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Reshuffling Responsibilities in Old Age: The United States in a Comparative Perspective

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Reshuffling Responsibilities in Old Age: The United States in a Comparative Perspective*

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I. Introduction

It is increasingly clear that the United States Congress and President Clinton have adopted a strategic goal to shift federally-funded entitlement programs from a defined benefit to a defined cost basis. The 1996 Welfare Reform Act does precisely this: changing a federal entitlement to a federal block-grant, setting a few ground rules, then largely letting the states decide who by definition is eligible for what benefits and when. It is my thesis that other federal entitlements are soon to follow suit, e.g., President Clinton's January 1997 proposal to cap federal Medicaid outlays beginning in 1988, and then Medicare and perhaps even Social Security (OASDI). And, if this thesis proves correct, who will be at-risk as economic and financial responsibilities in old age are reshuffled?

Health Care: Medicaid and Medicare

Private employers have already changed their health care systems from ones where employers paid increasingly more for a fixed set of benefits to one where they ask: "how much coverage can I get for a given amount of money" (Tallon 1996). The capitated world of managed care plans merely makes this goal easier to reach. Public health care finance is headed in this same direction. The President and federal policy makers clearly intend to turn the Medicaid program into a defined cost block grant to states. Congressional legislation to accomplish this goal was barely defeated in 1996; it has resurfaced in the President's 1997 budget. While state governors clearly oppose this legislation, the federal government may still achieve its objective.

And Medicare, beyond its immediate short-term deficit problem, is headed in the exact same direction. The impending "bankruptcy" in the Medicare trust fund must be dealt with within two years. Current proposals for cost reduction include the usual suspects of reduced physician fees (to be made up later by a higher volume of services); and higher premiums and copays for higher income beneficiaries will buy three to seven years of budgetary grace. It is clear to all parties that the federal government must ultimately undertake more substantial structural changes in the way that it funds

and delivers Medicare services. Here I predict that they will follow the lead of employers (and some state Medicaid programs) by providing a given amount of money—a voucher—which the aged can use to select their own health care plan: managed care or other. The level of the subsidy and its adjustments for risk factors (age, gender, morbidity) will be the key details in such a decision.

In each of the cases above, the locus of responsibility for costs, above and beyond those which the federal government decides it can afford, will be shifted to other parties: lower levels of government (states and localities) in the case of AFDC and Medicaid, and then to individuals and their families (Medicare, AFDC, and Medicaid). In the case of Medicare there will be double cost shifting, from Medicare (primary insurer of the aged) to secondary insurers: employers for the well-to-do, and Medicaid for the poor. The vast middle class of the aged, which we have elsewhere called the 'tweeners (Holden and Smeeding 1990), will end up paying more out-of-pocket or more for supplemental premiums to purchase capitated medical care plans.

Note that such devolutions as these definitely have tangible benefits. Globally, the federal government will need only to estimate "Q" the number of beneficiaries for Medicare, ignoring any increase in "P"—the price or cost of medical services. Medicaid and AFDC is even easier, since Congress only needs to decide the size of the block grant. This does serve to put a lid on the unanticipated growth of federal entitlement expenditures and makes budget balancing and federal deficit reduction much easier to accomplish. State finances may prove to be quite another story as states and localities struggle to decide how they will meet the acute health care and chronic care needs of the Medicaid population.

Devolution of AFDC and Medicaid, and the restructuring of Medicare may have other benefits as well. Waste and fraud in the Medicare program, currently running $10 to $15 billion per year (Kettl and DiIulio 1995) will be largely reduced by moving to a capitated system with a less frequent

and less confusing billing system. The onus for cost reduction, health care quality decisions, and efficient service delivery are shifted from governments to managed care providers. Both states (Medicaid) and patients (Medicare) will benefit from the increased choice of health care providers made available by the health care market place. Hopefully, the experiences of the aged with managed care will be better than those of the 1980s, as younger retirees already enrolled in managed care plans, shift their major source of subsidy from employers to federal vouchers. A recent National Academy of Sciences (Feasley 1996) report presents some hope that managed care for the aged will improve.

But these choices and benefits come at a price. The federal government strategy is liable to have important distributional consequences if, as expected, federally defined contributions grow more slowly than the cost of services. And already groups such as minorities and low income persons have less access to and use of Medicare services than do the nonelderly (Gornick et al. 1996). On the other hand, the creation of a defined cost Medicare voucher allows the federal government the option of carefully defining income and wealth-related subsidies to allow low income, low wealth enrollees to afford an adequate level of coverage.

Social Security

Recent proposals for reform of the OASDI system indicate that it may be headed in the same direction. The Quadrennial Advisory Council for Social Security has provided three options for partially dealing with the long-term deficit in Social Security. One would maintain benefits in more or less their current form, with Social Security investing trust fund surpluses in private market stocks and bonds. This is the proposal with the least effect on the current system. It is also the one least likely to guarantee a long-term solution to the cost of the retirement of the baby boom and therefore require added taxes or reduced benefits (e.g., via later age of benefit receipt).

A second proposal would add a small *mandatory* defined contribution pension on top of the current system, much closer to the way that European corporations add a *voluntary* employer provided "second tier" to their social security system. This proposal is designed to gradually allow the system to shift to a defined contribution plan, with a reduced defined benefit system. Unlike the first plan, individual workers would be responsible for dealing with their own individual investments.

