jointly financed had to pay the entire cost after retirement.

The plans studied by the Bureau of Labor Statistics are more or less typical of those in unionized industries and among large employers and refer to less than 10 percent of all wage and salary workers. They undoubtedly do not reflect the situation in smaller or nonunionized firms, which generally offer less in the way of health and welfare benefits. It seems clear that fewer than half of today's workers can count on the extension of present health benefits into retirement years.

Policy conversion

To a very large extent, older persons retiring from employment have an opportunity to convert to an individual policy any health insurance which they had held as an employee. In general, however, the benefits are considerably reduced and the cost substantially increased on conversion, in large measure because the employer no longer shares in the cost.

Initial nongroup enrollment

The situation is less favorable with regard to purchase of health insurance on an individual basis by older persons not in the labor force. There are a number of problems apart from cost. Some aged persons cannot buy insurance because of age limits on nongroup enrollment or because they are poor risks due to preexisting conditions. Some can obtain policies only if they accept a waiver of coverage for preexisting conditions. Some find it impossible to renew individual policies or may have their policies canceled. In all these respects, however, the situation has improved in recent years.

Restrictions because of age

Almost all of the Blue Cross and Blue Shield plans now have nongroup enrollment provisions. As of January 1962, all but 2 of the 79 U.S. Blue Cross plans had nongroup enrollment, but only 18 had no age limits for individual enrollment. Thirty-one plans among the 79 also offered "senior" certificates, i.e., without age limit, but these commonly restrict benefits and/or cost more as compared with nongroup contracts offered to younger persons. Nearly one-fourth of the plans did not accept initial nongroup enrollment from persons over 65 (table 30). All but 2 of the 68 U.S. Blue Shield plans had nongroup enrollment, 16 with no age limits, and 27 offering "senior" certificates. Although data on membership are not available by age limits, the situation seems somewhat more favorable than appears from a count of plans because the larger plans tend to have fewer age restrictions.

TABLE 30.—*Blue Cross and Blue Shield plans: Age limits on initial nongroup enrollment, end of 1961*

Age limits	Blue Cross plans	Blue Shield plans
Total	79	68
"Senior" certificates offered	31	27
No age limit	18	16
70 years	2	1
66 years	1	
65 years	15	17
60 years	10	4
56 years		1
No nongroup enrollment	2	2

Source: *Blue Cross Guide*, Jan. 1, 1962, and *Blue Shield Manual*, late December 1961.

Although some of the 730 insurance companies which write individual (nongroup) policies do not sell insurance to individuals past 60 or 65, the majority now accept applications from persons up to 70 or even 75, and some have no age limits. All such insurance is written at rates which vary with age and sex, however. Rates for those persons 65 to 70 years are 50 to 100 percent higher than for persons of, say 30 years, and mount sharply for those beyond 70. Moreover, policies available to persons 65 and over generally have more limited benefits than those offered to younger persons.

Restrictions because of ill health

The great majority of the Blue Cross and Blue Shield plans which enroll aged persons on a nongroup basis require a health statement from the person applying for coverage. An applicant with a health history which indicates that he may be a poor risk is apt to be rejected or the policy written with a waiver of coverage for specified conditions. Many of the plans exclude coverage for preexisting conditions for a year or two, or even for life.

Nearly all insurance companies require a health history statement of the prospective individual enrollee with rejection likely if his statement indicates he is a poor insurance risk. In some cases policies sold contain a waiver of benefit for one or more specific conditions.

Renewal guarantees

The assurance that a policy is noncancelable and guaranteed renewable is always important to policyholders, but especially for those 65 years and older.

Most Blue Cross and Blue Shield plans follow a policy of never canceling or refusing to renew a member's certificate because of his age or conditions of health. Exceptions are very rare.

The great majority of insurance companies, on the other hand, have reserved the right to refuse to renew an individual hospital, surgical, or medical insurance policy on its anniversary date. Despite steady public complaint over the years, most individual health insurance policies are renewable only at the option of the company and companies do not hesitate to refuse to renew a policy on an insured person who has become a poor risk.

These practices are less common than they were, however. Some 30 to 40 commercial companies now issue policies which are guaranteed noncancelable and renewable for life. If the company wishes to raise the rate on an individual policy of this character, it can do so only if it raises the rate on all policies of the same class. An estimated 500,000 of the 2½ million aged persons covered by insurance companies have individual policies which are guaranteed renewable.

