REFORM IN THE GREAT SOCIETY: THE CASE OF MEDICARE

by Allen J. Matusow

In 1965 President Lyndon B. Johnson exploited a favorable moment to push through Congress most of the liberal reform proposals of the previous twenty years. The first session of the Thirty-ninth Congress, "the greatest in American history" according to the President, enacted Medicare for old people, Medicaid for poor people, school aid for disadvantaged children, a voting rights bill for disfranchised Southern blacks, rent supplements for low income families, economic assistance for Appalachia, increased funds for the new Office of Economic Opportunity (OEO), and much else of importance. Johnson told Congress in October 1965, "you have begun a march which will not be stopped."[1] But in fact the liberal hour was already over. The programs of the Great Society, greeted at first with enthusiastic public applause, would quickly become engulfed in controversy, lose popular support, and largely be repudiated by the new administration elected in 1968.

In part the Great Society was the victim of unfortunate historical circumstances, a casualty of ghetto rebellion and war in Vietnam. But the major cause of the failure of the Great Society lay in the conceptions that shaped it. Great Society reforms were so conservative in their design and execution that they were bound to disappoint the reformist hopes invested in them. The conservative limits imposed on Johnson's programs had two causes. First, post-war liberalism had developed complacent assumptions about the American social order and would not seriously contemplate redistribution of wealth and power. Second, Johnson's passion for consensus, which paid such handsome dividends in the 1964 election, meant that whatever he did for the weak would have to be acceptable to the strong.

The war on poverty was the main component of the Great Society. A serious strategy for this war would have set a minimum floor under the income of the unemployable poor, created government jobs for the employable poor, and sought to reform the repressive and unresponsive institutions controlling the

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lives of poor people. But warfare on this scale would have increased taxes on the affluent, risked inflation, and aroused the enmity of entrenched and powerful special interests. Though varieties of this strategy won favor at times in the OEO, they never had a chance in the White House. The administration's poverty war was only an uncoordinated collection of palliatives, whose effects were often of doubtful social value.

If the Great Society had one overriding flaw stemming from its conservative premises, it was this: it chose as the instruments of reform the very institutions that had failed the poor. School systems notoriously indifferent to culturally disadvantaged children received billions to combat the educational effects of poverty. The private home-building industry, never noted for altruism, was enlisted to help supply housing for low income families. The local community action agencies created by the OEO quickly abandoned agitation for institutional reform and became mere conduits for dispensing social services through traditional welfare bureaucracies. And in the case of Medicare-Medicaid, the government intervened in the medical market place with billions of dollars without requiring any changes in the existing health care industry.

The case of Medicare-Medicaid can serve to illustrate the general limits of Johnsonian reform. Of all Great Society programs, the Medicare part of this measure was the most popular, expensive, and important; and since it provided undoubted benefits to many, it remains the most defensible. Nevertheless, Medicare, along with Medicaid, had some unintended and largely unrecognized consequences that make even it something less than an unambiguous boon to the general welfare. In choosing a conservative strategy to pay the medical expenses of part of the population, the reformers of the mid-1960's created almost as many problems as they solved.

The Medicare bill submitted by Johnson to Congress in 1965 had a long and interesting history.[2] After World War II President Truman had proposed compulsory comprehensive medical insurance for every citizen, to be financed primarily by a payroll tax on employers and employees. The American Medical Association (AMA) spent millions to discredit Truman's plan, and in 1949 a conservative coalition in Congress easily defeated it. In 1957 the issue resurfaced in drastically refashioned form. Liberals now proposed compulsory government health insurance only for persons 65 or over. Benefits would cover only hospital-related costs. And financing would be tied directly to the existing social security mechanism. Called Medicare, this proposal predictably won the support of liberals and Northern Democrats, while repelling Republicans and the organized doctors.