The final proposal would maintain employer contributions to a defined benefit Social Security system, but all of employee contributions would be left at the disposal of workers to invest in private securities as they see fit. Such a change would over time create a two tier benefit system, with a flat lower tier (at about 65 percent of the poverty line—less than the current SSI level of 75 percent of poverty) for all beneficiaries paid from employer contributions. The second tier would become a defined contribution plan directed by workers. This last proposal will also require added taxes to cover the costs of transition to the new system.

The last two proposed changes are designed to boost confidence in the system for younger workers and to increase their return on Social Security contributions. They may provide a new source of capital for the domestic economy and improve economic growth and overall national income, to the extent that they added to total national savings. However, the distributional impact of these proposals is open to question. Retirement income will depend more on where individual contributions are invested than on a defined benefit style government transfer. Just as in the case of health care, individuals will have to assume greater responsibility to make market choices, this time for financial investments. None of the proposals, as currently written, would change the benefit structure to aid low income beneficiaries relative to the current system. Thus, the pockets of poverty currently extant among the aged would not be reduced and, in fact, might be increased.

Changing Earnings Distribution

The final element of importance to economic security in old age is pre-retirement income. Recent evidence indicates that the distribution of annual earnings are becoming more unequal while income mobility—which might compensate for low annual earnings—is either constant or decreasing in the United States (Gottschalk 1996). Taken together these facts support a wider distribution of lifetime earnings for future cohorts. Trends in wealth and income distribution data further support the hollowing out of the distribution of economic well-being thereby indicating a widening of the lifetime income as well as lifetime earnings.

Other evidence indicates that the distribution of health insurance and pension coverage is also widening, with coverage decreasing among low wage workers and increasing among high wage workers. While overall wealth is increasing among the older baby boom generation, a significant fraction—25 to 33 percent—of older households (head 50+) are facing retirement with little or no private retirement income assets (Hurst, Luoh, and Stafford 1996).

Thus, the future retirement prospects of families with low earnings and little or no retirement assets remains an important facet of the otherwise improving retirement income prospects of the elderly. It appears that heterogeneity in retirement will continue to be an important aspect of economic well-being among the aged in America, and may even grow. The way in which OASDI benefit structure changes will be of increased importance in a more heterogenous world where the aged are much more likely to have to make important choices which affect their long-term economic status, health care finances, and related matters.

Long-Term Care

After the failure of President Clinton's Health Security Act, the notion of additional formal federal support for long-term care has faded from national view. While Medicare has increasingly become an effective substitute for medium term care and home health care, impending budgetary

changes are liable to reduce its support for the chronically ill. If Medicaid devolves to the states, there will be increased pressure and conflict among different groups funded by this system: the old, the disabled, and low income families with children. Thus, it is not likely that there will be significant increases in public long-term care financial support over the next several years. While home and community based care will become increasingly common and effective due to economies of scale and increasing use of home technology, self-finance is liable to grow as federal and states' financial support fades. Private long-term care insurance, still in its infancy, will continue to grow. Whether to buy such insurance will be another important financial decision that the aged and their agents will need to make.

Summary

These impending changes in social responsibilities are liable to create a reshuffling of responsibilities from the federal government to state and local governments (for health and long-term care) and from all levels of government to individuals. In each of these areas, we can predict the types of economic responsibilities that are liable to arise in America. Of key importance, it seems, are the risks which these changes bring to subgroups of the aged. In every area, health care finance, social security reform, and long-term care finance, the most disadvantaged among the elderly seem to be at higher risk. Thus, the floor beneath the incomes and assets of the aged, and demands on these incomes and assets for acute and chronic health care needs, are liable to be even more important in the future than they are at present.

Similar changes are taking place in Europe where governments are increasing cost sharing for acute health care, attempting to cut back on future social retirement benefits (by raising retirement ages), and shifting the locus of responsibility for long-term care among various levels of government and individuals. However, these shifts are less drastic than those proposed for the United States and

in some cases run in the opposite direction, e.g., the federalization of long-term care in Germany and Austria, and formal plans for publicly funded chronic care at subnational levels of government in other nations (Henessey and Werner 1996; OECD 1996).

While it is difficult to estimate all of the effects of these expected changes, we can at the very least look at the current structure of economic security and responsibility for the aged in general, and the most vulnerable among them—older women living alone—in particular, to see the distributional outcomes of the current system of economic security in the United States and elsewhere. From here we can move to more informed speculation of the types of changes needed to protect the most vulnerable older Americans as these transitions take place.

The next section of the paper presents comparative cross-national information on acute health care expenses among the aged, and on poverty rates and income distribution among all persons aged 65 and over and among older women. It also summarizes the sources of income which support the poor as compared to the rich among the aged. Next we turn to long-term care where the international evidence is less clear in a quantitative perspective. In the final section, we conclude by recommending several types of policies which could provide economic security in old age for the most vulnerable Americans at the same time that we permit the economic fortunes of the nonpoor aged to be subject to increased personal responsibility.