New York State prohibits cancellation or refusal to renew an individual policy, unless similar action is taken with respect to all policies of the same class. North Carolina has enacted similar legislation and some other States have considered or are considering such legislation.

Promotion of sales to the aged

Availability of individual policies without age restrictions does not mean that the Blue Cross-Blue Shield plans or the commercial companies make an effort to sell such insurance. Indeed, some contracts may be available to aged persons only during a limited period, such as 2 weeks or a month each year.

A number of insurance companies have experimented with mass sales to older persons of policies which are guaranteed noncancelable and renewable. The policies are made available, without a health history inspection, to all aged persons in a city or some larger area for a limited period following extensive advertising. One company has a contract with the American Association of Retired Persons for specified health insurance benefits for all members who desire to take such insurance. Over 400,000 aged persons are reported to be covered under these contracts.

The State of Connecticut passed legislation authorizing cooperative action among insurance companies which offer health insurance "against major financial losses" to aged persons. An organization known as Associated Connecticut Health Insurance Companies has been formed, underwritten by some 30 companies. The organization offers a number of major medical and basic benefit policies to all aged persons in the State, such policies being available during limited enrollment periods. During the first enrollment period—the month of September 1961—21,850 persons enrolled. Some of them may already have other coverage. Losses or gains are shared among the companies on a prearranged basis.

Low benefit ratio on individual insurance

Individual insurance, which is all that is available to many aged persons, is a relatively poor buy as compared to group insurance. In 1960 benefits amounted to only 53 percent of premiums, on the average, in the case of individual health insurance policies sold by commercial companies. This compared with 90 cents in benefits per premium dollar for group enrollees with insurance companies and 92 cents for Blue Cross-Blue Shield plans (the latter including some individuals but mainly group coverage). The operating expenses of individual health insurance are necessarily high because of high initial selling costs and subsequent premium collection costs.

Paid-up-at-retirement policies

There has been considerable discussion of paid-up-at-retirement policies. Such a policy guarantees that a specified set of health insurance benefits will be available to the policyholder during the remainder of his life. The benefits are on a cash indemnity basis (a specified number of dollars for up to a specified number of days of care, plus an allowance for hospital extras). It would be very difficult for an insurance company to estimate the future cost of a service benefit (guaranteeing up to a specified number of days of care regardless of rising hospital costs). This is a new approach and little of this type of coverage has been sold. If the policy is not purchased until the date of retirement, the initial costs are high ($700 to $1,300 per individual). Similarly, even if purchased prior to retirement, the annual payments required for persons already approaching retirement would be substantial.

If the costs were spread over the full working life of the individual, the annual payments would be small, and might be coupled with current health insurance premium payments throughout his working life. There is a practical barrier, however, since most workers obtain their health insurance through their place of employment. Few persons spend their entire working lives with one employer, so continuous coverage under a single insurance carrier would be difficult to maintain. Aside from the uncertainty as to whether they will still be with the same employer when they retire, there are other factors that could make workers reluctant to participate in purchasing this form of insurance. They may anticipate that their existing health insurance coverage will continue after retirement or they may fear that a specified set of cash indemnity health benefits may prove inadequate if the trend of rising medical costs continues.

THE EXTENT OF HEALTH INSURANCE PROTECTION FOR THE AGED

It is estimated that about 8.7 million persons aged 65 and over had some protection against hospital costs as of July 1, 1961, and about 7.9 million against surgical costs. This assumes the same ratio of duplication (i.e., coverage under more than one policy) among Blue Cross-Blue Shield plans, insurance company policies and independent plans as assumed by the Health Insurance Council for the population of all ages.

The Blue Cross plans reported in July 1961 that they had 4,250,000 persons enrolled who were aged 65 and over and the Blue Shield plans had 3,250,000 aged members. Virtually all of the Blue Shield members are included among those who have Blue Cross coverage. On the basis of a recent survey in which 90 companies that write two-thirds of the health insurance business participated, the Health Insurance Association of America estimates that some 4¾ million aged persons have hospital coverage through insurance companies. Assuming that the proportion of members who are aged 65 and over is the same as for all other types of health insurance coverage, there would have been nearly 370,000 aged persons in independent plans with hospital protection and about 430,000 with medical-surgical service coverage.

