Economic Status of the Aged

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I've been asked to comment upon the economic and financial status of the aged. The reason is that the proponents of a Federal government, compulsory health-care program for the aged claim that the medical costs and "health needs" of the aged are greater than those of other age groups and that they cannot afford to pay for them -- either directly or through private medical care insurance. This is the basic premise of Forand-type legislation.

Before doing so, however, I'd like to comment briefly upon the politico-economic background -- the ideological background -- underlying both this premise and the current struggle.

The nature of health care for the aged, the question of how aged people do, or ought to, pay for their health care, the question of how such health care aged people ought to buy, and under what circumstances, are subjects that seem to arouse violent differences and equally violent emotions.

The violence of these differences suggest that there may be insignificant recognition of the nature of the ideological spectrum. Differences among people can arise from several sources: one type of difference can be resolved

ordinarily by looking at the facts. A second type of difference, less easily resolved than the first, is that arising from illogical or erroneous interpretation of facts.

But the third type of difference is the most difficult of all; it does not arise out of disagreement over what the facts are, nor out of illogical and erroneous interpretation of those facts, but out of diametrically opposed, antithetical philosophical positions. To the extent that this third type of difference occurs, the matter cannot be settled by an appeal to fact or to logic; it can only be settled, if at all, by persuasion or by fighting it out in the political arena.

Let me state clearly my own position. I want to preserve, to protect and to promote the private (non-gov't) practice of medicine in the United States. I am unalterably opposed to any policy that threatens to obscure or to subvert that objective. To me it is evident that some others have different objectives; and most vigorous and forceful among these are those who wish to establish the practice of medicine as a monopoly of a group of salaried physician employees of government.

These are the ends of the ideological spectrum and I leave it to your individual judgement which is left -- and which is right.

Even a cursory examination of the politico-economic history of our times supports this assertion. For example, although the United States does not have a national system of governmentally controlled health service, the struggle on the part of proponents of such a system to achieve enactment of a federal, compulsory health insurance program on the one hand against opponents on the other is part of current history. Certainly there was agitation for such a program in the years 1934 to 1936 when the Social Security Act was first proposed. Since then there have been several instances of important political pressure for compulsory medical care programs. The Truman administration

support for the Wagner-Murray-Dingell type of legislation is well known. Innumberable bills have been introduced into Congress and extensive hearings have been held on a number of such proposals. The proponents of such legislation have made numerous statements concerning the inability of any other system to "do the job", and the opponents of the system have developed equally vigorous phrases in their opposition to it. Few will deny that a great deal of heat is generated in these struggles.

The question of health care of the aged is only one part of the struggle concerning a system of health care for the United States. Fundamentally there are only two ways of coordinating the activities of large numbers of people; one, is to provide some sort of central direction involving compulsion and coercion. This is the technique of the Army, of the centrally planned state or totalitarian state carried to its logical conclusion. The second method of coordinating the activities of individual people is through their voluntary cooperation and, indeed, this is the technique of the market place. For a system of health care, the first method requires government intervention to an ever greater degree into the health care mechanism; it requires coercion by the government to bring about a specific end. It is basically paternalistic in outlook, and seeks to achieve a health care system on a basis of what the individual should have. A health care system based on the voluntary cooperation of individuals, on the other hand, is achieved only through some kind of market mechanism and voluntary exchange bringing about coordination of activities without coercion. A health care system organized through voluntary exchange is a free, private enterprise, competitive exchange system. What we presently have, is not of course, purely one or the other. It is always much easier to state the varying principles in general terms than it is to spell out in detail what actually is, or even what should be. But it cannot be denied, I think, that this fundamental clash of philosophical ideology is

noticeable as much, if not more, in the area of health care than in other areas of our society.