II. United States in a Comparative Context

Responsibility for economic security in old age in America is shared among three groups: primarily the aged themselves (via earnings, savings, and pensions); the public sector through social insurance and other income support programs; and finally the families of the aged as a last bastion of support where other sources fail. The economic well-being of the aged is then a function of their

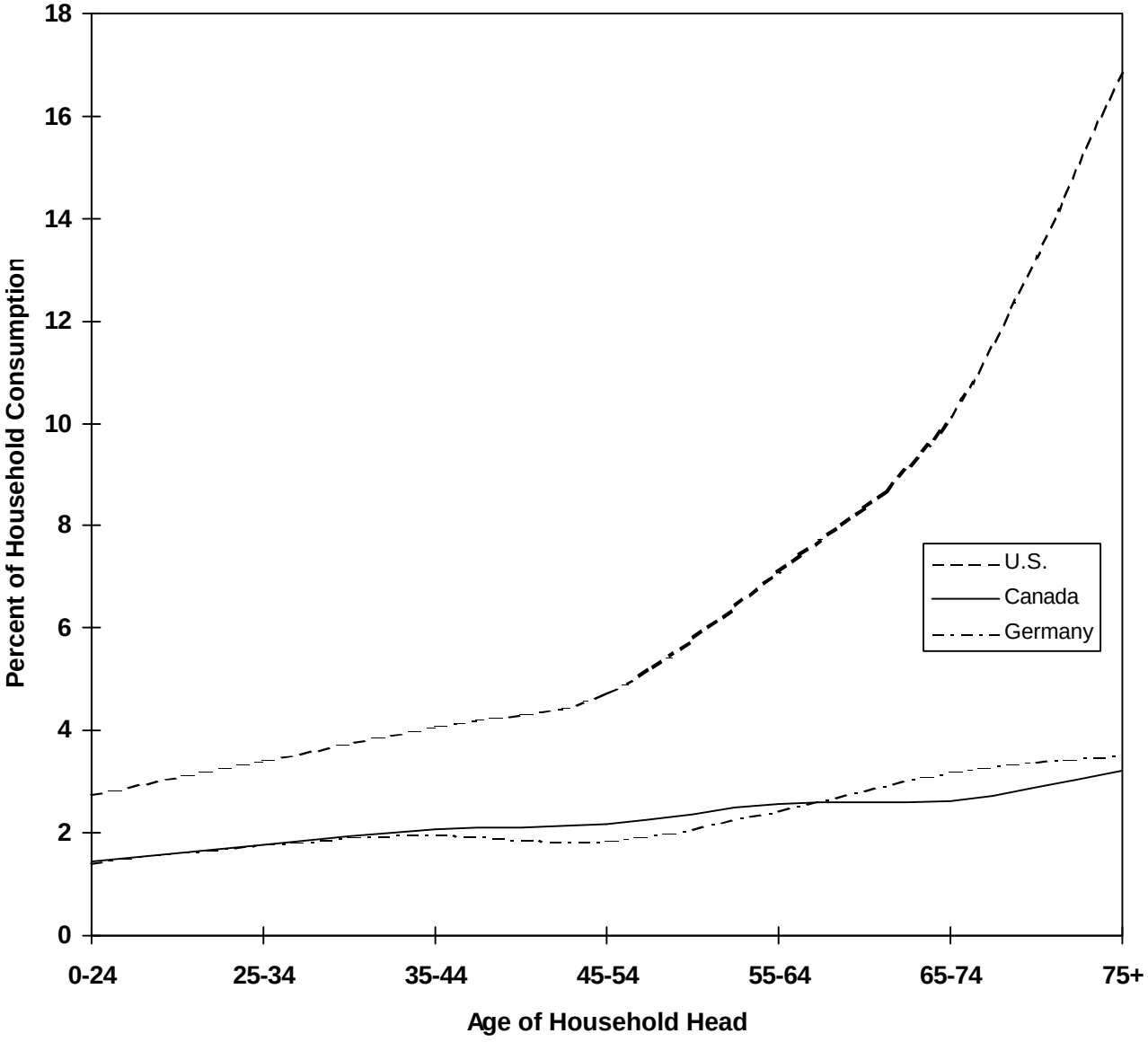
economic and social resources relative to their consumption needs, including health care costs. These health care costs include both acute and chronic care needs. In this section of the paper we review the economic circumstances of the aged in the United States compared to other nations paying careful attention to the distribution of these resources among the aged population.

Acute Health Care Expenses and Economic Security

Average total acute health care expenses for an aged (aged 65 or over) American male are more than six times those of a younger citizen (aged 25 to 29) and almost four times as high for women of similar ages (Burtless 1993). Thus, health care finance in old age is a source of some concern. Virtually all of the American elderly are covered by Medicare. But Medicare pays for only about two-thirds of the acute health care expenses of the aged, mainly hospital and physician services. The remaining one-third of expenses is covered by three sources: Medicaid for the poor aged; employer provided insurance for many better off retirees; and finally by the aged themselves via purchases of health insurance (Medigap, employer premiums) and out-of-pocket expenses. Out-of-pocket expenses for health care and health insurance increase constantly as persons age, rising from 3 to 4 percent of total consumption at younger ages to 12 percent at age 65 and 18 percent at age 75 (see Figure 1). In contrast, the health care systems of Canada and Germany impose out-of-pocket expenses of only 2 to 3 percent on the aged in these nations (Figure 1). While we have no direct comparison of the different range of health care services in the United States as compared to these nations, it is clear that the United States elderly *on average* spend more on health care than do their Canadian and German counterparts. As one might expect, there is additional variance among aged subgroups. Since the late 1980s health care expenses have grown faster than incomes leading to some groups of persons, e.g., women aged 80 and over, who spend 30 percent of their incomes on average on acute health care expenses (Moon 1995).

Figure 1

Health Care Spending as a Percent of Current Household Consumption by Age of Head



Sources:

1. **U.S., Canada, Torrey and Jacobs (1993), U.S. Consumer Expenditure Survey, 1986.**
2. **Germany, Merz (1995), German Income and Expenditure Survey, 1983.**

Changing from a defined benefit to a defined contribution health care system is liable to increase personal financial responsibility on average, but to reduce its variance as managed care plans assume greater internal responsibility for catastrophic expenses. Plan premiums will rise and with them required premiums for the elderly. The federal and state government's challenge will be to construct viable schemes for subsidizing premiums for the aged and disabled based on their incomes and assets.

