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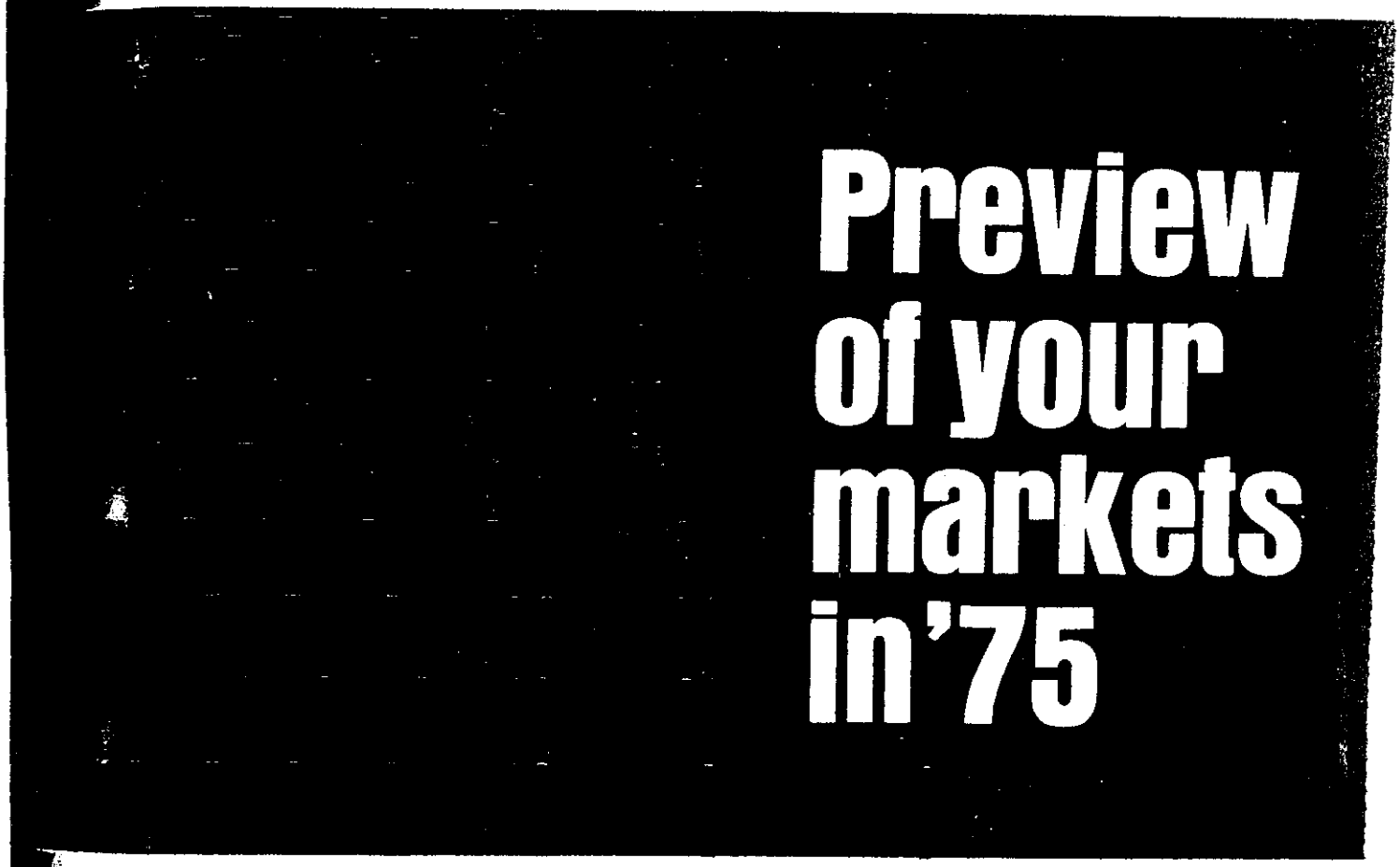

