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PUBLIC EXPENDITURES AND THE ELDERLY

Lester C. Thurow

Otto Eckstein began his career analysing public water resource expenditures. As a student I remember his course in public finance as one of the highlights of my graduate education. Later he directed the classic Joint Economic Committee study on employment, growth and price stability. I started my career at Harvard teaching the course he had developed out of that study. At the intersection of these two Eckstein interests lies the federal deficit. As a Keynesia Otto appreciate the need for deficits to push the economy out of depressions or recessions, but as a Keynesian he also appreciated the need to eliminate those deficits as the economy approached full employment if inflation were to be avoided.

With a $200 billion plus budget deficit on the horizon as far as the economic eye can see, he would have been at the forefront of the public policy debate as to how those federal deficits could be eliminated if he were still alive. No one would appreciate more than he, however, that it simply isn't possible to just raise taxes or cut expenditures. One needs to go back to first principles to see what government should or should not be spending.

In this spirit I would like to analyse two of the major social welfare programs in the federal budget -- Social Security and Medicare.

THE ELDERLY

Social welfare programs immediately conjure up images of vast amounts of money being spent on the poor, but that is not in fact where the money is spent. Middle class Americans tend to forget that most social welfare spending goes to keep middle-class Americans middle class when they become ill or elderly. In 1982 35 percent of the entire Federal budget went to help the elderly. In 1983 pensions absorbed $186 billion, medical care $57 billion and disability payments $25 billion in the federal budget.

America can afford to do what is necessary to keep the elderly (ourselves) from declining into a miserable existence as they (we) grow older. The right level of expenditures, however, depends upon an analysis of intergenerational equity. How much should children contribute to the support of their parents? How much of a burden should parents impose on their children? For this is what Social Security is all about. Each of us on average is basically paying the benefits that go to our own parents; each of us on average hopes to get benefits from our children when we are old.

Social Security is the crown jewel of American social legislation. If it did not exist, it would simply have to be reinvested. Left alone many individuals simply won't save enough for their old age and the rest of us are not willing to see them starve. President Reagan is just wrong when he says, "I am not sure that the benefits that you will receive when you come to the point of retiring from the work force will justify the amount of that (social security) tax." Social security taxes do not disappear. They are paid to our own parents and grandparents. If the system did not exist, each of us would individually have to pay for our own parents or watch them squirm in poverty.

While America hasn't eliminated poverty among the elderly any more than it has eliminated poverty among the non-elderly, great progress has been made. In 1967 the incidence of poverty among the elderly (29.5 percent) was more than twice that of the entire population (14.2 percent.)[1] A just society does not economically discard its citizens simply because they have reached 65 years of age. As a result Social Security benefits were expanded to lower the incidence of poverty among the elderly. The programs succeeded. In 1983 the incidence of poverty among the elderly was lower (14.1 percent) than that among the population as a whole (15.2 percent).[2]

Similarly when Social Security was started there was a sharp gap in the living standards between the average elderly person and the rest of the population. By 1982, however, the per capita cash household income of the elderly slightly exceed that of the entire population.[3] Since the young pay for their medical care while the elderly enjoy Medicare and since the elderly have more wealth than the non-elderly, it is clear that the average eldeerly family now enjoys a standard of living higher than that of the nonelderly. Much of this progress can be traced to Social Security. If Social Security and Medicare were to be abolished, the income of the average elderly family would be more than cut in half. Many elderly families depend entirely on Social Security for their standard of living.

In many ways America should hold a victory celebration. It has created a just society where the elderly are treated as well as everyone else. That is something to take pride in. A victory celebration does not, of course, obviate the need to solve the system's financial problems.

Part of the problem is caused not by the elderly but by the performance of the economy. With no growth between the first quarter of 1979 and the first quarter of 1983, tax revenues did not rise as rapidly as expected. A stagnant economy inevitably leads to stagnant Social Security revenues. But those stagnant revenues are real and require changes in the nature of the system.

Social Security also suffers from one of those good news-bad news dilemmas. During the 1950's, Americans who reached the age of 65 could expect to live an average of 14.1 additional years.[4] By 1980, a 65 year-old could look forward to 16.4 years of life with most of the increase occurring during the period after Medicare came into existence--good news. But an increase in life expectancy of 2.3 years raises system costs by 16 percent since everyone has to be supported for 16.4 and not 14.1 years -- bad news.

