PROVIDING MEDICAL CARE FOR THE POOR: A PROPOSAL*

LOUISE B. RUSSELL, PH.D.
Research Professor of Economics
Institute for Health Care Policy and Aging Research
Rutgers University
New Brunswick, New Jersey

MY charge is to discuss my views "on establishing a floor of entitlement to health care for low income persons and children in the United States." I present here my views, not as one especially expert in the needs of the poor or the current system for meeting them, but as one knowledgeable about many aspects of medical policy in the United States who, looking across the range of problems to be addressed, sees care for the poor as the most urgent.

I propose a unified, uniform, comprehensive program that would provide care directly to the poor. Everyone with a family income below the federal poverty line would be entitled to care through this system. The eligibility criteria would be the same for everyone everywhere in the country, and everyone would be entitled to the same benefits. It would be easy for the poor to find local providers associated with the program because all would be identified by the same name and logo throughout the country. The system would provide comprehensive medical services and prescription drugs. Dental care might ultimately be included. It would probably be best to handle long-term care separately, as part of the Medicare program.

The proposed program would be a joint federal-state system, with the framework provided by federal legislation, administered by the states and financed by both. Care would be provided through existing government hospitals and clinics—federal, state, and local—or through hospitals and clinics under contract to government. The program would unify the structure that already serves the poor rather than add another piece to the current patchwork. Financing would proceed in the same way, first combining the resources already used for the poor and then adding as necessary. My estimates indicate that $6 billion to $9 billion in new money would be needed. A tax on hospital revenues is proposed as the major source of new funds.

*Presented as part of the National Health Policy Seminar, *Toward a Health Care Financing Strategy for the Nation*, held by the Committee on Medicine in Society of the New York Academy of Medicine from October 1986 to August 1988.

The system would be available to all citizens who are or who become poor. It would end the categorical approach to providing medical services to the poor and would offer instead a true safety net that would protect everyone in the United States. It would do this by accepting a "two-class" system of care, even institutionalizing it. It can be argued, and I will argue, that a separate system can serve the needs of the poor better than one designed to cover the whole population. But the ultimate aim would be to make the "second" class so good and dependable that many in the "first" class would want to join.

The rest of this paper first briefly outlines the needs of the poor and the deficiencies of the current system, principally Medicaid, for meeting them. It then describes the proposal in detail—how the system would work, its advantages, and how it would be financed. The description attempts to cover the major points, but inevitably leaves many issues still to be addressed, or addressed in more detail. The paper concludes by explaining why I think a "two-class" system may serve the poor better than a "one-class" system designed to cover the whole population.

THE CURRENT SYSTEM SERVING THE POOR

Although it started out in that direction, Medicaid has not developed into a program that serves all the poor. Eligibility for Medicaid is based on the same complex set of categories used for welfare benefits, categories that pick up large parts, but not all, of the poor in three groups: the elderly, the disabled, and children and their mothers.[1,2] The remainder of the poor are served by a patchwork of programs, when they are served at all: state and local assistance, Community Health Centers, the Veterans Administration, the Indian Health Service, and other programs. "Uncompensated" or charity care takes care of many of the rest.

A major reason that Medicaid does not serve all of the poor, even in the categories that are covered, is that the states are free to set income limits for eligibility below the federal poverty line. As of December 1986, 32 states set limits for families of three (one adult and two children) that were 50% or less of the federal poverty line.[2] Primarily because of the wide variation in income limits among the states, the proportion of the poor covered by Medicaid also varies enormously: in 1983 it ranged from a low of 21% in the Mountain states to a high of 55% in the mid-Atlantic region.[3]

Benefits available under Medicaid also differ from state to state. Some states cap the number of hospital days or physicians' visits a recipient can use in a year—in a few cases, at numbers so low that they are inadequate to cover even a fairly routine acute illness.[2] In many more states the low payment rates

for providers seriously limit recipients' access to care. Crawford[4] observes that in most states "Medicaid payment to nonhospital providers, especially physicians, is so low that Medicaid patients generally can only secure primary care in hospital outpatient settings."