Why have the proponents of government medicine, of socialized medicine decided to press so vigorously in the case of the health care of the aged? It would be a mistake -- I am inclined to say a fatal mistake -- to assume that the reason is any deep-seated desire to solve the problem. You will find the question of care of the aged, I think, just as much a problem after 12 years of socialized medicine as it was before -- and perhaps more so. The basic reason for the present attack, on a limited front, is the fact that the proposal for a nation-wide federal government subsidized, compulsory, all-age program was defeated. You will notice that the argument is made for it almost wholly on humanitarian grounds! I can tell you in advance what the argument will be for extension -- if a Forand-type program is successful. These same proponents will then argue that we cannot afford not to do the same for all the population. Why? Because, they will say, extension will pay for itself; the better health resulting will so increase total output by restoring productive power that there will be no net cost to the nation! This is a sort of semantic sleight-of-hand.

In my opinion, the McNamara Hearings, the Forand bill hearings, the CIO rallies, and so on, have been merely window dressing. They have served their purpose well; they have been responsible for the attention being paid to the so-called problem and they have helped to generate a political climate to force action (and I would say is action the wrong direction!).

Do we need more facts? I doubt it very much. We do need to guard ourselves against being misled by so-called facts. The famous British economist, Alfred Marshall, wrote many years ago:

> "Experience in controversies...brings out the impossibility of learning anything from facts till they are examined and interpreted by reason; and teaches that the most reckless and treacherous

> of all theorists is he who professes to let facts and figures speak for themselves. . ."

The aged are not homogeneous. This group is comprised of 15.4 million people. In December 1958 less than 4 million were employed or were wives of employed persons; 9 million were received OASDI benefits; 2 million were receiving government pensions; 1¼ million were receiving private pensions and 1 million were receiving annuities individually purchased. Fifty percent of all aged had some income from assets such as interest, rent, or dividends. On the other hand, 2.5 million were receiving some form of public assistance.

Income of the aged, during the last decade, has been rising faster than the general level of prices thereby improving considerably their real financial position. Figures substantiating this improvement are found in the 1957 national survey of OASI beneficiaries. The Bureau of Census reported that the median income of the aged between 1947 and 1951 had failed to keep pace with the rise in median incomes for all ages but since 1951 the median income of older men increased by one-half, to $1,500 in 1958 whereas that of all men rose only by one-fourth, to $3,700 in 1958.

The Census data for all aged, including the 16 percent receiving public assistance, show that the average income in 1957 for males 65 years and older was $2,100 and $800 for women 65 years and older.

The phrase "low-income," as it is generally used, does not apply in any distinctive sense to the aged as a group, but primarily to the retired aged who, on the average, have lower incomes than other members of the working population, whether aged or not. For example, a full-time male worker 65 and over earns, on the average, about $140 less annually than a male worker 20-24 years of age. Furthermore, the family responsibilities of the aged worker are much less, whereas his younger counterpart, married, with two children, has different financial demands, undoubtedly greater than an elderly couple with no dependents.

The OASI data (that generally excludes all those aged persons earning more than $1,200 per year in covered employment) showed an annual median income in the fall of 1957 of $2,190 for aged beneficiary couples, $1,145 for single retired workers, and $880 for aged widows. This would appear to narrow the application of the "very low income" label to aged widows rather than to all retired aged.

The income figures cited are income before taxes. But aged persons, particularly those retired and receiving OASDI benefits, occupy a beneficial position with respect to income taxes. For example, a married OASDI beneficiary receiving OASDI benefits of $2,000 and $2,000 of other income, pays no Federal taxes on his total income of $4,000 whereas a young man earning $4,000 a year, married, and with two children, pays approximately $245 Federal income tax and $120 social security tax, or a total annual tax on his income of $365.