In the long-run the system also runs into problems after 2012 when the baby-boom generation starts tor etire and must be supported by the baby-dearth generation.[5] With more retirees per worker, tax rates would clearly have to rise in a stagnant economy, but the extent of the rise in a dynamic growing economy depends upon how fast real per capita income (productivity) is rising. If productivity were to rise at a fast enough rate, Social Security tax rates would not have to rise even if there were more retirees relative to the number of workers. As a result restoring economic prosperity is of relevance not just to the work force but to those in retirement.

One of the ways to create that prosperous economy in the 21st century is to build up a surplus in the Social Security trust funds that can be used now to make the investments that are necessary to recreate prosperity and can then be drawn-down to ease the burdens of those who are working and paying Social Security taxes in the 21st century.

In 1982 President Reagan appointed a bi-partisan committee that came to be known after its chairman as the Greenspan committee on how the Social Security problem should be 'solved'. In the aftermath of the Greenspan report Congress placed a bandage (higher payroll taxes, a longer delay in cost of living increases, a later retirement age in the 21st century, included new federal employees in the system, and taxed benefits for high income -- over $32,000 -- retirees) on the financial bleeding that will prevent any Social Security crises from emerging in the next few years, but long before the 21st century rolls around fundamental reforms will have to be made in Social Security.

The correct solution is not to bandage the bleeding but to fundamentally reform the financial base of the system. On the tax side payroll taxes should be reduced by one-third and any growth in Social Security expenditures should be financed with revenue from a new value added tax. Such a change has a number of advantages.

Lowering the payroll tax would reduce the current distortions in the relative prices of capital and labor. As the system now exists robots are subsidized through the accelerated cost recovery system in the corporate income tax while human workers are heavily taxed in the payroll tax system. If a significant fraction of Social Security spending wer financed through a value added tax those who save (consumed less) would essentially be able to buy their pension benefits cheaper that those who do not save. By taxing consumption, capital income, as well as earnings, would effectively be taxed. Elderly people would also continue paying retirement value added taxes after they have retired. As a result the system would end up being much less of a transfer from poor workers to wealthy retirees than it is now. Such tax changes would make the system both more efficient and more equitable.

Given that Social Security is a system of intergenrational transfers (not an insurance system) and given that the income of the elderly now slightly exceeds that of the non-elderly, the time has come to recognize that Americans are all in the same economic boat subject to the same economic tides. If the tide is rising and national standards of living are rising, the standard of living of the elderly should rise along with those of active workers. If the tide is falling or rising more slowly, then the standards of living of the elderly must fall or rise more slowly. The standards of living of the elderly cannot rise while those of the rest of the country fall. That is neither fair nor economically feasible.

Since the average American income is governed by what happens to the per capita GNP, the standard of living of the elderly should be governed by the same factor. To accomplish this, Social Security benefits should be indexed to the per capita GNP instead of being tied to the consumer price index and periodic increases in benefits as they are now.

Indexing the system to the per capita GNP neither raises nor lowers future benefits. It simply makes future benefits contingent on the degree of future economic success. If the American economy is very successful over the next few decades, the elderly's real standard of living would rise faster tied to the per capita GNP that it would rise under the current system. If the American economy fails, then the elderly would get less. In the stagnant economy of the early 1980s, for example, such a change would have meant a July 1982 benefit increase of 4 percent rather than the 7.4 percent actually allowed under the present system.

To do less is to be unfair to the elderly. To do more is to be unfair to the nonelderly.

The final problem is that of the retirement age. If Americans are living longer and remaining healthy longer, what was a reasonable retirement age (65) becomes an unreasonable retirement age -- both in terms of forcing people to retire or in allowing them to retire. While ancient numbers seem to have an instinctive wisdom, a retirement age of 65 is not one of those numbers that has instrinsic wisdom. No one, for example, has every presented health studies indicating that 65 is the age at which working abilities star to suffer a rapid deterioration.

Bismark is usually given credit for picking 65 as the retirement age, but he actually chose 70 as the minimum retirement age in the first public retirement system in the 19th century.[6] Geermany lowered the retirement age to 65 in World War I. With a high retirement age and a short life-expectancy what looked like a generous social welfare system, and what was in fact with longer life expectancy later to become a genrous social welfare system, cost very little at the beginning.

Realistically as the number of years of life expectancy at age 65 lengthens the retirement age is going to have to rise. Two factors have to be kept in mind as the retirement age lengthens, however. First, everyone should receive plenty of warning as to when they are going to be allowed (or forced) to retire. Retirement takes prior planning in terms of being able to do enough savings to supplement Social Security and have the retirement income that the elderly would like to have. Retirement plans cannot be changed on short noticed. As a result everyone should know at least 15 years ahead of time as to what their own retirement age will be.