At its best, in the mid-1970s Medicaid covered about two thirds of the poor.[5,6] In recent years coverage has declined, so that currently something less than half the poor are covered. This decline has occurred at the same time that the proportion of the population that is poor has grown, peaking at more than 15% in 1983 and falling somewhat since then, to just under 14% in 1986.[7] Worst of all, the percentage of children living in poverty is higher than the population average—20% of all children lived in poor families in 1985.[8] Younger children are more likely to be poor than older ones—almost one in four preschoolers lived in a poor family. Yet only about half of all poor children are covered by Medicaid.[9]

One principal goal that many of Medicaid's supporters shared was to bring the poor into the mainstream of medical care. While there is no question that the program has improved the care of many poor people,[10,11] it has failed in this larger goal, partly for reasons beyond its control and partly because of its own deficiencies. At the same time, Medicaid has not been a good vehicle for addressing the special needs of the poor, who differ from the middle-class in more ways than having less money, because it has been predicated to a large extent on the assumption that they have no needs that mainstream medical care can not handle.

But the poor do have special needs, arising from their special circumstances, and any program that would serve them well must take these into account. Because of their poverty, the poor must deal with bad housing, stress, and, often, poor nutrition. Areas in which they live suffer from higher rates of crime, against both persons and property, than do middle-class areas. Drugs and alcohol are often serious problems, even for families that abstain, because of the social conditions created when drug traffic and drug use are open and widespread in the community. For all these reasons, "the lives of the poor are characterized by more disruption and daily struggle as well as more simple physical hardships."[12]

These conditions partially cause the higher rates of death and disease that afflict the poor.[12,13] It has been documented repeatedly that both poor children and poor adults have higher mortality rates than the average in the United States and elsewhere. Differentials are so consistent across causes of death and across countries that they have "led some analysts to suggest that a more general process of breakdown and vulnerability may be at work that

transcends disease entities".[12] At the same time that the poor suffer from more of the same illnesses as the middle class and under more difficult circumstances, some of their health problems differ from the rest of the population—lead poisoning among children who ingest old, peeling, lead-based paint in poor housing is a good example.

A system that would care for the poor needs to be able to address these special needs and the particularly difficult circumstances in which medical help must be given and received. It must also recognize that the poor are a heterogeneous population made up of a variety of groups, each with its own special needs. These include poor children and their parents (working and nonworking), people with AIDS who have been impoverished by their disease, the chronically disabled who are poor because they cannot work, elderly people impoverished by the cost of long-term care, and the homeless.

THE PROPOSED SYSTEM IN MORE DETAIL

When I began reading for this paper, I discovered for the first time Fitzhugh Mullan's similar proposal. Like Mullan, I propose the creation of a single, unified system of direct provision out of many of the pieces that now serve the poor. He urges that "whatever is done should unify rather than fragment the system of care for the poor."[14]

Resources that serve the poor include three major groups of institutions: public hospitals and their outpatient clinics; the offices and clinics of state and local public health departments; and federally supported programs of primary care, among which Mullan counts community health centers, migrant health centers, and National Health Service Corps sites. These institutions receive financing from Medicaid, the Maternal and Child Health Program, various federal health block grants, state and local funds, and various funds that pay for charity and uncompensated care. Together they comprise a substantial network of resources where the poor now go for care, backed by substantial funds.

Unifying these many elements is an important aim of the proposal. There are a number of reasons why unification is important, but the one foremost in my mind is that any poor person should know where to go to get medical care—not where to go to be considered for eligibility, but where to go to get care. Even better, anyone, poor or not, should know where to direct a poor person who needs care. This aim can best be met by a single system, operating under a single name for the whole country. Then anyone, anywhere in the country, need only ask for the nearest hospital or clinic of, say, Publicare.

Eligibility for this system should be as simple as possible, even at the risk of letting in a few people who might not be poor or might not be poor for the

entire period of eligibility. If the program is to serve as a true safety net, it cannot be too eager to disqualify people. And, after all, another very important aim of this proposal is to make the system for the poor so good that many of the nonpoor will want to use it. When the large numbers of nonpoor showing up for services become a problem, the system will have succeeded.