These figures are based in considerable degree on estimates and may be somewhat wide of the mark. The estimated net numbers with hospital and surgical care protection are equivalent to 51 and 42 percent, respectively, of the total aged population as of July 1, 1961, compared to 73 and 68 percent for the population of all ages.

Probably more reliable data on the extent of health insurance among the aged come from a survey conducted by the National Health Survey in July–December 1959. They found that of all aged persons not in institutions, 46 percent had some type of hospital insurance, 37 percent had surgical insurance and 10 percent had insurance covering doctors' visits in the home, office, and hospital. Among the general population, by contrast, 67 percent had hospital, 62 percent surgical, and 19 percent medical insurance. Some part of the difference between the National Health Survey figures and the estimates set forth above may be due to growth in coverage of the aged between July–December 1959 and the middle of 1961; a part may also be due to underestimation by the Health Insurance Council of the extent of duplicating coverage.

As might be surmised, persons 65 to 74 are more likely to have insurance protection than those 75 and over. The data from the National Health Survey on the percent with insurance follows:

Age group	Hospital	Surgical
65 to 74	53	44
75 and over	32	24

Of the aged who had hospitalization insurance, the survey found:

43 percent were covered by Blue Cross;

7 percent by a "Blue Plan" and other type of plan;

49 percent by some other plan, i.e., an insurance company or independent; and

1 percent did not know the type of insurer.

A survey by the Health Insurance Institute in 1957 found that among persons 65 and over who had health insurance, approximately twice as many had "individual" as had "group" insurance.

The proportion of the aged having health insurance was greater in urban than in rural areas and higher in the Northeast and North Central areas than in the South and West.

The extent of health insurance coverage is much lower among the aged with low incomes than among those of middle or high income. Thus, as with the general population, they are least able to meet sickness costs out of pocket (table 31).

TABLE 31.—*Insurance coverage of aged persons: Percent of aged persons with hospital insurance by income, July to December 1959*

[Noninstitutional population of the United States]

Family income	Percent
Total	46.1
Under $2,000	33.3
$2,000 to $3,999	53.2
$4,000 to $6,999	59.6
$7,000 and over	59.4

Source: Public Health Service, U.S. National Health Survey, *Interim Report on Health Insurance, United States, July–December 1959* (Publication No. 584-B26). December 1960.

The proportion of the aged with some type of health insurance has been increasing. Thus, two surveys conducted by the Census Bureau found 26 percent of persons 65 and over had some type of health insurance in March 1952 and 37 percent in September 1956. Another pair of surveys found an increase from 31 percent in mid-1953 to 43 percent in mid-1958, compared to the 46 percent found by the National Health Survey in the second half of 1959.

Figures showing the percent of the aged who have some health insurance must be understood for what they are. The scope and adequacy of coverage varies widely. An aged person who has hospital insurance paying $5 a day for 30 days against the room cost and $50 against the cost of the specific services ranks on the same footing as one who has insurance that will pay all of his bill in semiprivate accommodations for 180 days or more.

Among all cases of aged persons discharged from short-stay hospitals during a survey, July 1958–June 1960, some portion of the bill was paid by insurance in 51 percent of the cases. Three-fourths or more of the hospital bill was paid in 30 percent of the cases. Among persons under 65, insurance met some part of the hospital bill in 70 percent of all discharged cases, and three-fourths or more of the bill in 54 percent of the cases.

REASONS WHY AGED PERSONS DO NOT HAVE INSURANCE

A study conducted by the National Opinion Research Center for the Health Information Foundation found that in 1957 about half the aged persons without health insurance would have liked to be covered, just over one-quarter had not thought about it, and just under a quarter didn't want it. Among those who wanted coverage, 68 percent couldn't afford it and 32 percent had been refused insurance or had insurance formerly but it had been canceled.

About one-sixth (16 percent) of the aged surveyed in this HIF–NORC study had formerly been covered by health insurance but were not covered at the time of the survey. Among the reasons given for not continuing health insurance were: Could no longer afford it (31 percent); retired or gave up working (26 percent); dissatisfied with policy's coverage (24 percent). Other reasons were that "company discontinued plan"; "did not feel need"; "job change without policy's carrying over."

A similar picture emerges from the responses of OASI beneficiaries to the question as to why they do not have health insurance. According to a survey of beneficiaries in 1957, 68 percent of the aged beneficiaries who did not have hospitalization insurance had never had such insurance. Thirty percent had been insured at one time, but the policy was dropped before the survey year. For 2 percent the insurance status before the survey year was unknown. The reasons given by those without insurance for not having it are given in table 32.