Given what has been happening to life expectancy at age 65 the currently enacted increases in the legal retirement age, 66 in 2004 and 67 in 2009, are unlikely to be large enough. Basically the retirement age should escalate with life expectancy so that the average person can expect the 16 years of retirement benefits that he or she now enjoys. Based on what has actually happened to life expectancy in the previous decade, the retirement age should be raised with a 15 year lag. Thus in 1985 we would raise the retirement age in the year 2000 to 67 if life expectancy has risen by 2 years from 1975 to 1985. Then in 1995 we would again raise the retirement age in the year 2010 based upon how much expectancy had gone up between 1985 and 1995.

While change such as those just suggest for social security do not save any money in the short-run, they have a tremendous impact on reducing budgetary pressures in the long-run.

The goal should not be a year to year bandaging of the system, but a major operation that puts the patient on its feet again for another half century. In doing so it is not necessary to cripple or dismantle Social Security. The necessary changes can make it into a better program than it now is.

Health Care

Health care is arelated area where budgetary policy, or more accurately social policy, must be developed. Health is an area where better policies are necessary not just for the Federal budget (Medicare and Medicaid) and not just for state budgets (Medicaid), but also for the private economy (health insurance). Public and private expenditures on health care have risen from 5 to 11 percent of the GNP from 19160 to 1983. Clearly the country cannot afford to let health care costs rises at the same rate over the next two decades but this is precisely what is now happening.

Health care expenditure problems are created by an implosion between our poorer

economic performance, rapidly advancing and ever more expensive medical technology, and an inconsistent set of ethical principles.

As a matter of simple algebra no set of expenditures can forever rise faster than the GNP. There is no magic precise limit on health care expenditures, but there is at the same time a limit. Every dollar spent on health care is a dollar that cannot be spent on something else. Just as one can go broke buying luxury goods so can one go broke buying health care. At some point spending has to slow down to the rate of growth of the GNP. If this did not happen, health expenditures would gradually rise to absorb all of GNP.

The United States is reaching this point sooner rather than later because of the economy's poor performance over the past 15 years. If productivity had consistently grown at a three percent rate and the economy had consistently been operated at full employment, today's health care spending would only account for 7 to 8 percent of the GNP and there would be less pressure to control health care spending.

The need to restore productivity growth with more investment in physical and human resources means, however, that the growth of something else must be restrained and health care is a big part of that something else. Rising international competition makes health expenditure reforms almost a necessity. American auto workers, for example, make only slightly more than Japanese workers ($10.27 in Japan and $11.80 in the United States) but fringe benefits expand the difference with total wages rising to $13.50 in Japan and almost $22 in America.[7] At the Chrysler corporation medical care accounts for $2.74 per hour of those fringe benefits. Health care costs are an important part of the competitive problem.

It has been traditional medical practice in the United States to employ treatments until those treatments have no marginal payoff or until the undesirable side effects start to overwhelm the primary benefits. But with the development of more and more expensive techniques (artificial kidneys, heart transplants, expensive diagnostic machines) that can marginal prolong life, the expenditures that have to be made before this traditional stopping point is reached have grown to almost unlimited levels. If, for example, just one-half of those in their last year of life were to give a Barney Clark type artifical hearts, this treatment alone would take one-third of the GNP. As it is, Medicare spends 21 percent of its funds on those in the last six months of their life.[8]

The problem is not wasted expenditures where benefits are zero or negative but cases where there are benefits -- the probability of an accurate diagnosis goes up from 97 to 98 percent, the chance of survival rises from 3 to 3.1 percent -- but the benefits are very small in relation to the costs.

The development of this new medical technology requires a shift in medical practice. Instead of stopping treatments when benefits cease to exist, treatments must be stopped when marginal benefits are equal to marginal costs. But who is to make this ethical decision and decide where that point lies -- the patient, the doctor, some third party payer? Where lies the point where we can no longer afford a medical treatment that will in fact marginally benefit someone?

All of this leads to an ethical debate and Americans are very uncomfortable having to make ethical decisions. In the past Americans have simply lived with inconsistent ethical principles. They were simultaneously egalitarians and capitalists. None of us wanted to die because we could not afford existing treatments and few of us want to see others did because they could not afford to buy existing treatments. But we were also

capitalists and believed that individuals should be allowed to spend their money on whatever they wished, including health care.

