CHAPTER 3

Income Security and Health Issues

THE FEDERAL GOVERNMENT, over the years, has undertaken and expanded a wide range of programs in pursuit of social objectives related to the health and welfare of society. Many have benefited from the programs. The elderly have gained a measure of income security. Low-income families have been able to supplement their purchasing power with food stamps and public assistance. The poor, aged, and disabled have improved their access to medical care. However, the growing scope and cost of these programs have begun to attract serious analysis of their impact on the allocation of resources, the distribution of income, and the general well-being of the public. This chapter brings together analyses measuring the effects and identifying the problems of a number of Federal income security and medical care programs.

The first section considers several welfare and social insurance programs which provide income security to the poor, the retired, and the unemployed. In the second section we examine several government programs related to medical care. Although these are also income security programs, the role of the government in this area is broader and more complex. Thus medical care is the subject of a separate section.

This chapter relies heavily on the research of economists and statisticians employed in government, universities, and private nonprofit research firms. Although the policy of not citing individual authors or research papers in the *Economic Report of the President* is being continued, documentation may be helpful. Therefore, on request, the Council of Economic Advisers will send interested readers a bibliography of the external sources used for the preparation of this chapter.

INCOME SECURITY PROGRAMS

Income security programs redistribute income in cash or in kind to individuals and families. Some may have the effect of increasing future earning potential, but that is not their primary purpose. The Federal programs having that purpose, such as those for schooling, job training, and rehabilitation, are not considered in this chapter.

Income security programs have been a major factor in the growth of the Federal budget. As classified in the national income accounts (NIA),

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Federal transfer payments to persons (excluding Federal pensions for military and civilian Government employees and for veterans and railroad workers) amounted to $120 billion in 1975, 34 percent of Federal expenditures. As a source of income to persons, Federal, State, and local government transfers (again excluding all the above items and their State counterparts) accounted for 13 percent of disposable personal income. The magnitude of income transfers in 1975 was, of course, unusually high because of the recession, during which earnings were depressed and the cyclically responsive transfers high. But even in 1973 net Federal transfers were 28 percent of Government expenditures and net Federal, State, and local transfers 10 percent of disposable personal income. This represents a substantial growth from the middle 1950s. In 1957 these percentages were 14 percent and 5 percent respectively.

Although all the income security programs involve the redistribution of income, they differ considerably in their specific goals, the people they serve, and their sources of funds (Table 28). Some programs are related to need and provide or supplement income so that particular groups may attain a higher level of purchasing power—supplemental security income (SSI) and aid to families with dependent children (AFDC). Others attempt to ensure an adequate or more nearly equal level of consumption of particular

TABLE 28.—*Aspects of selected Federal income security programs*

Program	Basis of eligibility	Source of funds	Form of aid	Fiscal 1975	
				Expenditures [1] (billions of dollars)	Beneficiaries (monthly average; millions)
OASDI	Age, disability, or death of parent or spouse Individual earnings	Federal payroll taxes on employers and employees	Cash	62.6	30.9
Supplemental security income (SSI)	Age or disability Income	Federal revenues	Cash	5.5	4.0
AFDC [2]	Certain families with children [2] Income	Federal-State-local revenues	Cash and services	8.6	11.1
Food stamp	Income	Federal revenues	Vouchers	4.4	17.1
Unemployment compensation	Unemployment	State and Federal payroll tax on employers	Cash	13.0	16.0
Medicare	Age or disability	Federal payroll tax on employers and employees	Subsidized health insurance	14.1	[3] 24.7
Medicaid	Persons eligible for AFDC, or SSI and medicaliy indigent	Federal-State-local revenues	Subsidized health services	13.0	8.3

[1] Expenditures by Federal and State and local governments; excludes administrative expenses.
[2] Families with children deprived of support because of death, absence from home, or incapacity of parent, or in some States, in certain circumstances, unemployment of father (AFDC–UF).
[3] Estimated number of enrollees.

Source: Council of Economic Advisers (based on program information).

goods or services that are considered essential. Thus some programs supplement income with in-kind transfers of food, medical care, or housing. Another category of programs is not directly based on need but replaces a proportion of wages lost as a result of retirement, disability, death, or unemployment. Included in this group are the unemployment insurance programs and the largest of all income transfer programs—old-age, survivors, and disability insurance (OASDI), commonly referred to as social security.