An individual or family should be eligible to receive services for a minimum of one year. The one-year minimum serves both the patient, who needs continuity of care, and the provider, who needs continuity of patients and of funds.[15-17] Determination of eligibility could be initiated simply by arrival at a Publicare institution of any member of the family in need of care. The care would be given first and eligibility for further care determined afterward. The primary requirement would be that the individual's or family's income be below the federal poverty line. Other requirements, having to do with assets for example, should be kept simple, and in no case should the eligibility process interrupt the patient's care; if it is later decided that the patient is not eligible, then the family could be billed for the care received, perhaps on a sliding scale related to income.

The system would provide comprehensive medical services and the full list of services would look like that of a good health maintenance organization. Comprehensive outpatient centers and clinics would be the point of entry for these services. The program would encourage providers not already organized in this fashion to reorganize, where it makes sense to do so, to provide comprehensive service. To promote continuity of care, patients would be encouraged to use, or assigned to, one center, and the center would assign each patient or family (or let them choose) a primary care physician.[18] If the center chose, the physician could serve as a formal case manager.

Not all of the poor can be served, or served well, in such centralized settings. In some areas the poor are too few and too scattered; the program would probably contract with individual providers to serve these people, but those providers would not be able to become as expert in caring for the poor. They would, however, be able to call on the larger network of institutions for special care and expertise, and would be identified by the same name and logo as other providers in the system. In still other cases, the poor cannot be counted on to come to a center. For example, the homeless may need special outreach teams that work directly in the shelters or on the streets.[19] These teams can benefit from being affiliated with and working out of a centralized location that provides them with an array of backup services.

Payment to providers would be prospective. An all-inclusive per capita rate would cover outpatient care. Clinics and centers that primarily treat poor

people would then operate with budgets based on the number of people assigned to them, much as HMOs or British physicians do. Yet capitation would also work in those areas where there are too few people to support a clinic or center; local practitioners could be paid the per capita amount for each poor person on their "list." Some individual practitioners are paid this way under Medicaid's case management demonstrations.

The method for calculating capitation rates should be kept as simple as possible. Medicaid's experience in Wisconsin indicates that this is possible and that it need not treat either the payer or the provider unfairly.[20] There, HMOs that enroll AFDC Medicaid recipients are paid a flat per-person rate, negotiated separately for each HMO. Although the enrolled population has changed since the demonstration began—toward younger people and fewer women of child-bearing age—program administrators' calculations indicated that it was not worthwhile to try to adjust the rates for these changes. The point here as elsewhere is to minimize the effort that goes into administering eligibility and payment,and focus instead on good care.

Prospective methods would also be used to pay hospitals. The most likely payment method would be a per-case system like DRGs. Where a provider treats many poor people, the hospital could opt for an annual budget based on the projected number of cases and the DRG payments for those cases. At the same time, DRGs make it easy to contract with institutions that treat only a few poor patients.

The system should be designed to serve communities, and every effort would be made to make both providers and patients feel part of a common enterprise. The community should be involved in quality assurance, in fund-raising, and in decisions to make major changes such as new construction or closing or relocating a clinic. Each provider or area would have members of the community on its board, and on committees to oversee quality, patient grievances, and the like.

Federal legislation would be needed to create a single, unified system from the current fragments. The legislation would set out the framework: eligibility criteria, minimum benefits to be provided, institutions to be brought together under the system, federal financing to be combined and provided, state matching funds, and incentives to induce the states to participate. The states would be responsible for administration of the system, many of whose components are already under state control. This federal-state partnership builds on the current organization of Medicaid and also resembles Canada's federal-provincial system of national health insurance.

A few pieces may not fit into a unified program. In particular, long-term care probably makes more sense as part of the Medicare program than as part of a program for the poor. In addition, the Veterans Administration, and probably the Indian Health Service, would continue to operate as separate systems, although individual institutions in those systems might serve as contractors to Publicare.