While we have no comparable international figures, simulations which subtract health care costs of 2 or 3 percent from the incomes of the aged (and 1 percent from those of the nonaged) produce poverty rate differences of 1 percentage point or less. In contrast simulations made by the Urban Institute (Meier 1997) indicate that United States health care expenses for the aged could produce increases of up to 10 percentage points in the United States aged poverty rate, roughly doubling it from its current 11 percent level.

Economic Security: Poverty and Income Distribution

Next we turn comparisons of economic status of the United States aged as compared to those in six other OECD nations: the United Kingdom, Australia, Canada, Germany, The Netherlands, and Sweden. In other work (Smeeding 1996), we have expanded the comparison set to 12 OECD nations but here we concentrate on just seven nations.

We investigate three separate issues:

> **poverty**, as measured by the fraction of aged (and subgroups) with incomes less than various fractions of overall median income, adjusted for family size (Table 1).
>
> **income distribution**, as seen by the fractions of the aged with incomes below 60 percent of the overall median (low income), between 60 and 120 percent of the median (middle incomes), and above 200 percent of the median (high income) (Table 2).
>
> **income sources**, the income sources of the bottom, middle and top deciles of adjusted income (Table 3).

Defining poverty in an international context is not an easy task. Different nations and groups employ different definitions. Here we present a range of estimates. The United States poverty line is about 40 percent of the United States median income; the most commonly used international poverty line is 50 percent of median (which roughly includes both the United States poor and the United States near poor—those between 100 and 125 percent of the poverty line); and the Scandinavian nations choose to set their low income standards at about 60 percent of median income (or 150 percent of the United States standards). We begin (Table 1) by examining the poverty status of four separate groups among the aged: all those aged 65 and over (elderly), all women aged 65 and over, all women aged 65 and over living alone, and finally, all women aged 75 and over living alone. In almost every nation, and at almost every poverty level, poverty increases as you move down the groups in Table 1. That is, in general, women are poorer than average, older women living alone are poorer still, and the oldest old who also live alone are the poorest group. Thus, vulnerability increases with gender, single person, living arrangement, and age.

At the lowest poverty standard, the United States stands out with the highest overall poverty rate. As we move cumulatively up the poverty scale, the United Kingdom and Australia have poverty rates which exceed those found in the United States. Canadian and European poverty rates are in the single digits until we reach the 60 percent of the median standards (Table 1, Panel A).

While older and the oldest women living alone generally do worse than the average older person, some nations—e.g., Sweden, the Netherlands, Germany, and Canada—do better than others—the United States, the United Kingdom, Australia. In these last three countries, between 55 and 77 percent of older women alone—and 60 percent or more of the oldest women have incomes

Table 1
Poverty[1] Rates Among the Aged[2]

Country	Year	Percent of Population with Incomes Less than Given Percent of Adjusted National Median Disposable Income: 40%	50%	60%
A. Elderly (65+)				
United States	1994	13.4	22.7	31.7
United Kingdom	1991	10.9	30.5	47.3
Australia	1989	7.1	28.6	50.5
Canada	1991	1.5	7.1	23.0
Germany	1989	4.5	8.1	17.4
Netherlands	1991	3.0	4.4	23.7
Sweden	1992	1.5	6.4	19.8
B. Elderly Women (65+)				
United States	1994	16.7	27.5	37.0
United Kingdom	1991	13.4	34.8	52.3
Australia	1989	8.0	34.1	54.2
Canada	1991	1.4	8.3	27.4
Germany	1989	5.2	9.5	20.2
Netherlands	1991	2.8	4.0	27.7
Sweden	1992	1.9	9.1	26.1
C. Elderly Women (65+) Living Alone				
United States	1994	26.9	43.1	54.6
United Kingdom	1991	23.3	50.1	70.3
Australia	1989	12.3	62.1	77.5
Canada	1991	2.4	16.2	49.0
Germany	1989	6.7	12.7	25.8
Netherlands	1991	2.1	3.4	38.7
Sweden	1992	3.1	14.7	40.1
D. Elderly Women (75+) Living Alone				
United States	1994	27.7	46.5	59.7
United Kingdom	1991	25.2	51.5	73.0
Australia	1989	12.3	64.5	81.5
Canada	1991	2.1	15.6	55.9
Germany	1989	7.7	11.3	26.6
Netherlands	1991	1.6	3.1	41.2
Sweden	1992	3.1	17.4	50.9

Source: The Luxembourg Income Study

Notes:

[1] Poverty is defined as percentage of elderly living in households with adjusted disposable income less than given percent of median adjusted disposable income for all persons. Incomes are adjusted by E=0.5 where adjusted DPI = actual DPI divided by household size (s) to the power E: Adjusted DPI = DPI/s^E.

[2] Aged are all persons aged 65 and older. Person level and household level files were matched and income data were weighted by the person sample weight from the person level file.

less than 60 percent of the median. All nations except Germany have half or more of the oldest groups living in this state of vulnerability.

We next examine dispersion of the aged in these same groups across the overall income range (Table 2). The low income group is the same as the 60 percent poverty rate in Table 1, the remainder of the population is split into two groups: middle group (60 to 120 percent of the median) and high group (120 percent of the median or more). Several patterns emerge. The United States has the highest fraction of older persons (and older women) at both ends of the distribution, with Germany having the same fraction of higher income aged but a much smaller fraction of low income elderly (Table 2, Panel A). British and Australian elders tend to be concentrated in the low and middle ranges of the distribution. The other four nations have a remarkably high fraction of the overall aged: 55 to 65 percent who live in the middle income range. In these four nations, the status of the median or "average" elderly person is a good descriptor for the aged as a whole. In the other three nations, 41 percent or less of the aged can be found in the middle group and median income is not a good description for the group as a whole. Most elderly can be found either in the low income group (Australia, United Kingdom) or both higher *and* lower income groups (United States).