The design of the new program proved politically shrewd. In selecting old people for Medicare's benefits, liberals hit on a popular minority demonstrably in need of hospital insurance. In limiting coverage to hospital costs,

Medicare seemed a cautious rather than a radical innovation. And, liberals argued, linking Medicare to social security made Medicare not charity dispensed after imposing a means test, but a form of insurance entitling all contributors to benefits as a matter of right. In making this last argument, the liberals were exploiting a popular misconception. Social security was not really insurance, and neither was Medicare. Workers paying social security taxes were not contributing to their own benefits but to benefits for the already retired. (For years after Medicare's enactment, its actual beneficiaries had paid hardly any taxes into the program.) Social Security pensions and Medicare were income redistribution mechanisms which transferred wealth from the young to the old, rather than from the rich to the poor. Social security taxes were, in fact, sharply regressive, a disproportionate share of their burden falling on low income groups. Nevertheless, the social security feature of Medicare was one of the big reasons for its undoubted popular appeal.

Conservatives reacted as violently to the new Medicare proposal as they had to Truman's national health insurance scheme. They complained that it augmented the power of Washington bureaucrats, diminished individual liberty by making participation compulsory, and prepared the way for socialized medicine. To weaken the liberal case for Medicare, Congressional conservatives in 1960 devised an alternative solution to the problem of burdensome medical costs of the aged. This was the Kerr-Mills program, passed that year and named after its sponsors, Representative Wilbur Mills and Senator Robert Kerr. Kerr-Mills increased federal aid to help the states pay for the medical care of old people on public assistance. More important, it initiated a new program of federal matching grants to any state undertaking to assist a new class of Americans—the "medically indigent" aged. The medically indigent were defined as those with incomes too high to qualify for public assistance but too low to pay their medical bills. (The concept of medical indigency would later profoundly shape Medicaid.) Kerr-Mills perfectly fit the ideological requirements of contemporary conservatism. The program was to be administered by the states; it removed the element of compulsion; and it imposed a means test to make sure that only the needy obtained benefits.

Kerr-Mills did not quiet agitation for Medicare. President Kennedy had campaigned for it in 1960 and pressed Congress to enact it throughout his abbreviated tenure. Kennedy's case was immeasurably strengthened by the poor performance of the Kerr-Mills program. Only twenty-eight states had enacted programs for the medically indigent aged by 1963, and five rich states were receiving nearly all the act's benefits.[3] But Kennedy failed to convert Congress to Medicare. The key Congressional obstacle was the House Committee on Ways and Means, whose majority was solidly opposed

to medicare and whose chairman was Wilbur Mills. When the Senate finally passed Medicare in 1964, even President Johnson could not persuade Mills to dislodge the bill from his House committee. Then came Johnson's landslide election victory in November, bringing into the House thirty-eight new liberal Democrats and assuring Medicare's triumph at the next Congressional session.

In testifying for Medicare before Ways and Means in early 1965, Anthony Celebrezze, Secretary of Health, Education, and Welfare (HEW), added little to arguments that had been refined through nearly a decade of debate. The average person 65 years or over, Celebrezze had pointed out many times, had only half the income of younger Americans, but used hospitals three times more frequently. Probably fewer than one million of the nation's nineteen million old people had insurance covering as much as 40% of average medical costs, and eight million had no insurance at all. Medicare, said Celebrezze, was necessary to prevent "personal bankruptcy, unwilling dependency, . . . and loss of pride" among the nation's aged population.[4]

The basic provisions of the administration's Medicare bill committed the government to pay for most of the hospital-related charges incurred by the aged: hospital rooms, nursing care, and other hospital services. This bill covered neither physicians' nor surgical fees. To discourage doctors from unnecessarily keeping aged patients in hospitals, the bill provided coverage for certain economical substitutes for hospitalization: post-hospital care in nursing homes, house visits by nurses and therapists, and out-patient diagnostic services such as x-rays and lab tests. For the one person in six who was not eligible for social security benefits the bill offered identical coverage paid for from general federal revenues.[5]

Faced with imminent passage of the Medicare bill early in 1965, the AMA and the Republicans executed a major change in tactics. The trouble with Medicare, they now said, was that it did not go far enough. Testifying before Congress in February, the president of the AMA noted estimates that Medicare "would cover only 25% of the annual health care expenses of the average person over 65." Where, he asked, "are the needy aged to get the other 75%?"[6] The Republicans submitted a substitute to meet Medicare's alleged deficiencies. It provided voluntary federal insurance to cover not only hospital-related costs, but also physicians' and surgical fees and drug costs. Beneficiaries of this insurance would pay half the premiums; the government would pay the other half from general revenues.[7] The Republicans sought to achieve two purposes with this proposal: reap political gain by offering more coverage than the Democrats; and maintain ideological purity by sponsoring a voluntary program.