ADVANTAGES OF THE PROPOSED SYSTEM

A unified system, designed to serve the poor, would have many advantages for patients. A major one, already stressed, is that a patient would know where to go to get help, and could be sure of getting it when he or she arrived. As Mullan describes it, under the current system "there is no one-stop shopping for the poor. More often than not, a mother seeking an immunization for her child ("well-child care") is required to visit another clinic for treatment if the infant happens to have an ear infection ("sick-child care"). The converse is also true, as primary care patients are dispatched to public health clinics for immunizations because immunizations are "free" in that setting. From the patient's perspective, the distinction between preventive services and personal services is surely elusive, and the number of visits and the number of different locations to which he must travel to obtain care loom as barriers to care."[14]

A single system would permit, and should be used to encourage, greater continuity of care. As suggested earlier, patients should be assigned, or encouraged to use, a single center, and should have a primary care physician or case manager at that center to whom they can turn for guidance. Medicaid's case management demonstrations suggest that traditional providers to the poor, not always committed to continuity of care, can change their ways under the incentives of case management and prepayment, although they are understandably reluctant to do so without assurances that they can count on staying in the business for the long term.[15] The uncertainty arises from the current requirement that one quarter of their enrollment be neither Medicare nor Medicaid patients, a requirement difficult for them to meet and to be dropped in the proposed system.

A system for the poor, by specializing in their care, can develop expertise unavailable elsewhere. It is frequently argued that a system designed to serve the poor will be a poor system, institutionalizing the notion of two classes of care. The flip side of the argument is that a system devoted to the poor and their special problems can do a better job than one that pretends that they do

not differ from the middle class. Patient advocates have voiced concern over Medicaid's case management experiments on exactly this ground—they fear that middle-class providers are not equipped to deal with the special needs of the poor.[15,21] These concerns have been expressed about both the "healthy poor"—children and pregnant women—and about those with chronic physical or mental conditions.

Specializing in the care of the poor allows providers to become good at dealing with their problems: prenatal care for poor women, lead poisoning among children, immunization outreach, special programs to deal with drug problems, and so on. Where the poor are geographically concentrated, as they often are, specializing in their care is a logical extension of the idea that providers should serve communities or "catchment areas"—the epidemiological approach to medical care. Further, many institutions already do specialize in the care of the poor to some degree, and the proposed system would build on their strengths.[16,22,23]

Many examples show that specialized providers can do a better job for the poor, and often do. Community Health Centers have received high marks for their imaginative approaches.[10] Teams that care for the homeless in shelters learn to look for and control problems that do not often appear in middle-class practices.[19] Historically, many of the nation's teaching hospitals provided care for the poor that, in view of contemporary observers, was probably better than that received by the middle class.[24] These institutions still receive fond tributes from those who work in them and those who go to them for care.[22]

That providers who specialize in the poor can and often do serve them better does not guarantee that they always will, and there are also many examples where they have not. I will return to the importance of quality control later.

Specializing in the care of the poor has advantages for providers as well. They too gain from the opportunity to become more competent at handling problems common among the poor. With most of the resources available for the poor combined in a single system, providers should be better able to identify and to call on other services they need. Hospitals can identify the appropriate primary care clinics to which to refer patients they have treated. Primary care clinics will have more direct links to hospitals, drug rehabilitation units, and other specialized services. Indeed, the organization of providers in a single service should stress improving and formalizing these links between different institutions. A single, unified system can also do more to promote safety in high-crime areas and to develop the collegiality that helps

make service enjoyable as well as worthwhile, both of which should help in attracting staff.

In any system, and particularly one for a population with as many health and health-related problems as the poor, there will be more things to do than time and money to do them. It is important to be able to identify problems and to direct resources to the most pressing ones, to be able to decide what should be done now and what must wait. A unified system, drawing on all the resources available for the care of the poor, starts with an advantage in priority-setting simply because of its unity. It is responsible for all the problems and has at its command all the available resources. And in the current climate, with the middle-class subject to pressures to cut down and cut out, it may no longer seem so unfair to suggest that the system for the poor will also need to set priorities and to limit some services. No system can do everything.[25]

Prospective payment will help in priority-setting. The methods that would be used give general guidelines to providers about the levels of resources available, but leave the details of the decisions to them, where they belong. In fact, providers should be allowed discretion to tackle a health problem at its nonmedical source when they believe that to be the best approach. Administrative oversight should focus on care and on the quality of care rather than on the intricacies of payment.