This set of beliefs lead to an explosive chain reaction. A new expensive life-prolonging treatment is developed. Being capitalists the wealthy are allowed to buy the treatment privately and marginally extend their lives. Moderate income individuals who cannot privately afford the treatment want it. They demand it. And being egalitarians they get it either through private health insurance of public programs.

Being quais-egalitarians we do not have the political ability to say 'no' to a man dieing of a treatable disease on the steps of the Massachusetts state house while some other wealtheir man is next door being treated at the Massachusetts General Hospital for the same problem. Being quasi-capitalists we also do not have the ability to tell the wealtheir man that he cannot spend his own money to save his own life so that we can say 'no' to the man who cannot afford to pay. We have to give the treatment to everyone or deny it for everyone, but we can neither deny it nor afford to give it.

In the summer of 1982 such a situation arose with heart transplants. Regulatory authorities were preventing Massachusetts hospitals from performing heart transplants to save money. Some Massachusetts citizens were able to afford to fly to California to get transplants, others weren't, but needed them just as badly. The media and the public essentially wheeled those needing treatment up on the state house steps and dared the public authorities to let them die for want of treatment. No surprisingly the public authorities did not dare to do so. They altered rules and regulations to pay for the California heart transplants and quickly began allowing Massachusetts hospitals to perform heart transplants.

As medical costs rise, it becomes less and less possible to live with our inconsistent ethical believes. At some point, and the point is now, they have to be sorted out.

America's traditional answer has been health insurance, but it cannot do what needs to be done. Insurance is an appropriate answer to situations where there is a small probability of a disaster which will incur large fixed loses. Fire insurance is the best example. Only a few of us will be unfortunate enough to have our home burn down and the maximum loss is fixed by the value of our house. As a result we pool our risks and compensate those who suffer loses. Companies make money by being better at estimating risks and choosing who they wish or do not wish to insure.

In contrast large health expenditures are becoming almost universal. Before they die everyone will be able to make use of large amounts of health care. In this circumstance insurance becomes not a pooling of small risks but a distortion of incentives. In any insurance system where costs are being paid rather than previous loses refunded, prices are set below costs as the individual sees it. Each of us makes a lump-sum payment, our insurance premium, and then when we use medical care we are able to buy it below cost. Insurance pays all or part of the bills. This encourages each of us to consume more medical care -- on the margin it is cheap -- but when we all do so we raise next year's lump-sum payments.

This is a problem in any case where the loses are not fixed as they are in the case of the burnt house but elastic depending upon how we plan to treat our ailments. In health insurance the problem is magnified since each of us has an incentive to ake the don't spare the expenses' route since we are talking about our own life or our own health. Each of us knows that if all of us use a lot more health care each of us will have to pay higher insurance premiums but we also know that our own individual expenditures

have essentially no impact on next year's insurance rates. As a result we each go ahead with our 'don't spare the expenses' purchases and in the process collectively raise next year's insurance rates by a substantial amount.

The system essentially becomes a pass-through system where the insurance companies are making money not be assessing risks and selecting their potential patients more carefully (we legally insist that everyone have access to health insurance), but by taking a management fee that depends upon total expenditures. In this circumstance the insurance companies have an interest in higher health care expenditures, doctors have an interest in higher health care expenditures since their incomes go up, and each of us has no interest in restraining our own health care expenditures. The result is not surprisingly a system with exploding expenditures.

The health care problem is not a federal budget problem. It is a social problem. The limits are the same regardless of whether the money is spent through the Federal budget or private insurance. Somehow we are going to have to learn to say 'no'.

One solution is to use the market mechanism but this is basically to let the capitalistic part of our ethics dominate the egalitarian part. We often talk as if the market mechanism is a mechanism for producing less waste, but that isn't is prime virtue. If is a mechanism for saying 'no', but saying 'no' in a very inegalitarian way. Since the richest 20 percent in the United States, any efficient market mechanism will end up giving 11 times as much care to the top 20 percent as it gives to the bottom 20 percent.

The present proposals of the Reagan administration for higher deductables and prospective rather than retrospective payment are good examples of the problem. The government announces that Medicare will pay less and users must pay more to discourage use of expensive health care facilities. Private health insurance companies quickly announce that they will sell private health insurance to cover what is not covered by the government -- thus under cutting the whole purpose of the larger payments by patients. Those with money can afford the co-insurance and do face the incentives. But are we really going to say that patients who cannot make the necessary private payments are not going to get medical care when they need it and others are getting it?