The central figure in the curious history of Medicare in 1965 was Wilbur Mills. A consummate politician who valued consensus within his commit-

tee, Mills could read the election returns as well as any man. Mills announced early in the year that he now supported Medicare and would see to it that Ways and Means soon reported a bill to the House floor. On March 2, 1965, Mills's committee met with officials from HEW in executive session to work out details of the legislation. In the midst of a spirited discussion on the Republican substitute, Mills unexpectedly made a suggestion. Why not combine the administration and Republican bills into one? he asked. As Mills described it, Medicare would have two tiers. The first would be compulsory hospital insurance financed primarily by social security taxes. The second would be voluntary insurance for the aged covering physicians' and surgical fees and certain other medical charges. The government and the beneficiaries would share equally in the cost of the voluntary insurance program. Mills turned to Wilbur Cohen, Assistant Secretary of HEW, and asked if the administration would consent to adding supplementary voluntary insurance to its bill. Cohen readily gave his approval, and that same evening, so did President Johnson. Cohen recalled later, "It was the most brilliant legislative move I'd seen in thirty years. The doctors couldn't complain, because they had been carping about Medicare's shortcomings and about its being compulsory. And the Republicans couldn't complain, because it was their own idea. In effect, Mills had taken the A.M.A.'s ammunition, put it in the Republicans' gun, and blown both of them off the map."[8] Embarrassed by Mills's maneuver, the Republicans wound up opposing a bill that included their own proposal.

Mills was not done yet. Medicare would obviously leave the Kerr-Mills program with a much diminished role in paying the medical bills of the elderly poor. Rather than abandon a program bearing his name, Mills decided to add an expanded version of Kerr-Mills as the third tier of his committee's bill. Mills offered federal aid to states which would make medical payments for certain categories of the poor and medically indigent *below* the age of 65. This became the program popularly known as Medicaid. Medicaid could potentially assist millions of the non-aged poor and near-poor in paying their medical bills. It might one day even reach more people and cost more money than Medicare itself. Surprisingly, few paid much attention in 1965 to this major innovation in the nation's public assistance program.

By the time the bill left Ways and Means, the administration's original proposal had been drastically revised.[9] Wilbur Mills, once a conservative foe of federal involvement in medicine, had drafted a measure that went far beyond anything Lyndon Johnson had dared contemplate in January. Mills's confection survived largely intact all the hurdles of the House and Senate. On July 30, 1965, Johnson flew to Independence, Missouri, to sign

the bill in the presence of Harry Truman. The new law added two titles to the Social Security Act of 1935:[10]

Title 18. Part A of Medicare provided federal hospital benefits for up to ninety days for each spell of illness for an aged person. The patient would have to pay a deductible of $40 for the first sixty days and $10 a day for the next thirty days. Post-hospital patients were entitled to one hundred days of nursing home care; outpatient diagnostic services, for which patients paid the first $20 and 20% of remaining costs; and up to a hundred home health care visits by nurses and therapists after discharge from a hospital. Part B of Medicare created voluntary supplemental insurance to cover physicians' and surgical fees. Enrollees would pay $3 a month, and the federal government would pay a matching amount. This insurance covered 80% of doctors' fees after an annual deduction of $50. Covered also were x-rays, lab tests, ambulance service and certain optometrist fees.

Title 19. This title established Medicaid. First, it codified and liberalized medical payments for the four categories of federally-aided public assistance recipients: the indigent aged, blind, totally and permanently disabled, and members of families with dependent children. Second, states were now offered the option of extending medical payments to include those of the aged, blind, disabled, and families with dependent children *not* eligible for public assistance but nevertheless medically indigent. The federal government offered to pay grants to the states varying from 50% to 83% depending on the wealth of a state, as the federal share of the cost of these two programs. A state's Medicaid program at a minimum had to cover the costs of hospitals, physicians, nursing homes, x-rays, and lab tests.