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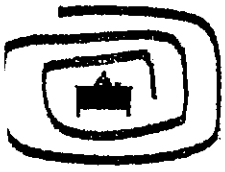
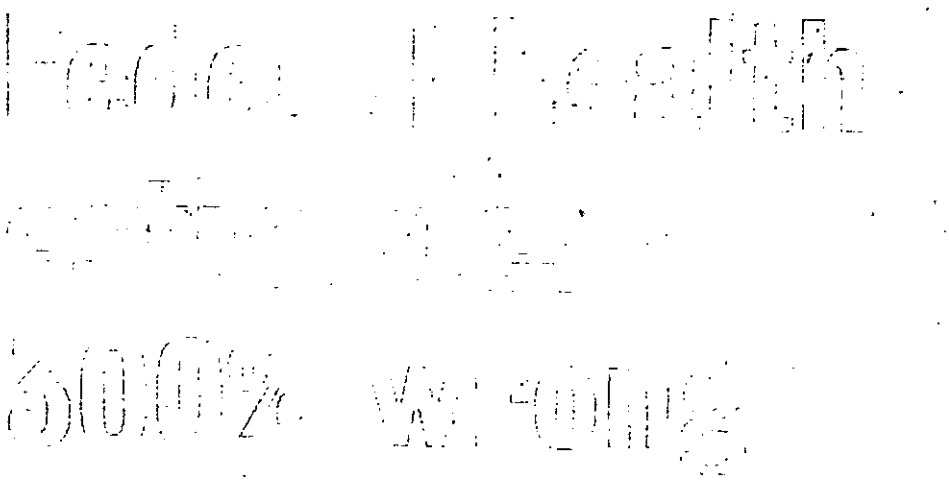




Medical cost expert shows government figures far too low

THE TRUE COST of the proposed federal health plan for the aged can now be told.

If enacted into law, the federally administered plan paid by social security taxes actually would cost at least three times what the bureaucrats say it would and eventually perhaps 10 times as much.

This is the conclusion of an authoritative, nonpartisan analysis of the proposed government health care scheme—one of the major economic and social issues of the day.

The analysis was made by a nationally respected expert who has lived with health and welfare cost estimates during nearly 35 years of government service. He has just retired after failing to persuade federal welfare officials to use what he considers realistic methods to find the cost of government health care.

The authority, Dr. Barkev S. Sanders, made a number of the original cost estimates for the U. S. social security program 25 years ago. He is a medical statistician, sociologist, psychologist and attorney.

In his analysis for NATION'S BUSINESS, Dr. Sanders concludes:

"On the basis of all available evidence, even in the first year [of the proposed federal aged health care program] its cost would be at least three times the estimated cost. It is more probable that the multiplier would be four."

Dr. Sanders points out that the British National Health Service, a more comprehensive socialized medical plan adopted in 1948, ran up expenditures the very next year that were three times the cost estimates.

Looking into the future, Dr. Sanders judges that if the U. S. scheme "comes into operation in 1965, the expenditures for it 15 years later would surely be more than seven times the latest government actuarial estimate, and it is probable that it would be 10 times more in terms of 1964 dollars."

In part, this judgment is based on the experience of the British health plan which, despite restrictions imposed when actual spending far outran estimates, cost $2.9 billion in 1963.

This was seven times what the original expense was calculated to be.

An American plan of medical care for the aged certainly would be expanded to cover more medical costs and younger beneficiaries than currently pro-

PURCELL—PIX

Barkev Sanders, noted medical and welfare statistician-sociologist did study on which this article is based

posed, as both opponents and proponents have said. And the wage base on which the social security tax is figured, as well as the amount of the tax itself, almost certainly would be enlarged in line with the historical development of the social security program.

The proposal—which certainly will be re-introduced in the next Congress—is the remnant left from elaborate and comprehensive government medical and health plans proposed in the 1940's.

When Congress repeatedly beat back these attempts at broad coverage of health services, the strategy of the government health advocates finally shifted to a flanking movement. This was the present limited hospital, nursing facility and home-care coverage plan for the aged.