With prospective payment, hospitals are paid based on the disease diagnosed and not on how much it costs to treat the disease. What results? Hospitals require more out-patient tests and procedures to reduce in-patient costs and dmit only those patients who are 'low cost' patients in each diagnostic class. Once again this leaves the high cost patients out in the cold.

These patients are then 'dumped' as uninsured high cost patients are now dumped. No hospital wants to real patients without money and they are sent on to other hospitals--usually the municipal hospital in big cities. Boston City Hospital reports that it gets an average of four 'dumps' per month.[9] It also spends twice as much on charity care ($148 million in 1983) as all of the other hospitals in Boston combined. But as city governments with their own budget problems attempt to restrain municipal hospital expenses treatment at such hospitals increasingly becomes second-class treatment.

Market mechanisms work when the buyer is knowledgeable or willing to live with mistakes and when society is willing to distribute goods and services in accordance with the market distribution of income. In the case of health care neither of the wo necessary conditions exists.

In the process of doing what markets do, they also create and alter values. Markets are supposed to encourage firms to segment, cream, and dump markets to seek the most profitable nitches while ignoring areas of low profitability. To deny that this is what they will do is to deny that markets are efficient. In a market environment doctors and hospitals are income maximizers -- nothing more and nothing less. In a market environment cross subsidies cannot be extracted from the wealthy with minor ailments to help pay for the poor with major ailments. Every tub is on its own bottom.

What this forgets is that an egalitarian distribution of health care is one of the factors that creates social solidarity, a feeling of community, and non-monetary attachments. Market mechanisms are a way to say 'no' if we are willing to live with the consequences.

If we are not, as I am not, what is the answer. One answer is for the third party payers, the firms who pay 35 percent of all medical bills or the government which pays 27 percent of all medical bills, to write sets of rules and regulations as to what they will or will not pay and to prohibit others from buying what is not allowed under the private or public insurance systems. This is essentially how the British have kept health care spending at half the American levels.[10]

Such a procedure works, but it work clumsily since no set of rules can be adjusted to the nuances and subtle differences of individual medical problems. Far better if American doctors would begin to build up a social ethic and behavioral practices as to when medicine is bad medicine not because it has no payoff or because it hurts the patient but because the costs simply aren't justified by the benefits. Social mores can be created. If such mores could be created and then legally defended against malpractice suits, it might be possible to build up a system with doctor imposed cost controls that was much better and much more flexible than a system constrained with outside cost controls imposed by the third party payers. In all likelihood, however, are are going to be moving to asystem of third party controls.

As a society, how much are we willing to spend (willing to sacrifice) on prolonging life? The easy answer is 'any amount' but that answere is neither true nor feasible. As a result we are going to have to come to some social consensus as to he trade-off between costs and the life extending benefits that result.

THE BOTTOM LINE

Expenditures can be cut. Taxes can be raised. And both can be done in such a way that we have better society. But to do so requires a political process capable of allocating income reductions across the electorate. Few democratic political processes have proven capable of taking such actions without the help of an external threat. The next five years will simply be a test of whether America can politically respond to a severe problem that is not a crisis or whether it will let that severe problem fester creating problems that become harder and harder to solve.

References

1. U.S Bureau of the Census. Money Income and Poverty Status of Families and Persons in the United States: 1982. Government Printing Office, 1983, p. 21.

2. Ibid.

3. Ibid., p. 19.

4. U.S. Department of the Commerce, Statistical Abstract of the United States, 1982-83, p. 71.

5. Peter A. Morrison, "Demographic Links to Social Security" Challenge. Jan./Feb. 1982, p. 44.

6. Robert J. Myers, "Bismark Backed 70" Wall Street Journal, Nov. 7, 1977, p. 19.

7. "Wage Questions" New York Times. May 13, 1983, p. D3. "Chrysler Hurt by Costs' New York Times. March 5, 1984, p. B8.

8. U.S. Department of Health and Human Services, Health Care Financing. #1, Nov. 1983, p. 1.

9. Richard A. Knox, "Some local hospitals 'dump' the uninsured" Boston Globe. Feb. 6, 1984, p. 31.

10. Henry J. Aaron and William B. Schwart, The Painful Prescription. Brookings, Washington, D.C. 1984. Health Vote 1982. Public Agenda Foundation, 1983.