Older women living alone tend to be more often found in the low or middle income groups (Table 2, Panel C). With the exception of Germany, less than 13 percent of older women living alone can be termed "high income." Thus, older women are more liable to be more vulnerable to changes in economic status than are other groups of the aged in most nations. American, Dutch, and German women show the highest fraction of high income older women, but these are a clear minority of older women in every nation.

Finally, we look to the composition of the income of the aged at various levels. We examine five sources of income: earnings, capital/property income, occupational pensions (from private or

Table 2
Income Distribution[1] Among the Aged[2]

Country	Year	Low Income Up To 60%	Middle Income 60% - 120%	High Income 120% +	Total
A. Elderly (65+)					
United States	1994	31.7	41.0	27.2	100.0
United Kingdom	1991	47.3	37.4	15.3	100.0
Australia	1989	50.5	36.7	12.9	100.0
Canada	1991	23.0	55.0	22.0	100.0
Germany	1989	17.4	55.1	27.5	100.0
Netherlands	1991	23.7	56.1	20.1	100.0
Sweden	1992	19.8	68.0	12.2	100.0
B. Elderly Women (65+)					
United States	1994	37.0	39.4	23.6	100.0
United Kingdom	1991	52.3	34.0	13.7	100.0
Australia	1989	54.2	33.7	12.0	100.0
Canada	1991	27.4	52.1	20.5	100.0
Germany	1989	20.2	54.8	25.0	100.0
Netherlands	1991	27.7	53.8	18.4	100.0
Sweden	1992	26.1	65.4	8.5	100.0
C. Elderly Women (65+) Living Alone					
United States	1994	54.6	33.9	11.5	100.0
United Kingdom	1991	70.3	24.1	5.6	100.0
Australia	1989	77.5	17.8	4.7	100.0
Canada	1991	49.0	42.4	8.5	100.0
Germany	1989	25.8	52.1	22.1	100.0
Netherlands	1991	38.7	48.6	12.7	100.0
Sweden	1992	40.1	56.8	3.1	100.0
D. Elderly Women (75+) Living Alone					
United States	1994	59.7	30.8	9.5	100.0
United Kingdom	1991	73.0	22.9	4.1	100.0
Australia	1989	81.5	15.2	3.3	100.0
Canada	1991	55.9	36.6	7.5	100.0
Germany	1989	26.6	53.7	19.8	100.0
Netherlands	1991	41.2	48.3	10.5	100.0
Sweden	1992	50.9	48.5	0.6	100.0

Source: Luxembourg Income Study

Notes:

[1] Low income individuals live in households with adjusted disposable income up to 60% of the median adjusted disposable income for all persons. The relevant brackets for middle and high income are 60%-120% and 120% +, respectively. Incomes are adjusted by E=0.5 where adjusted DPI = actual DPI divided by household size (s) to the power E: Adjusted DPI = DPI/s^E.

[2] Aged are all persons aged 65 and older. Person level and household level files were matched and income data were weighted by the person sample weight from the person level file.

public sector employees), social retirement, and other income which is largely from means or income tested benefits in most nations (Table 3). We look at these sources at three points in the distribution: the lowest decile, the middle decile and the highest income decile. Several patterns emerge:

> In all nations (except Australia), social retirement is an important source of income for the lowest decile and for the median decile. Means tested income is usually second, indicating that the standard of living among the low and middle income aged is largely determined by public sector incomes (government transfers) to the aged, particularly those from social retirement benefits.
>
> At higher income levels one finds a more balanced portfolio in almost all nations. Earnings, property income, occupational pensions, and social retirement all help support the economic status of the better off aged (except for Sweden, where social retirement continues to dominate); and Australia, where the income tested old age benefit system peters out.
>
> Middle and lower income elderly receive two-thirds or more of their incomes from social retirement in every nation studied here. In fact, middle income older persons rely as much or more on social retirement as do low income persons in the United States, Germany, and Sweden.
>
> Older women look remarkably like all of the aged in terms of their income sources, with an even greater reliance on social retirement as an income source, and a lesser reliance on earnings.

We conclude that there is greater diversity among the aged with respect to poverty and income distribution, but greater similarity with respect to income sources. All of the aged, and particularly those at low and middle income levels rely on social retirement as a source of economic well-being. Property income and occupational pensions account for more than 25 percent of incomes only among the well to do elderly.