Procedures to review and to improve the quality of care should receive top priority in the proposed system. I say this as much from a belief that quality has been taken for granted too long as from any fear that the system would be subject to abuses. Unlimited money permits quality, but it does not guarantee it. It can even promote poor quality in some respects—witness the concern that too much surgery may be performed.

Quality assurance should begin by involving the community and the patients themselves. The committees that determine what routine reviews to set up, what special problems to investigate, and how to investigate them, should include representatives from the patient community. Peer Review Organizations and Medicaid case management demonstrations provide many examples of the kinds of activities that might be undertaken. These include monitoring the availability of the primary care provider, auditing medical records, undertaking small-scale outcome and sentinel event studies, and developing clinical management protocols.[16] Some of these activities should be federally mandated to allow quality to be compared across providers and nationwide.

FINANCING: IT CAN BE DONE

Financing for the program would come from all levels of government—federal, state, and local. The first and primary source of money would, of course, be the existing programs that are combined to create the new system. These include Medicaid, Maternal and Child Health, several federal public health grants, Community Health Center funds, state funds now expended on care for the poor, and state and local subsidies given to public hospitals for uncompensated care.

How much additional money would be needed? I have made some rough estimates, detailed in the appendix, to set the discussion of additional financing in context. My estimates indicate that, if the proposed system had been in place in 1985, an additional $9 billion would have been required, over and above the funds already being spent, to finance comprehensive benefits for all the poor. If the program were limited to people under 65, $6 billion in additional funds would have been needed.

These amounts are surprisingly small in my view. They are certainly in the realm of the possible. Although usually discussed in terms that suggest it is an insurmountable obstacle, financing may actually be the least of the problems of creating a decent program for the poor.

Where might the additional funds come from? First, with existing programs combined and the separate bureaucracies and requirements for them gradually dismantled, the money already being spent on the poor should be able to go a bit farther. This point has been tarnished by its association with the reduction of federal funds for health programs transformed into block grants in the early 1980s, but it is nonetheless a valid point. Combining programs will not free up huge amounts of money, but it should free up some.

General federal revenues are not likely to produce much new money. Even if the defense budget were cut sharply, that would only reduce the deficit to more reasonable levels, not free money for other uses. But Congress' willingness to expand Medicaid to pregnant women and young children shows that small amounts of new money are possible; some has already been approved as part of recent budget legislation bringing these groups more completely under Medicaid.[26]

The most likely source of substantial new funds seems to me to be the kind of taxes on hospital care that are already in place in Florida and New Jersey.[4,27] Both states tax hospital revenues to finance uncompensated care. Similar taxes could be mandated by the federal legislation setting up the proposed system. Something like the New Jersey system might work on a

national scale. In New Jersey, hospitals add a fixed percentage to every bill, keep what they need to pay for the uncompensated care they provide, and turn the rest over to the state to be redistributed to hospitals whose collections fall short of their unpaid bills. Similarly, a fixed percentage could be added to every hospital bill in the United States and collected by the states. Each state could keep the amount due it for care given its poor, and those with an excess would turn the rest over to the federal treasury for redistribution to states whose collections fell short of their needs. Or, if the act of collection seems too likely to create a sense of entitlement in the collecting state, the federal government could take the full responsibility for collection and distribution.

Tax rates that would be necessary to support the proposed system are reasonable. If all the poor were covered and all hospital revenues were taxed, the tax rate would be 5.4%, based on calculations for 1985. If only the poor under 65 were covered and Medicare revenues were excluded from taxation, the rate on the remaining revenues would be 5.1%; if Medicare revenues were included, the rate would drop to 3.6%.