TABLE 32.—*Reasons for no hospitalization insurance: Percent of aged OASI beneficiaries who did not have insurance, 1957*

Reason	Percent
Aged beneficiaries never insured	100
Could not afford it	41
Never thought about it	30
Not interested	18
Refused by insurance company	9
Other reasons	2
Insured at one time, policy dropped	100
Could not afford it	39
Group policy could not be converted at retirement	29
Not interested	14
Canceled by insurance company or terminated at death of husband	13
Other reasons	5

Source: Bureau of Old Age and Survivors Insurance, Social Security Administration, *1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.*

CHAPTER 7. METHODS OF PAYING FOR MEDICAL CARE

Many older persons, as has been demonstrated, have large medical bills, more so than younger persons. For most young families the uneven and unpredictable impact of heavy medical costs is likely to be offset at least in part by private health insurance. Relatively fewer retired aged persons, particularly those in poor health and in the older age groups where the burden of medical costs is greatest, have such protection. Older persons too, lack the possibility often open to those younger of accommodating to a medical emergency through increasing family earnings.

For medical care expenditures, more than for other items of family living, there is wide variation not only from family to family but for any given family from year to year. An unanticipated medical emergency can change expenditures from a comfortably manageable level to a new peak of crisis.

USING OWN RESOURCES

A 1957 study for the Health Information Foundation (HIF) on resources to pay for health services among those aged 65 and over reported as follows:

> In early 1957 the older population could be divided into three groups: Those who had resources from which they could meet a medical bill as large as $500; those who had no ready resources for meeting such a bill; and a small amorphous middle group whose position cannot be clearly ascertained * * *. No categorical statement can be made to summarize how older people said they would meet a large medical bill. Some felt they could pay a medical bill as large as $500 from a combination of current income and savings. This group included roughly 6 of every 10 couples, 5 of every 10 unmarried older men, and 4 of every 10 unmarried older women. On the other hand, some older persons would have to mortgage property, borrow on life insurance, ask help from their children, turn to public assistance or charitable aid, or say in despair, "No one would charge me that * * * I just couldn't pay it." This group included about 3 of every 10 couples, 4 of every 10 unmarried older men, and 5 of every 10 unmarried older women.

The HIF study asked people how they thought they would handle a large bill. The OASI survey in the same year obtained fairly comprehensive data on the means by which aged persons actually met their medical emergencies. More than two-fifths of the couples and roughly three-fifths of the nonmarried beneficiaries studied who spent some time in a general (or short-stay special) hospital in 1957 did not meet all the year's medical costs out of their own income, assets, and health insurance. Almost all beneficiaries hospitalized paid some of their medical bills from their own income and savings, but those with very long stays were least able to stretch their resources to cover all costs. For example, 78 percent of the nonmarried beneficiaries in a general hospital longer than 60 days did not assume responsibility for all their own medical costs for the year, compared with 55 percent of those hospitalized for shorter periods.

Medical debts were incurred—or increased—by 21 percent of the couples and 12 percent of the nonmarried beneficiaries with a hospital episode during the year. (For all the beneficiaries, whether or not hospitalized, the proportions were much smaller—7 percent and 3 percent, respectively.) And this does not count the cases where a doctor, for example, reduced his fees because he knew that the patient could not pay. Moreover, a considerable number of the beneficiaries who had more unpaid medical bills at the end than at the beginning of the year got help from outside as well.

HELP FROM OTHERS

Fifteen percent of the couples and 29 percent of the nonmarried beneficiaries who had a hospital episode relied for at least part of their medical care on public assistance agencies, hospitals, or other public and private health and welfare agencies. Less than half as many of the nonhospitalized beneficiaries had to turn to welfare agencies.

The number receiving help from relatives in one form or another was at least as large. When beneficiaries were asked how they met their medical bills, 15 percent of the couples and 26 percent of the nonmarried with one or more hospital episodes reported that relatives helped pay for them. (Less than half as many of the other beneficiaries had to turn to relatives.) Some additional beneficiaries with hospital bills in effect received as much or more help with their medical costs from relatives who helped support them either by sharing their home or by paying other regular living expenses.

The longer the period of hospitalization the more frequently relatives contributed to help out with expenses. Most of the relatives who were contributing to an aged person living in the household were themselves in the middle or lower end of the income scale.