Without doubt, Medicare-Medicaid affected more people and cost more money than any other single welfare program since the New Deal. Under Medicare nearly all aged persons in the country qualified for the government's hospitalization benefits, and 96% of them elected to buy the supplementary insurance as well. Government expenditures for Medicare quickly outstripped the government's estimates, rising from $3.4 billion in the program's first year (fiscal 1967) to $7.9 billion in fiscal 1971.[11] Medicaid caught on much more slowly, since its implementation depended on the initiative of the states. In fiscal 1967 more than four million people received the benefits of Medicare at a cost of $2.4 billion. By 1971 the estimated number of beneficiaries had grown to more than thirteen million, and the cost to $6.4 billion.[12] Thus by 1971 federal and state governments were spending over $14 billion a year to help pay the medical expenses of one-seventh of the population.

Medicare-Medicaid was the quintessential Great Society program. It aimed at far-reaching reform without change in existing institutions or challenge to vested interests. The government in effect turned the program over to the medical profession, paid its fees, and imposed only the feeblest regulations on it. The government did this despite the notorious inefficiency of hospital managers and the spirit of the *petite bourgeoisie* that permeated private medical practice. Though progressive in implementing medical technology, the medical profession remained in the hands of individual businessmen insistent on being paid a fee for service. It was a business where

consumers were ignorant, where practitioners had control over the number of potential competitors, and where a tendency to plunder non-profit insurance providers had long been manifest. Under the law, hospitals were to be reimbursed for their reasonable costs and physicians for their customary fees, a vague formula with incentives for padding costs and raising fees. The House Ways and Means Committee had made explicit the intent of Congress not to interfere with the existing structure of the health care industry. The Committee's report of March 1965 said, "The bill specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which services are provided, and the administration or operation of medical facilities."[13]

There were those, of course, who questioned whether expenditures of additional billions for health care was a good idea no matter how the medical profession conducted its business. In this view, the growing American taste for consuming medical services depended on wild overestimates of what these services could accomplish. The improvement in the health of populations in modern industrial societies was the result primarily of rising incomes, public measures to cleanse the environment, and basic research in bacteriology, physics, and other sciences. The therapeutic medical services rendered by physicians and hospitals more often eased symptoms than effected cures, and Eli Ginzberg of Columbia University went so far in 1969 as to say, "It is just possible that with regard to a wide range of conditions, those who were treated least made the best progress."[14] Nevertheless, the American people desired more medical service, and they valued equity highly enough to pay billions to increase the share consumed by disadvantaged groups.

By no means all the governmental expenditures for Medicare-Medicaid purchased an increase in services. To a large extent, these programs shifted the cost of treating charity patients from private sources or local governments to the federal government. Hospitals and doctors could now charge the government for medical care they had once given free. Medicare made it possible for hospitals to reduce the number of non-paying aged patients from 17% to 3%.[15] Of the $1 billion paid by the government to private physicians in fiscal 1968 for Medicare-Medicaid, an estimated $344 million simply replaced an equal value of services formerly rendered at reduced fees or no fees at all.[16] Neither hospitals nor physicians reduced charges to their paying patients following this gold strike at the federal Treasury.

But much of the expenditure for Medicare-Medicaid did make additional medical care available to the aged and the poor. Largely because of Medicare, the elderly increased their utilization of medical services by nearly 11% a year for 1966-1969, a rate three times greater than for the non-aged.[17] Increased utilization was especially marked in hospitals, where the number of days of care per hundred aged persons increased 25% during Medicare's

first year.[18] The skeptical doubted whether this increase was medically justifiable. Without incentives to economize on government-financed patients, doctors and hospitals proved too ready to commit and retain patients. Widespread suspicions led the General Accounting Office (GAO), an independent auditing agency of Congress, to examine in 1969 the problem of hospital utilization under Medicare. GAO investigated the medical records of 1,735 randomly-selected extended duration Medicare cases. GAO reported, "our consulting physicians questioned in 465 cases [27%] whether the care provided should have been under the Medicare program."[19] A secretary of HEW once estimated that if the hospital stay of every Medicare patient were decreased by one day, the annual savings to the government would be $400 million.[20]