A major issue is whether Medicare revenues should be subject to the tax. If they were, the tax would, of course, have to come out of federal revenues, and thus Medicare participation would depend on whether additional federal money could be raised, a poor prospect. The answer also depends, however, on whether the system is limited to people under 65 or includes the elderly. If it includes the elderly, then Medicare should pay the add-on. The alternative, which I find attractive, is that Medicare should take over all payment for the elderly, including special help for the poor elderly, and including long-term care. Medicare would then become the one-stop system, or at least the one-stop payer, for people 65 or older. In this case it could be exempted from paying the add-on, although it would certainly need additional funds to fill its new role and might find the add-on the best way to raise them.

The proposed system would aim to involve local communities in many phases of its operation, both to make the system better and to create a sense of ownership among those using it. In keeping with this aim, and with Lawrence Mead's philosophy that the benefits of citizenship carry obligations,[28] that involvement should extend to fund-raising. Community fund-raising should be a part of the system. I would not recommend that this take the form of charges for service; if these are used at all, they should be used to help to control the demand for services, but not first and foremost as a source of funds. Instead, the poor using the system might be asked to contribute a nominal annual premium, say $100 or $200 per year. More general fund raising could take place in the community, along the lines of the United Way

campaign, perhaps as part of it in some communities; the suggested premium might be incorporated as a form of contribution guideline.

Another important issue is what to do about low-wage employers, who rarely provide good health insurance and many of whose employees would be eligible for care through the system. Consideration should perhaps be given to taxing employers who do not provide health insurance. In designing such a tax, it would be important to minimize its effect on employment opportunities.

Finally, if the money were not forthcoming, or just to allow time for all the pieces to fall in place, the system could be phased in, with coverage extended sequentially to different parts of the poor population. Children should come first, and as quickly as possible. I would then phase in adults under 65 by income level, with those having a family income less than 50% of the poverty level first.

The elderly could be phased in last, or they might not be phased in at all. The alternative, as I suggested earlier, is to have Medicare take over all public responsibility for the elderly, including supplemental benefits for the poor, and long-term care. One of the advantages of this arrangement would be that the system for the poor would no longer suffer from a public relations problem that has troubled Medicaid. Some of the public thinks that the entire expenditure for Medicaid goes to AFDC families and, reasonably enough given that misunderstanding, wonders why any more is needed. If spending on long-term care for the elderly were folded into Medicare, the misunderstanding would be largely corrected.

Appendix

ESTIMATES OF THE FUNDS NEEDED FOR A COMPREHENSIVE PROGRAM FOR THE POOR, AND THE FUNDS ALREADY AVAILABLE, 1985

A. *Estimates for the Entire Population*

The funds needed

The funds needed were calculated by multiplying the 1985 per capita expenditure on medical care in the United States times the number of poor people.

1985 per capita medical spending: $1,721

1985 number of poor people: 31,882,000

Expenditure needed: $54,868,922,000, or approximately $55 billion

Sources:

Waldo, D.R., Levit, K.R., and Lazenby, H.: National health expenditures, 1985, *Health Care Financing Rev. 8*:13, Fall 1986.

Census Bureau: Receipt of Selected Noncash Benefits: 1985, *Current Pop. Rep.*, Series P-60, No. 155, January 1987, p. 15.

The per capita spending figure, although not precisely correct for the poor, should be a reasonable estimate. As a national average, it *under*estimates the requirements of the poor to the extent that the poor need more medical care than the average person, and to the extent that total national spending, hence the national average, is too low because too little care is currently provided the poor. But these factors are offset, at least in part, by two others that tend to make the national average an *over*estimate. The first is that the average includes funds for research and construction, not just medical services; the second is that it includes the elderly, who spend more than younger people but are less likely to be poor.

The funds available will be drawn from programs that currently serve the poor, in whole or in part. These are shown below with their expenditures for 1985:

Medicaid	$41.8 billion
Other state and local public assistance	1.9
State and local hospitals	7.3
Other public programs for personal care	4.7
Public health	11.9

Source: Waldo, Levit, and Lazenby: National Health Expenditures, 1985, p. 19.