The health plan for the aged in recent years has been embodied in the King-Anderson bill. It was approved by the Senate this year, but not the House of Representatives. It is popularly known as medicare although it makes no provision for paying doctors' bills. And it offers potential beneficiaries the choice, cafeteria-style and irrevocably, of 45 days, 90 days or 180 days of hospital care.

Officials of the U. S. Department of Health, Education and Welfare, who have backed the limited health program and made the estimates of its costs, have testified to Congress that the social security tax would not have to be raised more than about one half a percentage point of the taxable payroll for both employee and employer. The dollar estimate these officials have offered over the years has ranged between $1 billion and $1.5 billion annually for the early years of operation. Even by the year 2000, they have declared, the cost would not exceed $2.5 billion annually.

Dr. Sanders' analysis for NATION'S BUSINESS did not attempt to arrive at a precise dollars-and-cents estimate, since there are too many future variables for anyone to calculate specifically. But his analysis does show that information and methods have been available to federal officials for years which show their calculations are low to a remarkable degree.

He states in his analysis:

"With respect to its costs, the roots go back again to the early Fifties. At that time, the Division of Research and Statistics of the Social Security Administration was estimating the cost of hospital care for the aged as one half of one per cent of the payroll. And to validate their claim they made a survey of hospital utilization by the aged in 1952.

Hospital use in 1952 is still used as the only basis of cost estimates for more recent programs, including the most current congressional bill.

The federal welfare estimators calculated low and high figures on potential days of hospital use by aging beneficiaries.

But Dr. Sanders points out:

"The low cost estimate includes no upward adjustment for increased hospitalization under a federal hospital insurance program, while the high cost estimate assumes at most an upward adjustment of 24 per cent.

"These figures indicate that the estimators of medicare costs believe that hospital care received by the aged may be sufficient now, or that at most utilization would be increased by 24 per cent under the proposed program. The effect of medicare on utilization as reflected in these cost estimates would hardly support the contentions by the advocates of this program of dire need on the part of the aged for additional hospital services.

"The basic figures giving days of hospitalization were derived from a 1957 Old Age, Survivors and Disability Insurance beneficiary survey. This beneficiary survey missed 12 per cent of the interviewees in the sample. But nowhere has any attempt been made to determine the characteristics of these missing persons. It is quite plausible that many of these might have been missed because they were confined to some medical institution (including short-term hospitals), or had gone to live with relatives because of infirmities."

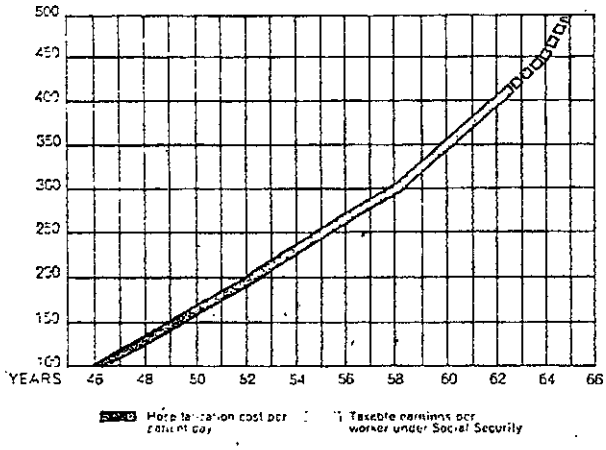
This one deficiency alone, if corrected, could add

Big jump in hospitalization cost revealed in index of Canadian health program over five years

Provinces	1959	1960	1961	1962	1963	1964
Newfoundland	100	165	178	219	262	305
Prince Edward Island	—	100	226	309	374	430
Nova Scotia	100	519	610	755	860	965
New Brunswick	—	100	173	209	238	276
Quebec	—	—	100	524	637	817
Ontario	100	547	643	795	929	1035
Manitoba	100	158	183	213	243	275
Saskatchewan	100	159	171	189	217	253
Alberta	100	179	193	225	294	323
British Columbia	100	160	176	202	235	264

—All provinces did not begin program the same year

Rise in U. S. hospital cost shows social security tax won't pay for hospital care



considerably to the volume of hospital services reported.