If the relatives—both in and out of the household—on whom responsibility fell were typical, many would have children of their own to take care of. Others, with no children, were themselves already at or close to the age when their own problems of retirement would loom large. The aforementioned study by the HIF asked the persons 65 and over to whom they would turn (other than their own husband or wife) in event of illness. More than 6 in 10 named a son or daughter or the spouse of a son or daughter. Those designated were described as follows:

> Those to whom older people would turn for help in a health crisis were already involved with many family responsibilities. If these individuals were sons or daughters of older people they were usually young or middle-aged adults. Three of every four among them (73 percent) had children of their own * * *. The relatives to whom older people without children would turn for help were themselves likely to be in the older age groups, and many of these were over 65 years of age; also, many were widowed or single.

When asked how they would pay a medical bill of $500 or more, about one-fourth of the aged women who were widowed, divorced, or single, and about one-eighth of the men who were not married, said they would turn to children or other relatives. Fewer of the married persons—1 in 13—mentioned relatives as a resource presumably because those still married tend to be younger and to have more income and savings than the widowed.

MEDICAL NEED AND PUBLIC ASSISTANCE

The exact number of aged who must seek public assistance because of medical need cannot be measured with exactitude. Depending on facilities available for the medically indigent and on local assistance practices, as well as on personal differences in reaction to a means test, some come for help at the time of medical need while others come to seek help in meeting daily living expenses only after using up their resources to pay their medical bills.

For example, the 1957 BOASI survey found that among all aged beneficiaries who incurred medical costs during the survey year, about 1 in 14 of the couples and 1 in 8 of the nonmarried were on public assistance at some time during the same 12-month period.

An analysis of the reasons for approving old-age assistance grants in about half the States in January–June 1961 shows that nearly 1 in 3 recipients needed assistance, at least in part, as a result of health problems in the 6 months preceding. Interestingly enough, aged persons receiving OASI benefits (numbering just about every other newly approved assistance recipient) were more likely to require the aid because of medical needs. Health problems of one sort or another were the reason for opening the case for two-fifths of the recipients drawing benefits as against one-fourth of those not on OASDI (table 33).

TABLE 33.—*Old-age assistance: Distribution of cases opened by reasons for opening, by OASDI status, 25 States, January–June 1961*

Reason for opening	Total opened	Receiving OASDI benefits	Not receiving OASDI benefits
All cases	100	100	100
Total involving health problems	31	39	25
Recipient's earnings reduced because of illness, injury, or impairment	11	11	9
Assets exhausted to meet medical care	7	9	7
Increased need for medical care (with no material change in income or resources)	13	19	9
Other reasons	69	61	75

Source: Bureau of Family Services, Social Security Administration, *Reasons for Opening and Closing Public Assistance Cases*, January–June 1961. (In process.)

THE ROLE OF HOSPITAL INSURANCE

Were it not for health insurance many more aged persons would have to turn to relatives or welfare agencies, or both, to meet their pressing medical needs.

Length of stay and portion of bill covered

Data from the National Health Survey for 1958–60 reveal that for half the short-stay hospital episodes of aged persons during a year health insurance paid no part of the bill.

Even when insurance was available to the aged it was less effective for long than for short stays, defraying three-fourths of the hospital bill for 47 percent of the stays lasting over a month, compared with 60 percent of those lasting no more than 30 days (table 34). Although the average elderly patient in a general hospital who leaves the hospital alive does so within 15 days, nearly 1 in 10 remains a month or longer. The longer his hospitalization last, the more likely it is the aged person will have to seek help from others to pay for his care.

TABLE 34.—*Insurance coverage of hospital costs: Distribution of short-stay hospital discharges according to proportion of bills paid by insurance, by age and length of stay, July 1958–June 1960*

[Noninstitutional population of the United States]

Age and length of stay	Total discharges	Proportion of bill paid by insurance			
		None of bill	Any part of bill		
			Less than ½	½ to ¾	¾ or more
65 and over	100.0	48.8	9.0	11.9	30.3
1 to 5 days	100.0	48.9	10.1	11.5	29.4
6 to 14 days	100.0	46.4	8.6	11.9	33.1
15 to 30 days	100.0	49.8	9.2	11.0	30.0
31 or more days	100.0	54.7	8.1	15.8	21.4
Under 65	100.0	30.0	4.9	11.2	53.8
1 to 5 days	100.0	31.6	4.6	11.1	52.7
6 to 14 days	100.0	25.1	5.3	11.7	57.9
15 to 30 days	100.0	28.2	5.2	12.3	54.4
31 or more days	100.0	49.1	7.2	8.7	34.7

Source: Public Health Service, U.S. National Health Survey, *Proportion of Hospital Bill Paid by Insurance. Patients Discharged From Short-Stay Hospitals, United States, July 1958–June 1960* (Publication No. 548-B30), November 1961.