These items total $67.6 billion. To arrive at a rough estimate of the amount actually spent on the poor, it is first necessary to subtract expenditures for nursing home care, which would not be covered under the proposed system, from the total for Medicaid; this leaves $27.1 billion from Medicaid (41.8–14.7). Then assume, again as a rough approximation, that all of the "other state and local public assistance" goes to the poor, but that only one third of the other state and local expenditure items do. The total then sums to $37 billion (27.1 + 1.9 + 8.0).

These adjustments leave a gap of $18 billion between the amount needed and the

amount available. But part of this gap is already being filled by Medicare, which pays for some of the care of the poor elderly. If the poor elderly receive Medicare payments in proportion to their share of the elderly population, then 12.4% of Medicare's total expenditure of $72 billion in 1985, or $9 billion, was on behalf of the poor elderly. When this amount is subtracted from $18 billion, the remaining gap is $9 billion.

Additional funds needed

An additional $9 billion would have been needed in 1985 to provide a comprehensive program that covered all the poor, including the elderly. If a tax had been imposed on all hospital revenues nationwide, the tax rate would have had to be 5.4 percent in order to raise that amount.

B. *Estimates for the Poor under 65 Years of Age*

The funds needed

The funds needed for the poor under 65 were calculated by multiplying an *adjusted* per capita expenditure on medical care in the United States, described below, times the number of poor people under 65 years of age.

Adjusted 1985 per capita medical spending: $1,215

1985 number of poor people under 65: 28,513,000

Expenditure needed: $34,643,295,000, or approximately $35 billion

Sources:

Waldo, D.R., Levit, K.R., and Lazenby, H.: National health expenditures, 1985. *Health Care Financing Rev.* *8*:13, Fall 1986.

Census Bureau, *Receipt of Selected Noncash Benefits: 1985. Current Pop. Rep.*, Series P-60, no. 155, January 1987, p. 15.

Fisher, C.R.: Differences by age groups in health care spending. *Health Care Financing Rev.* 1:4, Spring 1980, p. 66.

The adjustment was necessary because the national average of $1721 in 1985 includes the elderly, who spend considerably more per person than people under 65. In 1978, the most recent year for which published figures are available, spending per person for the elderly was $2,026 compared with $764 for adults 18 to 64 and $286 for children. If the same *ratios* held in 1985, and X is used to represent the average amount spent on children, then the national average in 1985 can be expressed as:

$$\$1{,}721 = (\%\ \text{children}*X) + (\%\ \text{adults } 18\text{–}64*2.7X) + (\%\ \text{elderly}*7.1X)$$

The percentage in the formula are the percentages of the total population who are children, adults 18 to 64, and elderly. The spending ratios for 1978, shown in the formula, and the population percentages for 1985 yield an X of $625.34. This is an estimate of the average spent on children under 18 in 1985.

When this estimate is inserted in the following formula, the result is an estimate of the spending required for each poor person under 65 in 1985.

Average per poor person under 65 — (% of poor who are children*$625.34)
plus (% of poor 18–64*$1,688.42).

For 1985 this yields an average of $1,215.

The funds available

Again, the funds available will be drawn from programs that currently serve the poor, in whole or in part. These are shown below with their expenditures for 1985:

Medicaid	$41.8 billion
Other state and local public assistance	1.9
State and local hospitals	7.3
Other public programs for personal care	4.7
Public health	11.9

As before, expenditures for nursing home care, which would not be covered under the proposed system, must be subtracted from the total for Medicaid, leaving $27.1 billion. Then assume that a further $5 billion of Medicaid funds is spent on the elderly, leaving $22.1 billion. Finally assume, again as a rough approximation, that one half of "other S&L public assistance" goes to the poor under 65, but that only one quarter of the other expenditure items do. The total already available then sums to $29 billion (22.1 + 1.0 + 6.0).

Additional funds needed

These estimates indicate that an additional $6 billion would have been needed in 1985 to provide a comprehensive program that covered the poor under 65 years of age. If a tax had been imposed on all hospital revenues nationwide, the tax rate would have had to be 3.6% in order to raise that amount. If Medicare revenues were exempt from the tax, the rate on the remaining revenues would have had to be 5.1%.