"Moreover, even the most perfect household survey attempting to record completed hospitalization for a 12-month period is susceptible to large losses, especially if it is for the aged, a significant proportion of whom are institutionalized at a given time."

Dr. Sanders says he spelled out these deficiencies in an official memorandum prepared in connection with the 1952 survey of hospital utilization of the aged, the results of which were to be used as a measure of such use under a government plan.

The character and magnitude of these deficiencies were explained even more explicitly, he says, in a 33-page memorandum dated December 3, 1962, which he addressed to the Chief Actuary of the Social Security Administration with a copy to the Commissioner of Social Security.

Hospital load miscalculated

Free or partially paid hospital care would sharply increase the load of hospital patients over current levels, Dr. Sanders also notes.

"Such an increase would be most pronounced for the initial year, but its effect would be evident at least for the first four or five years. This increase would not be limited to persons without voluntary, private insurance, as official estimates seem to indicate, but would include those presently insured as well."

Dr. Sanders explains that this seems to be another instance of contradictory thinking by the welfare officials. Despite their frequent claims of the deficiencies of existing private insurance protection, their estimates of the costs for a federal program are based on the assumption that those aged presently insured get all the hospital care they need.

"The full impact of medical care insurance in the first year or two," he states, "is reflected in the proportionate increase in costs for those Canadian provinces for which both the medical insurance program and the Dominion contribution began after 1958. For these the range of increase in per capita costs between 1958 and 1961 is between 51.1 and 98.7 per cent.

"Some of this increment is caused by the increase in hospitalization costs, but much of it results from increased use by patients.

"Considering the formula of Dominion payment, which encourages restraints on costs, as well as the fact that provinces remain directly responsible for about half of the insurance costs, and that the level of occupancy in Canadian hospitals is high, it is my opinion that increase in hospital use as a direct consequence of the most recent U. S. federal hospital care plan would be at the very minimu · 30 per cent, more probably 60 *(continued on page 112)*

HEALTH ESTIMATES

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per cent within five years or so, and possibly as high as 90 or 100 per cent."

In his research Dr. Sanders also compared the estimates of days of hospital use figured in the U. S. Social Security Administration's latest actuarial study with the actual days of hospital care under the Saskatchewan Province of Canada Hospital Service Plan. And these were also compared with estimated days per year of hospital care for aged American veterans in veterans' hospitals and elsewhere.

These comparisons showed that the estimates used by the Social Security Administration in connection with its support of the federal hospital care legislation were calculated on a basis for about "half the days of hospital care under the Saskatchewan Hospital Service Plan and one third of the hospital days used by veterans."

Dr. Sanders also notes:

"The hospital days for veterans are limited to those hospitalized for general medical and surgical conditions. It excludes all hospitalization for service-connected diseases, for neuropsychiatric conditions and for tuberculosis.

"It should be pointed out that veterans are not provided with hospital care for nonservice-connected conditions as a right. They are given such care if there are readily available beds in veterans hospitals and if the veteran can demonstrate his inability to pay for such care. It is therefore quite conceivable that under medicare the hospital utilization rate could go well above that found for aged veterans.

"In the government actuarial studies one finds no use made of the veterans' experiences. The veterans hospital study findings for 1957 were available at the time that the Health, Education and Welfare Secretary's report was prepared in 1959, yet there is no reference to them.

"The Saskatchewan Hospital Service Plan, like the proposed King-Anderson legislation, excludes mental institutions and tuberculosis hospitals and has accommodations for nursing homes. These are not included under hospital days.

"The Saskatchewan experience is not unique. A comparison of the assumed hospital utilization levels for the United States under medicare—without any cutoff—as opposed to that of all Canadian provinces in 1961 and 1962 shows that utilization is higher in every province, except Newfoundland.

"This, we believe, supports our professional judgment that realistic estimates of utilization levels of hospital care would in all probability be 50 to 150 per cent more than those used by the Department of Health, Education and Welfare and later by the actuary of the Social Security Administration."