The sources of funds and administration of the programs differ. Social security is entirely federally funded and administered. The funding and regulations in the food stamp program are Federal, but the regulations are implemented by the States. AFDC is funded by the Federal Government and the States, but is largely State administered. There are, in addition, some programs not considered in this chapter that are State funded and administered, in particular general assistance and emergency assistance.

Forty years ago there were virtually no Federal income security programs. The programs that have since been introduced have expanded in number; coverage has been extended to additional groups in the population; and real benefit levels have increased. As a result of the program growth, a substantial proportion of the needy have been able to improve their level of consumption.

It has, however, been difficult to measure the precise contribution of the programs to reducing poverty. Many of the programs provide benefits in the form of medical care, food, or other in-kind services whose value to the recipient is not easy to determine. For this reason in-kind benefits are not counted as income for purposes of determining poverty status or for purposes of determining eligibility for other programs. However, in 1974, Federal, State, and local spending on medicaid, food stamps, and child nutrition programs came to $16.8 billion. These programs are not intended exclusively for those in poverty, although they are means tested and targeted to lower-income people. The combined outlays for these programs, however, were equivalent to about 118 percent of the gap between the aggregate incomes of those below the poverty threshold and what their incomes would be at the poverty threshold. This figure is raised to 130 percent if Federal subsidies for public housing and rentals are included. The Bureau of the Census has recently started collecting data on the Federal food stamp subsidy received by different families in the population. But additional work is needed before we can fully evaluate the contribution of the in-kind programs to the poor and their effects on the overall distribution of income.

It would appear that we have made substantial progress in providing resources to those in need. We are now in the process of evaluating our programs with respect to how they have affected individuals and how equitably they have distributed benefits. For some of the programs new Federal legislation is proposed, such as in food stamp and social security financing. Other long-run problems do not have easy solutions at this time, nor do we even have all of the evidence necessary to propose alternative solutions.

This section discusses four income security programs, two of which are means tested (AFDC and food stamps) and two of which are social insurance programs (unemployment compensation and social security). Other programs such as supplemental security income, housing subsidies, and veterans' benefits are not discussed.

AID TO FAMILIES WITH DEPENDENT CHILDREN

The AFDC program is administered by the States with Federal guidance, while funding is shared by the Federal Government and the States. In some States a part of the State portion is funded by local governments. Benefits are provided to families in which dependent children are deprived of the support of a parent, usually the father, through death, disability, or absence. In 26 States, benefits are also available under some circumstances if the father is present but unemployed.

Benefit Levels and Participation

The level of income now available to AFDC families, although low compared to that of the average family, is high relative to the potential earnings of AFDC participants. For example, in a sample of 100 representative counties in 1972, a hypothetical AFDC family of four (consisting of a woman and three children) with no earnings or other income was eligible for an average of $2,947 in AFDC benefits and $884 in food benefits. Since benefits are not taxed, this would be equivalent to $4,104 in taxable earnings if the families viewed the food benefits as equal to the same amount of cash. There were also medical care services available for virtually all AFDC participants. Although the average medicaid payment per AFDC family was $770, a low-income family might not value such care at that amount. Adding only $400 for medicaid results in a taxable equivalent income of about $4,550. This does not include any housing subsidies or child care services that might have been received, but does include greater benefits than would have been received if the family had earnings or other income. Moreover, as with all averages, these data mask considerable variation among States. Thus in 1972, 63 percent of the poor lived in counties where AFDC cash benefits and food benefits were $3,000–$5,000 a year (before taxes) for a family of four with no private income; but 32 percent were in counties providing $1,500–$3,000 in benefits, and 5 percent in counties providing over $5,000 in benefits.

Since 1972, AFDC and food program benefit levels have increased. Incorporating increases in benefits for these programs and retaining the same medicaid benefits results in an equivalent taxable income of $5,348 in 1974 and $5,815 in 1975 for the hypothetical female-headed family considered above. This is not high compared to the median income of all families, which was $12,836 in 1974. But on the whole these benefit levels compare favorably with what many women earn. In 1974, women with the same level of education as those on AFDC, but who worked full time, year round, earned $6,175.

As indicated in Table 29, the number of families in the AFDC program has increased substantially over time, with the sharpest rise between 1965 and 1971 when the number of AFDC families almost tripled. Several complex factors seem to have contributed to the program's growth. First, information about the program became widespread, in part because of the efforts of various organizations concerned with poverty. In addition, participation in the program was facilitated by changes which raised the income eligibility standards and liberalized other provisions for eligibility (e.g., residence requirements). As a result, the proportion of families eligible for the program increased, as did the proportion of applicants accepted. The rising level of benefits also made participation more attractive. Between 1965 and 1971, AFDC payments per recipient, adjusted for changes in the consumer price index (CPI), increased by 22 percent, compared with the 10 percent increase in hourly earnings (deflated by the CPI) over the same period. The introduction of medicaid in 1966 and the growing availability of food stamps after 1965 also added to the benefits that could be obtained, particularly since AFDC families gain automatic eligibility for these additional benefits.