The OASI beneficiary survey also provides a measure of the degree to which insurance met hospital costs of aged patients. About 1 in 5 married beneficiaries and 1 in 4 of the nonmarried with insurance found it met all of the hospital charges. On the other hand about 5 percent of those with a hospital insurance policy found it did not cover any of the costs of their care in a nongovernmental general hospital (table 35).

TABLE 35.—*Insurance coverage of hospital costs of OASI beneficiaries: Distribution of aged beneficiaries in general hospitals according to proportion of costs paid by insurance, by marital status and hospital ownership, 1957*

Proportion of general hospital costs paid by insurance [1]	Married couples [2] [3]		Nonmarried beneficiaries	
	Total	Non-Government	Total	Non-Government
Total hospitalized	100	100	100	100
With no hospital insurance	43	39	48	41
With some hospital insurance	57	61	52	59
With some hospital insurance	100	100	100	100
No costs met by insurance	7	6	9	5
Less than 25 percent met by insurance	7	8	4	3
25 to 49 percent met by insurance	18	20	6	5
50 to 74 percent met by insurance	22	22	29	30
75 to 99 percent met by insurance	20	19	21	23
100 percent met by insurance	19	19	24	27
Unreported amount met by insurance	6	6	6	7

[1] Excludes surgeons' and inhospital physicians' fees. In the case of married couples, with both members hospitalized, represents hospital costs for the couple. (General hospitals include short-stay special hospitals.)

[2] Insurance status for married couples refers to the hospitalized person. If both were hospitalized, but only one insured, the couple is classified in the "with insurance" category and by the proportion of total general hospital costs for the couple which was met by the insurance.

[3] Aged beneficiary and spouse, whether or not entitled to benefits; spouse may be under 65 years of age.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration, *1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.*

Amount of insurance and amount of hospital utilization

Aged persons having insurance against costs appear to enter a hospital with greater frequency but have a shorter average stay than those with no insurance protection. Those with a higher benefit policy use the hospital more often than those with a lower benefit policy.

The National Health Survey found about 1 out of 3 hospital discharges with no part of the bill paid by insurance came from Government hospitals, as compared with 1 in 7 of those for which insurance did pay part of the bill. These proportions are the same for patients under 65 as for persons 65 and over. However, because fewer of those over 65 have any insurance, the Government hospitals accounted for a somewhat larger share of total general hospital stays of the aged than of persons under 65 (23 percent versus 20 percent, repectively). The fact that the aged patient is likely to remain in hospital longer than the younger patient gives this differential added significance.

The 1957 OASI beneficiary study also demonstrates the effect of ability to pay—as measured by health insurance protection—on the type of hospital used and on completeness of reporting of medical costs. Among 4 out of 5 of the couples with either member hospitalized and a little better than 7 out of 10 of the nonmarried, the hospitalization took place in a non-Government hospital. But, as table 36 indicates, beneficiaries with no hospital insurance policy were just about twice as likely to enter a Government hospital for their care as those who could anticipate insurance defraying some of the bills. Moreover, although very few of the hospitalized beneficiaries received their care in a Federal general hospital, almost all who did came from among the noninsured.

TABLE 36.—*Insurance status and hospitalization in public institutions: Distribution of aged OASI beneficiaries in general hospitals by hospital ownership and insurance status, 1957*

Hospital ownership[2]	Married couples[1]		Nonmarried beneficiaries	
	With no hospital insurance[3]	With hospital insurance[3]	With no hospital insurance	With hospital insurance
Total hospitalized	100.0	100.0	100.0	100.0
Non-Government	72.3	85.2	61.5	83.5
Government	30.1	17.0	39.2	16.5
State, county, and city	26.6	16.2	31.5	15.8
Federal	3.5	.9	7.7	.7
Hospital costs reported	100.0	100.0	100.0	100.0
Non-Government	84.1	88.6	76.4	83.8
Government	18.6	14.1	23.6	16.2
State, county, and city	18.6	14.1	22.2	16.2
Federal			1.4	
Hospital costs not reported[4]	100.0	100.0	100.0	100.0
Non-Government	50.0	71.1	43.1	81.8
Government	51.7	28.9	58.6	18.2
State, county, and city	41.7	24.4	43.1	13.6
Federal	10.0	4.4	15.5	4.5