The main purpose of Medicare had been to cut the direct medical expenditures of the aged. For those suffering catastrophic illnesses, Medicare was everything it was supposed to be. (Thirty-nine percent of Medicare reimbursements in 1967 were for services rendered to the 7.5% of Medicare patients with expenses of $2000 or more.)[21] But the average aged person still found his limited budget burdened by substantial medical costs. Among the expenses which the 1965 Medicare Act did not cover were the first $40 of hospital bills, 20% of doctor bills, the first $50 of physicians' fees, drug bills, dental bills and optometrist fees. True, the elderly had to pay only 47% of their total medical bill out-of-pocket in the first Medicare year, compared to 77% previously. But the medical bill of the average aged person rose so rapidly that first year that the benefits of Medicare were partially washed away. Thus despite Medicare, the actual out-of-pocket expenditures for medical services per aged person declined from only $229 in 1965 to $196 in 1967.[22] By 1970, out-of-pocket costs for the aged had gone back up to $226, compared to only $100 for the non-aged person.[23] Ironically, an important cause of rising medical costs was Medicare-Medicaid itself.

Medical prices had been rising more rapidly than other consumer prices since 1950, but beginning in 1966 the escalation became dramatic. That Medicare-Medicaid happened to commence operations in that year was no mere coincidence. Economists think of medical services the way they think of corn. When demand pushes against supply, prices go up. The huge infusion of government funds into the medical marketplace after 1965 predictably helped raise prices at a rapid rate for all patients. Between 1965 and 1970 total private and public spending for health in the U.S. increased from $39 billion to $67 billion. Medical prices, which rose 2.8% annually from 1960 to 1966, went up an average 6.6% in each of the first four Medicare years. Since the largest proportion of government expenditures went for hospital care, hospital prices rose fastest of all—from 7% a year in the first half of the decade to about 14% in the second half.[24] (Interestingly, while

physicians' fees rose 10.9% in Medicare's first year, drug prices, dental fees and optometrists' fees, which were not covered, remained virtually unchanged.)[25] Authorities agree that Medicare-Medicaid contributed significantly to medical inflation, but few economists have ventured precise estimates of the program's price impact. The one study brave enough to try examined medical prices in 1967 and 1968 and concluded that nearly the entire rise in hospital and physician prices in these years was attributable to Medicare-Medicaid.[26] Given inflation in the general economy, this finding seems exaggerated. One conclusion is, however, unchallengeable. Non-recipients had not only to pay sizeable taxes to support Medicare-Medicaid; they also had to pay significantly higher prices for their own medical care as a consequence of this same program.

The distribution of benefits under the 1965 act was hardly what its sponsors had anticipated. In fiscal year 1968, for instance, non-recipient households paid a net average of $114 in taxes to support Medicare-Medicaid. The net benefit for each Medicare household was $175, and for each Medicaid beneficiary, $200. But the real winners in this massive redistribution of income were the nation's nearly 200,000 private physicians, whose incomes increased an estimated average of about $3900 in 1968 thanks to Medicare-Medicaid.[27] Some doctors, of course, did better than others. Sometimes through fraud or exploitation of lax regulations, approximately 10,000 doctors each collected $25,000 or more a year from these programs.[28] As one study put it, "It is difficult to defend a policy which provided at public expense the greatest gains to one of the highest paid professions."[29]

Though Medicare covered all aged persons, the poor were supposed to be the chief beneficiaries of the 1965 act. Medicare's proponents had based their case mainly on the large number of elderly poor who could not pay their medical bills. As it turned out, Medicare left so many costs uncovered that medical bills continued to burden the elderly poor. Fortunately, Medicaid was often available to fill some of Medicare's gaps. Medicaid, for instance, paid 22% of the health bill of the elderly in 1969.[30] But Medicaid was exactly the kind of state charity, complete with means test, so abhorrent to Medicare's creators. Moreover, Medicaid benefits varied widely among the states, leaving millions of the aged poor and near-poor to pay many bills as best they could.[31]