After 1971 the rate of increase in the number of AFDC families slowed as a result of several factors. No substantial gains could be achieved from the spread of information, which was already widely disseminated by the early 1970s. There was a slower rate of increase in the combination of real cash and in-kind benefits available to AFDC participants. In addition the liberalization of eligibility provisions that occurred in the 1960s appears to have ended. A few States, including California and Michigan, have instituted programs to locate absent parents who are liable for a child's support.

TABLE 29.—*AFDC families, recipients, and cash payments, selected years, 1950–75*

Year	AFDC recipients (thousands)	AFDC families[1]		AFDC cash payments		
		Number (thousands)	Percent of all female-headed families with children	Annual total (millions of current dollars)	Monthly average per recipient[2]	
					Current dollars	December 1974 dollars[3]
1950	2,233	651	51.3	547	21	44
1955	2,192	602	32.2	612	24	46
1960	3,073	803	38.3	994	28	49
1965	4,396	996	40.2	1,644	33	54
1970	9,659	2,394	81.8	4,857	50	65
1971	10,653	2,783	82.7	6,230	52	66
1972	11,065	3,005	83.5	7,020	54	66
1973	10,815	3,068	80.8	7,292	57	64
1974	11,006	3,219	78.9	7,991	66	66
1975	11,300	3,395	77.1	----	71	68

[1] Excludes families with unemployed fathers. The number of AFDC families is for December of each year except 1975 which is for September. The percents are based on the number of female-headed families in March of each year except for 1955, which refers to April.

[2] Data are for December of each year except 1975 which are for September.

[3] Deflated by the consumer price index.

Note.—AFDC refers to the "aid to families with dependent children" program.

Sources: Department of Health, Education, and Welfare and Department of Commerce (Bureau of the Census).

(This type of program is to be made nationwide by the summer of 1976 under the Child Support Program enacted in 1975.)

Since the early 1960s there has been a rapid increase in families headed by a woman with children. It is possible that the rising benefit levels and more liberal standards of eligibility in the AFDC program made it easier for women to form their own households. Studies have found that women tend to form their own households when their earnings opportunities improve, while some respond in a similar fashion to increases in the AFDC stipend. However, AFDC provides an additional incentive for women to remain family heads, since eligibility for AFDC is conditional upon the absence of a husband. This may help explain why women on welfare have been observed to be about half as likely to remarry within a 4-year period as all women heading families with children.

Work Incentives

In response to the rapid growth in the AFDC program various measures were taken to encourage AFDC mothers to work and to become self-supporting. Starting in the early 1960s, training was made available and pecuniary incentives were granted through a modification in the reduction in benefits that occurred when an AFDC participant worked. Prior to this time, in many States, a dollar of benefits was lost for each dollar earned—a 100 percent marginal tax rate on benefits.

The Work Incentive Program (WIN), a result of the 1967 Social Security Amendments, further modified the implicit marginal tax rate—the amount by which benefits would be reduced when earnings increased—by providing that the first $30 of monthly income (net of work-related expenses) be disregarded, after which cash benefits were to be reduced by 67 cents for each additional dollar earned. Some States, however, allow a monthly income disregard greater than $30, and there is also considerable variation between States in allowable deductions for work-related expenses. For these reasons marginal tax rates are discontinuous as income rises and vary substantially between States. On average, however, the effective tax on AFDC cash benefits appears to be considerably below 67 percent, and even after taking account of additional in-kind benefits, the tax on total benefits has fallen below that of the pre-WIN era. By 1972 the study of 100 counties noted above indicated that an AFDC family consisting of a mother with three children could retain, in terms of a gross taxable equivalent, $3,236 in basic AFDC and food stamp benefits out of a potential basic benefit of $4,104, if the mother's earnings were as much as $3,200 for the year, an implicit average tax rate on benefits of 27 percent. If she earned another $800, she would lose $431 in benefits, a 54 percent marginal tax rate.