Daily costs way off

Dr. Sanders' analysis then moves from estimates of hospital use to actual daily costs of hospital care.

"The report of the Secretary of HEW set a per diem cost of $27 to estimate the cost of paying for hospital services for the aged in 1960." The American Hospital Association which has been compiling per diem costs for its member hospitals since 1946 had much different figures.

"According to AHA, the average per diem cost of all short-term general and special hospitals (exclusive of all federal, mental and tuberculosis hospitals) for the fiscal year 1960 was $32.23.

"In my judgment, a higher rather than lower estimate than the AHA figure should have been made. Over the initial five to 10 years of medicare there would inevitably be an inflationary effect on current per diem hospital costs because of heavily increased demand. The federal experts not only made no such adjustment, but they apparently assumed that the steep increase of hospital costs would disappear in 1960, or at least would be balanced by the increase in wage rates.

"This is an incomprehensible assumption to have been made in a report prepared early in 1959, when for the 13 prior years for which per diem hospital payments information was available the rate of increase in hospital costs had been two to three times higher than the increase in wage rates.

"Furthermore, since for cost estimating purposes only the taxable wage rates for social security would be meaningful, this would mean that the taxable wage ceiling would have to be raised frequently, perhaps every year, so as to parallel any annual increase in wage rates.

"In the latest actuarial study, it is said that the cost estimates which have been prepared assume a per diem cost of $37 from 1966 on. This is tantamount to saying that after 1966 the increase in hospital costs would have to be met by progressive annual raising of the ceiling on taxable payroll. Thus, the percentage given in the official estimates has at least two important if's in it.

"The first is whether the $37 per diem is valid for 1966 if medicare were enacted at this time with full benefit payments in force throughout the year. The probable average per diem cost as compiled by the American Hospital Association, without any drastic changes such as the introduction of medicare, would be about $46 in 1966. The stated reasons for reduction in the per diem cost given in the Secretary's report and incorporated in actuarial estimates, even if accepted, could not reduce the average payment for aged patients under medicare to $37.

"The second if is whether the trend in the rate of increase in per diem hospital costs would remain the same. In my opinion, the introduction of medicare would very much accelerate the upward trend in per diem hospital charges relative to wage rates, and would do so in such a way that the cost in 1966 would substantially exceed $46 and the anticipated time when the increase in wage rates will catch up to the increase in hospital costs would be even further away.

"Those preparing estimates for medicare probably could have found the expected effect of medicare on costs through a study of the Canadian experience. But nothing like this was done.

Dr. Sanders says that in 1959 he prepared a critique of the HEW Secretary's report on the cost estimates. He sought permission to make studies of what would happen with regard to hospital use by the aged if so-called medicare legislation were enacted. He reports that he was given no encouragement. Subsequently his statistical staff was taken away from him without explanation.

Looking ahead for NATION'S BUSINESS, Dr. Sanders says:

"There is every reason to believe that the steeper increase in hospital costs will continue for the foreseeable future. . . . On the basis of such evidence, an eventual increase of 150 or even 200 per cent would be more likely over the long range. Besides, the faster increasing costs of per diem hospitalization, the growing liberal use of hospital service, as well as the progressive further aging of our aged population, and medical advances over the foreseeable future would all contribute to this faster upward trend in usage and costs."

The official government assump-

HEALTH ESTIMATES

continued

tions about hospital days and hospitalization costs of the aged under the most recent proposal can be demonstrated to be unrealistic through another approach.

Dr. Sanders points out the Division of Research and Statistics of the Social Security Administration last year estimated total medical care expenditure, both governmental and private outlays, for those aged 65 and over as $4,915 million in 1960 and $5,355 million in 1961.

"The estimated expenditures indicate that—for 1961—$2,325 million of the total was spent for hospital care and $500 million for skilled nursing home care. Of the $2,325 million total, $495 million is estimated as the expenditure of public funds for mental and tuberculosis hospital services. Subtracting this amount would leave $1,830 million and an allowance of $30 million for private expenditures for mental and tuberculosis hospitals would finally leave $1,800 million as the total expenditure for aged for general hospitals.