Medicaid's general performance was the cause of much hand-wringing. It covered only about one-third of the poor in 1969,[32] neglected children in favor of the aged, and concentrated its benefits in a handful of rich states. California, Massachusetts, Michigan, and New York, containing less than one-quarter of the nation's poverty households, spent nearly two-thirds of all Medicaid funds.[33] Every state but Arizona and Alaska provided Medicaid benefits for welfare recipients, but only half the states provided for the

medically indigent. Run by weak and understaffed state welfare agencies, the program was an administrative monstrosity preyed upon by often unscrupulous doctors.[34] Medicaid's most obvious weakness resulted from its connection with the despised welfare system. Testifying before Congress in 1969, Dr. John Knowles, Director of the Massachusetts General Hospital, summed up the view of Medicaid's reformist critics. "Medicaid," he said, "has degenerated into merely a financing mechanism for the existing system of welfare medicine which is not adequate and must be changed. . . . It perpetuates the . . . inhuman and undignified means test in the stale atmosphere of charity medicine carried out in many instances by marginal practitioners in marginal facilities."[35] In New York City, for example, only 15% of eligible doctors consented to treat Medicaid patients, and among these were many who specialized in the poor and offered second-rate services.[36] According to one government report, "Medicaid has been forced to pay less than adequate prices for frequently less than adequate services."[37] By 1971 governments were pouring 35% of public assistance dollars into Medicaid, a huge proportion anticipated by no one.[38] If welfare recipients had received in cash the equivalent of the medical payments made in their behalf, they would probably not have chosen to spend so much on health. Dissatisfaction with Medicaid soon spanned the political spectrum, and everyone agreed that some better way had to be found to democratize access to medical services.

By the early 1970's galloping medical inflation had become a major political issue. Ignoring the role which the government's programs had already played in creating the crisis, liberals proposed compulsory national health insurance as their solution. The prospect of the government paying the health bill of every citizen in an uncontrolled medical marketplace should have gladdened few informed hearts. The lesson of Medicare-Medicaid is that without reform of existing medical institutions, no real solution to the medical payments crisis is possible. How such reform can be achieved is a complex and debatable matter. Should government pursue policies to increase the number of medical suppliers? Should it encourage an increase in the production of para-medics and an expansion of their function? Should it directly control medical prices? Should it use its tremendous economic leverage to seek replacement of fee-for-service with prepaid medical care, perhaps in neighborhood Health Maintenance Organizations? Should it own and operate its own hospitals? Should it socialize hospitals already in existence? Each of these possibilities poses problems of its own. And those that might best achieve the purposes of reformers would most offend the free enterprise traditions of the country and entrenched special interests in medicine. It should not, however, surprise a generation that lived through the Great

Society that the world yields grudgingly to mere good will, that cautious intervention can distort but not discipline the free market, and that real social change entails some measure of social conflict and social cost.

NOTES

1. Both quotations in this paragraph are from *Public Papers of the President: Lyndon B. Johnson, 1965* (1966), pp. 1058-1059.

2. For background on Medicare, see Richard Harris, *A Sacred Trust* (New York, 1966); Theodore Marmor, *The Politics of Medicare* (London, 1970), chs. 1-3; and Peter Corning, *The Evolution of Medicare: From Idea to Law* (HEW, SSA Research Report No. 29, 1969) chs. 1-4. For history of Medicare and a description of its operations, Robert S. Myers, *Medicare* (Homewood, Ill., 1970).

3. "Medical Assistance for the Aged: The Kerr-Mills Program, 1960-1963," Committee Print, Special Committee on Aging, U. S. Senate, 88th Cong., 1st sess., pp. 1-8.

4. "Medical Care for the Aged," Committee on Ways and Means, House hearings, 88th Cong., 1st and 2nd sess., pp. 25-27. The quote is on p. 37.

5. "Medical Care for the Aged," House hearings, 89th Cong., 1st sess., pp. 2-9.

6. "Medical Care for the Aged," p. 743.