Income alone, however, is an insufficient measure of an individual's financial position particularly since one's asset position improves, like wine, with age. An examination of the Federal Reserve Board's annual sample Survey of Consumer Finances reveals some interesting and supporting evidence concerning the liquid assets and the rate at which those assets have been accumulating between 1949 and 1958. Between these two years, persons aged 65 and over accumulated liquid assets faster than any other age group. The proportion of this group's ownership of liquid assets rose from 68 to 74% which means that in 1958 nearly three out of every four persons 65 and over owned liquid assets in some form. In contrast the percentage of persons 55 to 65 years of age who owned liquid assets dropped to 71% in 1958 while the average for all groups between the ages of 18 and 64 rose from 71 to 73%.

The proportion of those aged over 65 who had liquid assets of $2,000 or more increased from 30% in 1949 to 40% in 1958; for liquid assets of $500 or more, the respective increase was from 50 to 57%. Generally speaking, however,

the proportion of those over 65 years of age who have liquid assets of $500 or more, $2,000 or more, and $5,000 or more is higher than for any other age group. The Federal Reserve Board's survey also revealed that in 1953 the group aged 65 and over gained the highest median value in liquid asset holdings -- $800 for all aged persons and $2,450 for the 74% holding liquid assets.

Liquid assets, as defined by the Consumer Finances Survey only include savings accounts in banks, postal savings accounts, shares in savings and loan associations and credit unions, checking accounts, and savings bonds. Excluded are homes and other real estate, stocks, and bonds other than savings bonds. Homes, of course, are assets and probably the most usual type of asset owned by the aged person. Assets of this sort are, in general, a relatively unimportant source of income to the aged although they do act as a financial cushion enabling the aged to dissave and thereby enjoy a higher standard of living. Currently, over 70 percent of aged OASDI beneficiary couples own their own homes -- 87 percent of which are mortgage free. Moreover, the net asset position of the aged is clearly better than that of others since their indebtedness is low.

If it were possible to take into account ownership of equity securities and less liquid assets, the discrepancy in asset holdings between the aged and others probably would be even greater than the liquid asset data alone can illustrate. This observation follows the fact that the aged generally have more of such assets than is commonly realized. From 1951 to 1957 OASI beneficiary groups median net worth of a retired worker, with wife also entitled to benefits, rose from $5,610 to $9,616, or 71 percent. When adjusted for increases in the cost of living, their median net worth shows an improvement of 50 percent.

The aged are above average in the percentage of persons having savings in liquid form, and this percentage has been shifting in favor of the aged

group although the younger age groups would normally be thought to have a greater earning power. In September, 1958, the Federal Reserve Bulletin concluded that "There was a marked tendency . . . for the frequency of large holdings -- particularly of savings accounts or shares -- to increase with age. One-half of the savings deposit holders who were 65 or older had $2,400 or more in this form, compared with a median of $720 for all holders."

The problem then, is not one that centers around the aged as a group but centers on those individuals who are indigent and near indigent with just enough resources to meet current demands but not enough to meet the cost of catastrophic or prolonged illness -- or, for that matter, any other non-medical catastrophe. Proposals have been made for the federal government to give some form of direct aid to the group not on public assistance but whose resources are not sufficient to meet medical cost of catastrophic illness. The meeting of medical bills by those over 65 and unable to pay for their own bills is currently being met by local and state aid with some federal grants to the states, and by private charities. The extent that medical care is paid for in the form of money from state-federal aid varies from state to state in accordance with the public assistance policy of the state and the degree of reluctance of the individual to apply for such aid. Once this falls into the domain of the federal government, the result would be a permanent federal program for what appears from the evidence to be largely a temporary problem.