[1] Aged beneficiary and spouse, whether or not entitled to benefits; spouse may be under 65.
[2] A few had more than 1 stay in a general hospital involving more than 1 type of ownership. (General hospital includes short-stay special hospital.)
[3] For the hospitalized person. If both members were hospitalized but only 1 had hospital insurance the couple is classified in the "with insurance" category.
[4] In many cases, includes some "free" care, i.e., no bills rendered to anyone, or vendor paid directly by public assistance or other agency.

Source: Bureau of Old-Age and Survivors Insurance, Social Security Administration, 1957 National Survey of Old-Age and Survivors Insurance Beneficiaries.

[Chapters 8, 9, and 10 on Public Programs and Philanthropic Arrangements for Medical Care Have Been Excluded in Their Entirety]

CHAPTER 11. TRENDS IN SELECTED HEALTH SERVICES AND COSTS

Outstanding advances in scientific medicine have contributed not only to improved health and the well-being of people generally, but in addition have made for higher medical care costs.

The rising costs of health care are of particular concern for older people because of their relatively high utilization of hospital and other health services and their comparatively low financial resources for meeting such costs.

Trends in health care costs

The standard measure of price movements in the United States is the Bureau of Labor Statistics' Consumer Price Index. The "price" of medical care began to climb in 1941, but the big increase came after 1950. Between that year and 1961, medical care prices went up more than twice as much as the average "price" for all the goods and services used by families, whereas over the longer period, from 1940 to 1961, they went up only slightly more than the average for all goods and services (table 37).

TABLE 37.—*Consumer Price Index: Percent increase by category and for selected medical care items, 1950 to 1961 and 1940 to 1961*

Item	1950 to 1961	1940 to 1961
All items	24.3	113.4
Medical care [1]	51.8	121.3
Hospital daily service charges	109.7	376.8
Physicians' fees	43.0	99.6
Dentists' fees	29.0	96.7
Prescriptions and drugs	16.7	45.8
Food	19.7	153.3
Apparel	12.3	107.1
Housing	24.9	73.4
Transportation	32.9	111.9
Personal care	32.5	125.2
Reading and recreation	20.0	93.6
Other goods and services	26.6	83.0

[1] Includes optometric examinations and eyeglasses not shown separately. Hospitalization and surgical insurance included in the index for 1961 but not for the 2 earlier years.

Source: Bureau of Labor Statistics, *Price Indexes for Selected Items and Groups.*

Hospital daily service charges (and hospitalization insurance premiums) have risen most among the components of the medical care index. The rise in physicians' fees, dentists' fees, eye examinations, surgical insurance, and drug outlays has been more in line with the general price increase, or at least the increase in prices of other services, such as transportation and personal care.

Total expense per patient day in non-Federal short-term general and special hospitals, as reported by the American Hospital Association, somewhat more than doubled between 1950 and 1960, going from $15.62 to $32.23. This was slightly more than the increase in the price index of hospital daily service charges, presumably because the expense per patient day reflected some increases in services provided. Comparable data on expense per patient day are not available prior to 1946 when the average was only $9.39, hospital wages and hours were generally at prewar levels, and there were severe staff shortages.

Costs of health care will probably rise over the next 15 or 20 years at least as much as the rise in general price level. However, it seems fairly certain that the increase in health costs, particularly hospital costs, will not continue to exceed the increase in the general level of prices to the extent they have in the last decade.

Overall health costs and prospects

Public and private expenditures for health services, health research, construction of health facilities, and public health activities in 1960 took 5.4 percent of the Nation's total output. In 1929, all such health expenditures amounted to about 3.5 percent of the gross national output. Whether the proportion of the national output going into health services in the next two decades will change significantly depends both upon developments in the health technology and applied health care fields and upon the rate of growth of total output. The public needs and demands for health protection, including services for older people, will be a basic factor in determining its priority in relation to other living needs for sharing in the national income. If the productivity of our economy continues to grow, we shall be able to expand our health services well beyond present levels without strain and without significant change in the present ratio of health expenditures to total output.

○