Long-Term Care

The most frail aged often require long-term care services in the home/community or in nursing home facilities. Among the United States aged, these services are funded by public transfer systems, Medicare and Medicaid, and by private payers and other smaller government programs. Figure 2

Table 3

Within Decile Gross Income Composition[1] of Aged[2]

	All Aged			Single Women 65+		
	Decile 1	Decile 5	Decile 10	Decile 1	Decile 5	Decile 10
United States 1994						
Earnings	2.61	9.58	37.90	0.63	1.88	17.17
Capital or Property Income	6.12	9.16	23.16	9.28	5.79	34.64
Occupational Pension	3.68	14.68	20.05	2.65	6.56	21.22
Social Retirement	69.73	65.73	18.75	68.63	84.25	26.75
Means Tested and Other Income	17.87	0.85	0.14	18.81	1.54	0.21
United Kingdom 1991						
Earnings	0.00	1.98	25.30	0.00	0.27	3.14
Capital or Property Income	4.03	7.74	28.62	3.77	2.49	32.57
Occupational Pension	3.37	16.14	30.15	2.98	4.44	37.48
Social Retirement	85.04	65.62	15.32	85.51	64.65	26.75
Means Tested and Other Income	7.56	8.51	0.62	7.74	28.14	0.06
Canada 1991						
Earnings	2.17	5.35	33.75	0.21	0.03	8.24
Capital or Property Income	2.74	13.87	24.53	0.97	14.13	35.93
Occupational Pension	1.61	12.25	22.29	1.34	4.42	29.26
Social Retirement	87.88	65.22	16.97	92.01	79.97	22.10
Means Tested and Other Income	5.60	3.31	2.46	5.46	1.45	4.47
Germany 1989						
Earnings	6.54	6.53	33.56	1.26	0.00	5.27
Capital or Property Income	7.06	2.35	8.41	5.27	3.77	16.70
Occupational Pension	3.67	7.49	31.28	5.11	8.34	37.30
Social Retirement	73.86	83.51	26.44	83.09	86.64	40.72
Means Tested and Other Income	8.88	0.12	0.31	5.28	1.25	0.00
Netherlands 1991						
Earnings	0.21	0.31	11.14	0.00	0.00	0.87
Capital or Property Income	1.89	4.87	14.70	2.25	1.29	16.78
Occupational Pension	5.99	18.41	48.61	5.99	11.96	51.63
Social Retirement	81.54	72.80	24.73	74.91	82.20	30.23
Means Tested and Other Income	10.37	3.62	0.82	16.85	4.55	0.49
Sweden 1992						
Earnings	0.38	1.74	16.46	0.00	0.15	5.09
Capital or Property Income	7.01	7.09	12.37	7.28	12.09	10.65
Social Retirement[3]	76.80	90.58	71.17	78.98	74.66	84.18
Means-Tested and Other Income	15.80	0.60	0.00	13.74	13.10	0.08
Australia 1989						
Earnings	1.17	0.95	42.93	0.00	0.00	10.01
Capital or Property Income	16.44	15.63	40.50	23.04	6.15	46.44
Occupational Pension	2.17	2.94	9.56	3.79	1.88	29.55
Income Tested Benefits[4]	75.73	80.47	6.22	64.89	91.97	12.61
Other Income	4.50	0.02	0.78	8.28	0.00	1.40

Source: Luxembourg Income Study database

Notes:

[1] Deciles are determined by adjusted gross income by household type. Gross incomes (GI) are adjusted by E=0.5 where adjusted GI = actual GI divided by household size (s) to the power E: Adjusted GI = GI/s^E.

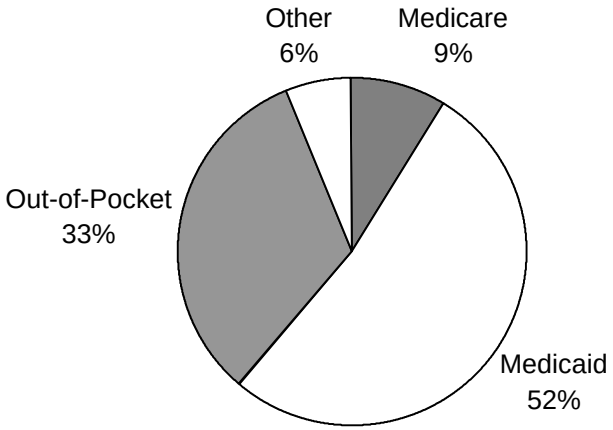
[2] Aged are all persons 65 and older. Person level and household level files were matched and income data were weighted by the person sample weight from the person level file.

[3] Social Retirement in Sweden includes occupational pensions which average about 8 percent of income.

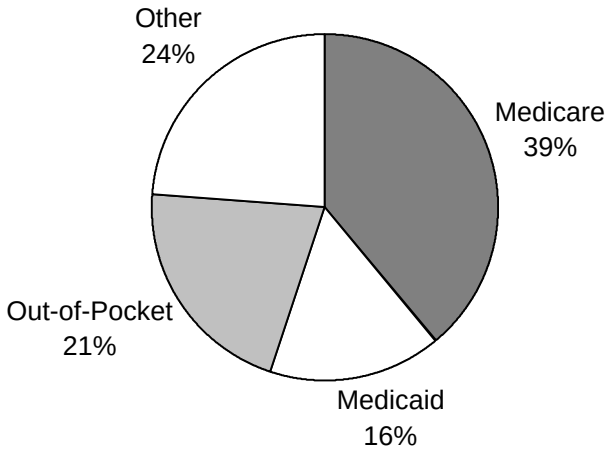
[4] Australia has no social retirement system but only an income tested benefit system of the aged.

Figure 2

Sources of Long-Term Care funding, 1993



Nursing Home Care
Total = $69.6 billion



Home Health Care
Total = $20.8 billion

Source: Kaiser Commission on the Future of Medicaid, 1995.

indicates that the two major public programs paid 61 percent of nursing home care and 55 percent of home health care in 1995. Out-of-pocket outlays were 33 percent and 21 percent respectively, while other sources of finance: private insurance, Older Americans Act funds, public health, Veterans' care, state programs, etc., amounted to 6 and 24 percent of outlays, respectively.