There is also an egalitarian aspect of arguments by those who would socialize medicine. An almost over-riding aim is to achieve greater equality even at the expense of less for everyone. Unlike Europe, the objective of redistributing income by systems of health care is seldom expressed specifically in this country. Perhaps such an aim is not a necessary part of health care systems, or even what one might call the welfare state itself. The end result in almost all areas where non-voluntary systems have been established,

including our own, has been the development of health care systems capable of being employed as tools for the redistribution of income. As one studies the effects of application of the welfare instruments to health care, it is impressive that there is first of all a compulsion requiring everybody to insure against health risks or to contribute to a system which purports to insure him against such risks. Coupled with this, almost universally, has been a requirement that he insure through one unified state organization; and this requirement is usually based upon assertions that this is necessary for efficiency and economy. The requirement is not always stated in so many words but the net effect is virtually to make impossible a continuation of the voluntary market mechanism. The instrument, and a monopoly instrument at that, thus produced is certainly capable of doing things and providing things that a voluntary arrangement could also supply. But it also becomes an instrument in the hands of political bureaucracy and can be used for other purposes. Whatever assistance, aid, subsidization and so on, is provided can be made dependent upon the imposition of all sorts of special conditions. In other countries at least, and I would argue in ours as well, this has become in the course of time the governing consideration. Moreover, it has the potentiality of being used as an instrument for an unlimited redistribution of income.

One of the curious aspects of the position presented by those who criticize the existing health care mechanism in the United States is an implicit assumption that an individual should not be required to provide for his own needs or wants, such as his life, his old age, his health. Instead they seem to believe that items of real significance such as these, or the life or education of his child, or his child's health or dental care, ought to be paid for by somebody else -- by his employer, or by the government, or by his union, or by his masonic lodge -- anyone it seems but himself. And frequently the same people seem to express this idea as one that should inhere in every

individual as a matter of right -- the right to compel or coerce other people to pay for their own necessities. As a philosophy this may be appropriate for the insane, or for children; it is scarcely a philosophy applicable to responsible, rational individuals in a free society.

Is there any way of ansering this question: What is the most desirable, the most efficient, the most economical, way for paying for health care of the aged, or anyone else for that matter? It's impossible to explore this question adequately in a short time without taking considerable space to describe the terms 'desirable,' 'efficient,' 'economical,' and so on. But I doubt whether there can be any single answer to such a question or, indeed, whether there should be. The "best" method of financing health care, of purchasing health care, will be the one best suited to the individual, considering all of the varying aspects of an evaluation by the individual bearing on his case. The important thing here is to permit the individual to have as much choice in the selection of the type of health care plan which he wants to receive as is possible under the circumstances. The matter should be, as far as possible, one of individual, personal choice. It may be that some people do not want any health care plan at all. I confess that I would prefer that they be permitted not to have any; or, at the very most, be required to furnish evidence that they have sufficient assets to assure themselves reasonably satisfactory health care. Even assuming that most people prefer a particular kind of plan, whether it be employee benefits, with or without Blue Cross or Blue Shield or some other device, there is available to them a wide variety of commercial health insurance or medical care insurance if they wish to supplement these plans or to handle their own individual problems in a somewhat different fashion. In fact, I think the outstanding achievement of our health care financial mechanism, is the great variety of plans available for people to buy, using their own judgement in providing for their own

well being in the purchase of health care.

Whether we like it or not, all of us constantly have to make judgements that involve setting economic factors on the one hand against non-economic factors on the other. These evaluations range in importance from the most insignificant item to the most significant evaluation in the world -- our life -- and such evaluations must be made whether one is wealthy or poor. It may be as I say, that we don't like to make them; it may be that we would like to push them off onto somebody else, but the fact of the matter is that we cannot really avoid them. The important question it seems to me is not whether or not the individual is competent to make medical judgements, but whether or not these evaluations which he must make, in one form or another, can be made by somebody else <u>for</u> him. If you will scratch virtually any of the arguments made against the voluntary method of purchasing health care, or if you will examine the arguments in favor of some impersonal, governmental, centralized mechanism for the provision of health care, you will discover that these do not reveal dissatisfaction because the existing market mechanism doesn't function; the objections are made precisely because the mechanism functions so well. What it gives to people is what they want instead of what some other group, or some other individuals, think they ought to have. In essence, at the bottom of most arguments against a system of voluntary health care is a lack of belief in freedom itself.