"This represents a per capita amount per aged of $106. The 1960 equivalent would be about $98.

"This contrasts sharply with the HEW Secretary's estimate of per capita expenditure in this initial year of government health care. The cost estimate for hospital care for the aged is given as $762.8 million for an estimated 11.6 million persons aged 65 and over eligible for benefits. This results in a per capita outlay for hospital services estimated at about $66 as opposed to the estimated amount actually spent of $98.

"Another way to look at this per capita figure of $98 is to project it to 1966, and compare the projected finding with the cost estimate in the latest federal actuarial study. The projection yields a per capita expenditure of $139 in 1966.

"The benefit expenditures, including administrative expenses for calendar year 1966, are given as $1,530 million in the latest actuarial study. The number of beneficiaries is estimated as 18 million for 1965. We can assume that this number would be about 18.4 million for 1966. On this basis the per capita benefit expenditure, according to the actuary, would be $83, or about 60 per cent of our estimated amount of $139.

"The actuarial estimate includes the costs of all the other benefits provided under medicare. If limited to hospital benefits only, on the basis of the percentage distribution of taxable payroll costs given for the latest estimates, the per capita amount for hospital benefits would shrink to $72, about 52 per cent of $139."

So, if the federal medicare plan is enacted, one or more alternatives would be needed to pay its costs—or make it actuarily sound. Either the benefits would have to be reduced to even more limited health care, or patients would have to pay more of the bills themselves. Or the amount of social security tax or the base on which this tax is levied would have to be boosted sharply.

Dr. Sanders' analysis clearly indicates that the Social Security Administration has avoided a study and presentation of the evidence that would yield the most probable costs of hospital care under the most recent congressional proposal. Under these circumstances estimates of other benefit costs—such as nursing home and home care—probably have little value, in Dr. Sanders' opinion.

A political expert tells what initial and historic moves the newly elected President must make. See **page 34.**

The various estimates convince him that these are figures that were selected with only one constraint in mind: "That the over-all percentage of the taxable payroll required should not move too far above the .5 per cent selected back in 1950 as the proper cost for hospitalization benefits for the aged.

"For 1966 the amount of skilled nursing home care for 18.4 million people, according to the government estimates, would be $68 million, $3.70 per aged. But, according to the 1961 expenditure study [done by the Social Security Administration], nursing home costs amounted to $500 million, or $29.40 per person."

In the light of current usage as well as the increasing rate of demand this $3.70 figure makes little sense.

"For home health services [the third category provided under the government health plan] the per diem amount would be about $6 per capita. Taking various cost trends into consideration, this would mean less than one nursing visit or other equivalent services per person every other year. Outpatient-hospital-diagnostic services [the fourth kind of services under medicare] would cost about $1.20 per person. Of course, the patient is required to pay $20 toward this service, but the government's inclusion of this benefit would cause inflation in the cost of the service, so that the actual cost to the insured would be increased rather than reduced."

Dr. Sanders explains that it is not his purpose to damn a health program for the aged or to deny a need for it—but rather to convey his personal and professional conviction that "the Social Security Administration has been concealing the truth by means of its actuarial estimates."

He declares that we should not delude the public as to the cost of an effective health program. "If a sound realistic health program cannot be accepted by the public on its merits it should not be imposed on them by the government."

Dr. Sanders' experience in government has included service as chief of the Division of Health and Disability studies in the Office of Commissioner of Social Security, research consultant with the Bureau of Old Age and Survivors Insurance and research consultant with the U. S. Public Health Service.

He was a member of the social security mission to Japan after the war and research analyst with the President's Commission on Veterans Pensions. He is a consultant to the United Mine Workers Welfare and Retirement Fund. Presently he is doing statistical research for the George Washington University and is consulting actuary with the University of Pittsburgh's Graduate School of Public Health on a special study.

The authoritative opinions and judgments of Dr. Sanders are his own and should not be attributed to any organization or institution with which he has been or is associated. **END**