We have no comparable figures for other nations though public funding seems to play an even larger role in all of them. Public funding for long-term care is predominant in Australia, Canada, Sweden, Germany, and The Netherlands, and also in the United Kingdom (OECD 1996). In the Netherlands, Sweden, and the United Kingdom, most of these expenses are financed at the federal level but services are delivered at the local government level, particularly for home care. In Germany, Australia, and France, strong federal programs provide this care while in Canada, long-term care provision is a provincial decision. While many nations such as these are turning toward a social insurance arrangement, or a federally funded/locally delivered system, to share the risk of long-term care, the United States has turned in the opposite direction (OECD 1996; Henessey and Warner 1996). But in all OECD countries concern over the financial burden of long-term care in old age is increasing and governments are considering income testing and variance forms of private payments to help offset public costs (OECD 1996). Thus, while current levels of support in other nations are more generous than those found in the United States at present, decreased public support for these services is predictable in many nations, with the exception of Germany and Austria.

III. Discussion and Policy Implications

Given this tapestry of income sources and health care uses, what can we learn about shifting responsibilities from the United States federal government to other sources of funding, both lower level governments and individuals?

Acute Health Care

In the arena of acute health care expenses, the United States elderly already expend a high fraction of their incomes for health care. Turning to a defined contribution system for Medicare may increase these expenses, driving the United States aged at or near the poverty line deeper into poverty. Unless Medicaid, which is liable to be under severe pressures of its own, can pick up these expenses, even more aged will fall into poverty once these expenses are taken into account. Here public policy needs to support catastrophic limits for out-of-pocket acute care expenses among the lower income aged. In short, we need another, but a better, catastrophic health care plan for the aged than the one which we created and then abolished at the end of the 1980s. One way to create such a system is via an HMO-style Medicare program where a fixed price is paid for a given package of services, including catastrophic expenses. Income and/or wealth-related premiums could then be designed to help relieve the unduly high costs of coinsurance on the low-income and wealth aged. There seems to be room for additional cost sharing for acute care expenses in Europe (at least in Germany) and Canada—where poverty rates and out-of-pocket medical expenses—are both far lower than in the United States. In Australia and the United Kingdom, low income elderly can not very well tolerate such charges.

Social Retirement

Lesser reliance on traditional social retirement plans pose a great risk to the low and middle income aged, but not the high income aged. Since there are no serious proposals concerning the restructuring of social retirement comparable to those that have been proposed in the United States, we do not expect that benefit levels found in other nations covered here are in risk of being reduced. Changes in social retirement in Europe today focus on such issues as raising the retirement age,

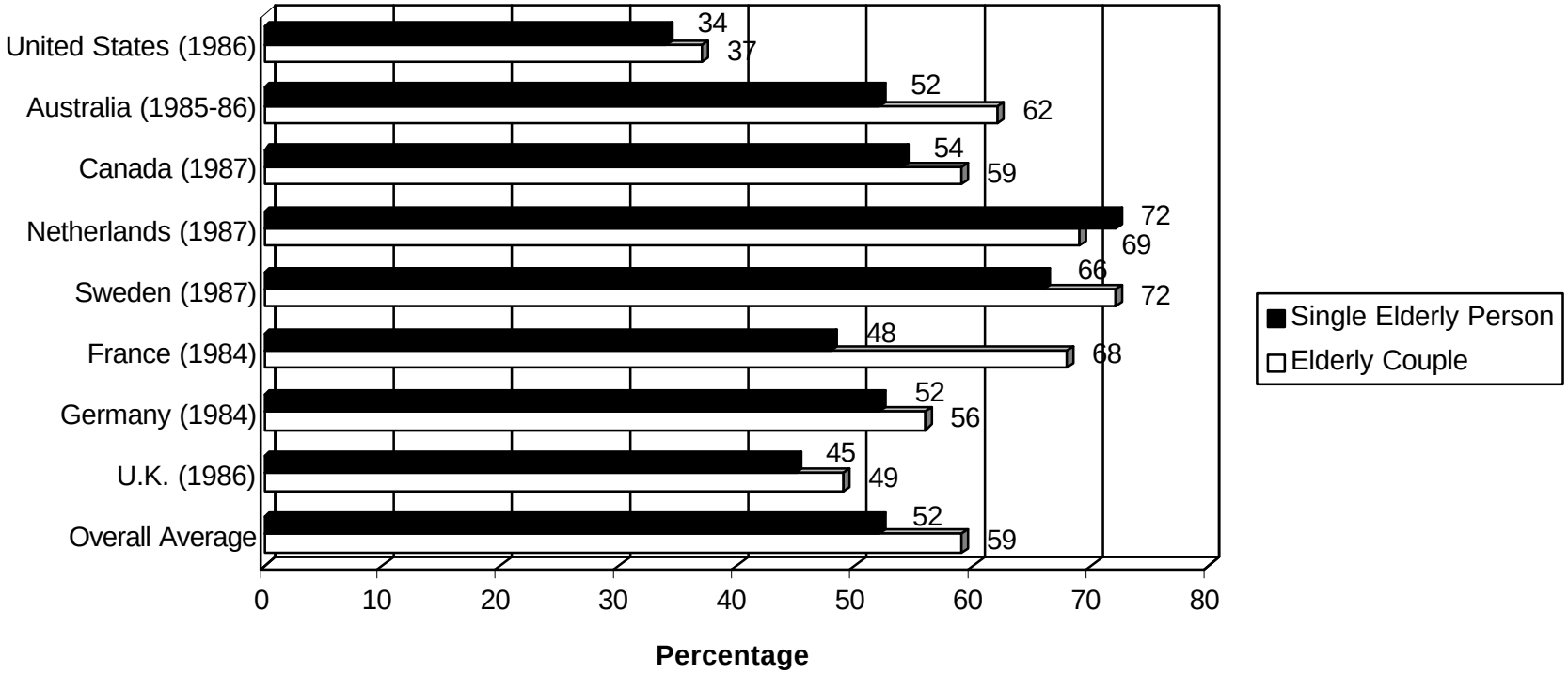
tightening eligibility for early retirement and reducing benefits for the high income elderly, e.g., through taxation.