7. The Republican bill is explained in *Congressional Record*, 89th Cong., 1st sess., pp. 7219-7222.

8. For accounts of this meeting, see Marmor, *Politics of Medicare,* pp. 66-69; and Harris, *A Sacred Trust*, pp. 186-189. Cohen is quoted in Harris, p. 187.

9. See House Report 213, 89th Congress, 1st session.

10. *U.S. Statutes at Large*, Public Law 89-97.

11. Howard West, "Five Years of Medicare—A Statistical Review," *Social Security Bulletin*, **34** (Dec. 1971), 18, 19.

12. Alfred M. Skolnik and Sophie R. Dales, "Social Welfare Expenditures, 1970-1971," *Social Security Bulletin*, **34** (Dec. 1971), 5; Myers, *Medicare*, p. 303.

13. House Report 213, pp. 21-22.

14. Eli Ginzberg, *Men, Money, and Medicine* (1969), p. 22; see also *Law and Contemporary Society*, **35** (Spring, 1970), especially the articles by David Mechanic and Judith R. and Lester B. Lave; and *The Annals of the American Academy of Political and Social Science*, **399** (January 1972), especially the article by Irving Levenson.

15. Regina Lowenstein, "Early Effects of Medicare on the Health Care of the Aged," *Social Security Bulletin*, **34** (April 1971), 10.

16. Bruce C. Stuart and Lee A. Bair, *Health Care and Income: The Distributional Impacts of Medicare Nationally and in the States of Michigan* (Research Paper No. 5, 2nd ed., Michigan Department of Social Services, September 1971) pp. 90-95, 104.

17. Barbara J. Cooper, "Medical Care Outlays for Aged and Nonaged persons, 1960-1969," *Social Security Bulletin*, **33** (July 1970), 12.

18. Lowenstein, "Early Effects of Medicare," p. 6.

19. Comptroller General of the United States, "Improved Controls Needed Over Extent of Care Provided by Hospitals and Other Facilities to Medicare Patients," July 30, 1971, pp. 17-18.

20. Same GAO report, p. 1.

21. West, "Five Years of Medicare," p. 27.

22. Lowenstein, "Early Effects of Medicare," p. 16.

23. Barbara S. Cooper and Mary F. McGee, "Medical Care Outlays for Three Groups: Young, Intermediate, and Aged," *Social Security Bulletin*, **34** (May 1971), 7.

24. "Basic Facts of the Health Care Industry," Committee Print, House Committee on Ways and Means, 92nd Cong., 1st sess., pp. 9, 15, 51.

25. Lowenstein, "Early Effects of Medicare," pp. 14-15.

26. Stuart and Bair, *Health Care and Income*, pp. 95-99.

27. Stuart and Bair, *Health Care and Income*, pp. 103-106.

28. "Medicare and Medicaid," Committee on Finance, Senate hearings, 91st Cong.,1st sess., p. 2.

29. Stuart and Bair, *Health Care and Income*, p. 106.

30. Cooper and McGee, "Medical Care Outlays for Three Groups," p. 4.

31. Report of Advisory Committee of the Special Committee on Aging, reprinted in "Economics of Aging—Health Aspects," Special Committee on Aging, Senate hearings, 91st Cong., 1st sess., pp. 697, 699, 711-714.

32. *Report of the Task Force on Medicaid and Related Programs* (HEW, June 1970), p. 10.

33. Bruce C. Stuart, *The Impact of Medicaid on Interstate Income Differentials* (Research Paper No. 3, Michigan Dept. of Social Services, Jan. 1971), p. 11.

34. See for example, Comptroller of the United States, "Control Needed Over Excessive Use of Physicians Services Provided under the Medicaid Program in Kentucky," 1971.

35. "Economics of Aging—Health Aspects," Senate hearings, pp. 582-583.

36. Norman L. Cantor, "The Law and Poor People's Access to Health Care," *Law and Contemporary Problems*, **35** (Autumn 1970), 921.

37. *Report of the Task Force on Medicaid and Related Problems*, p. 8.

38. Skolnik and Dales, "Social Welfare Expenditures," p. 5.