Any drastic change in OASI for the United States elderly will need to carefully address the issues of benefits among those who rely most heavily on it—the poor and middle income recipients, particularly older women. Movement to a privatized higher risk system need be balanced by increased income security for low income Americans. As we have noted before (e.g., Burkhauser and Smeeding 1994; Smeeding 1996) the United States income support system for the aged has a far less generous income guarantee than do other national plans (Figure 3). National minimum benefit levels are highly correlated with the national poverty rates observed in Table 1. The only practical and sure way to ensure that older Americans can be removed from poverty is to restructure benefits so that we achieve this objective by raising the United States guarantee to a higher fraction of median income, than the 34/37 percent shown in Figure 3.

The current wave of Social Security reform proposals therefore present an opportunity to restructure both minimum social retirement benefits *and* income tested benefits in a way that guarantees a nonpoverty (in United States terms) standard of living for *every* older American. Such a system—two tiered, double decker, whatever—could eradicate the remaining severe poverty for older women, be they divorced, widowed, or never married; minority or majority. Hence, I see benefit restructuring as part of system restructuring presenting an opportunity for an American president and Congress to declare that the "new" Social Security system is both financially sound *and* able to guarantee a nonpoverty living standard for *all* Americans. Such systems are not beyond the realm of possibility. For instance, the Canadians have been able to reduce their elder poverty rate from 20.5 percent in 1981 to 5.7 percent in 1991 by restructuring their income support system in old

Figure 3

Minimum Old Age Benefit[c] as Percentage of Adjusted Median Income



Source: Luxembourg Income Study (Smeeding, 1996a).

[a] Income is adjusted using the simple LIS eqivalence scale that counts the first person as 1.0 and all other persons as 0.5 regardless of age. Elderly heads are 65 and over.

[b] Poverty rates are percentages of persons aged 65 and over whose disposable after tax incomes fall below the specified percentage of adjusted median income. The U.S. poverty line was 40.7 percent of adjusted income in 1986.

[c] Minimum benefits as published by the Organization for Economic Cooperation and Development (OECD) were compared with adjusted median income after adjusting for national price changes. For the United Stattes, the figures include the Supplemental Security Income benefit; plus the Old Age and Survivors Insurance disregard; plus Food Stamps as indicated in U.S. Congress, House, Committee on Ways and Means, *1992 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means* (Washington, DC: U.S. Government Printing Office, 1992).

age (Smeeding, Torrey, Rainwater 1993). The important question is not how, but if, we can accomplish this goal.

Long-Term Care

In the area of long-term care, the federally defined contribution/block grant approach to Medicaid, and the reluctance of Medicare to cover such expenses will shift financial reliance from the public to the private sector. Medicare recipients will need to choose health care plans that offer various amounts of home care (or nursing home care) in markets where charges reflect costs. Medicaid long-term care expenses for the aged will compete even more than at present with the needs of the disabled and children, 23 percent of whom are now covered by Medicaid. As public Medicaid dollars are stretched, quantity and quality of services will thin for all parties—aged and nonaged. Responsibility for long-term care for middle and higher income disabled will fall back to the aged themselves (out-of-pocket or via private long-term care insurance) and their families.

Revenue

Finally, should additional general revenue be needed to top up social retirement incomes for the otherwise poor aged, to limit out-of-pocket medical expenses for the low income aged, or to otherwise cover long-term care services, most OECD nations are reconsidering the favorable tax treatment of the well to do aged.

To quote Scherer (1996):

> Public pension transfers are increasingly flowing to a sector of the population which, on average, has considerable other incomes and assets. There can be no question of reneging on the pension promise: incomes and asset holdings are skewed, and situated below that average there are a majority whose life situation is structured around their (social) pension income. However, it may now be time to reconsider the favored fiscal treatment which the elderly often receive: they are often exempt from social charges (which are levied on earned income in many countries) and also often receive favored treatment in the general tax system. Those with extensive capital assets in the form of housing stock are often unable to access this to fund income needs, or are

> encouraged not to do so by exemption of such assets from tax assessment and (at least in Australia) from the criteria which determine entitlement to means tested support. Similarly, general publicly subsidized concessions to the elderly represent further "in-kind" benefits (which are not generally captured in the data)—benefits which are often not available to younger low income families. Old age is no longer a useful "proxy" for income distress, although many tax systems do still reflect that assumption.

Thus, the well to do aged need to share in support of the low income aged as do the rest of the better off taxpayers in this and other nations. This is a responsibility that should be reshuffled back to all of those with the ability to pay for these needs.

IV. Conclusion

This paper has reviewed the changing United States structure of income and health care security for the low income aged in a comparative context. We find that the United States aged pay more for acute and long-term health care than do their counterparts in other nations. We also find that single older American women have very high poverty rates compared to their peers abroad.

We also argue that Medicare, Medicaid and Social Security restructuring bring with them an opportunity to address many of these shortcomings while at the same time meeting the objectives of Social Security reform proponents and federal budget exigencies. It remains to be seen if this is just the wishful thinking of a "tooth fairy," or if progress can be made in raising the economic security of the low-income United States aged, particularly single women living alone.

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