Additional measures to encourage work among AFDC recipients were introduced as a result of legislation implemented in June 1972. This program, known as WIN II, requires all employable AFDC recipients to register for training or placement services as a condition for receiving welfare payments. AFDC recipients aged 16 or more who are neither disabled nor students

under 21 years, and women who do not have a child under 6 years are generally classified as employable. WIN II provides child care services for trainees as well as training, employment placement services, employer subsidies, and public employment. The WIN II program costs were about $314 million in fiscal 1975.

The effect on employment of the various work incentive programs appears to be very slight, although a full evaluation has not been made. Periodic surveys of mothers in the AFDC program have shown that the percentage who were employed fluctuated between 15 and 16 percent from 1961 to 1973 (the latest available data), although the proportion employed full time as opposed to part time has increased. These are low rates of employment compared to those for all women with children, of whom 41 percent were employed in 1973. The percentage of all AFDC mothers who were in the labor force, but unemployed, jumped from 5.7 percent in 1971 to 11.5 percent in 1973 even though 1973 was a year of lower unemployment for the population as a whole. This increase in reported unemployment, which resulted from a change in status from outside the labor force to unemployed, appears to be related to the provisions of WIN II requiring registration for job placement or training.

The weak response to the work incentives introduced over time is likely to have been the net result of different and offsetting factors. There is evidence that AFDC mothers respond to changes in benefit tax rates: holding benefit levels and labor market conditions constant, employment rates are higher in States where the effective benefit tax rate is lower. But the effect is not very strong. It is estimated that, holding other things constant, even with an effective tax rate on benefits of zero, the percentage of the current population of AFDC mothers who would work is unlikely to exceed 25 percent, compared to the 16 percent employed in 1973. However, benefit levels were not held constant during the late 1960s. While the effective tax rate was being reduced, rapidly rising cash and in-kind benefits were increasing the income level available to AFDC participants who did not work. It appears that the negative effect of these rising real benefits on employment almost completely offset the positive effect of lower marginal tax rates.

An increase in employment, it may be noted, would not necessarily lead to a reduction in AFDC participation, since liberalized marginal tax rates make it possible to remain on AFDC with fairly high earnings. The shift to more full-time employment among AFDC mothers does suggest that some AFDC participants, possibly those with higher earnings opportunities, did increase their work effort and remained in the program after an increase in work effort, in response to the lowered tax rates on earned income. On the other hand, a substantial proportion of AFDC mothers, either coming into the program or already there, may have decreased their work activities. Indeed, there is evidence that during the period of increasing work incentives, 1967 to 1970, the largest increases in female heads of families who were economically eligible for AFDC were among those with no earnings and those with

earnings above $2,000, with virtually no increase among families in the $0–$2,000 range.

The generally weak work attachment of AFDC mothers would appear to be related to factors which contribute to their being on AFDC in the first place. One factor is their low level of education—in 1973 only 33 percent were at least high school graduates, compared to 71 percent for women 15 to 44 years old with children. Studies have also found a higher incidence of physical and mental disabilities among women on AFDC compared to all women. Thus as indicated above, considering taxes, child care, and other work-related expenses, an unskilled woman with two or more children may well find that the cash and in-kind benefits available through AFDC provide her with nearly as large an income as work.

Several aspects of the AFDC program have led to concern, including the uneven treatment of single-parent and intact families. Some of the disparities between States in AFDC benefit levels and between single-parent and intact families are mitigated by the food stamp program, which is available in all areas and to all families. Because the same schedule determining benefits applies to all localities, low-income families entitled to smaller or no AFDC benefits as a consequence of their State of residence or their family composition are eligible for higher food stamp benefits. Because the basic benefit level provided by food stamps is low and the marginal tax rate on benefits is low, work disincentives from the food stamp program alone are probably not substantial.

AFDC–UF

The AFDC program for unemployed fathers (AFDC–UF) provides aid to intact families with a nondisabled father who is unemployed, as long as other conditions of AFDC eligibility are satisfied. In the 26 States which have elected to participate, the father must have been unemployed for at least 30 days, have had sufficient work experience to satisfy a minimum requirement, be seeking and available for work, and be unemployed or working less than 100 hours per month. In addition, until a June 1975 Supreme Court decision, a family was categorically ineligible for AFDC–UF benefits if the father was eligible for benefits under a Federal or State unemployment compensation program. Most of the approximately 100,000 participating fathers in 1974 and 1975 had exhausted their unemployment compensation benefit entitlement or were in an uncovered sector.

In July 1975, 113,000 families received AFDC–UF benefits and an average monthly cash benefit per family of $311, in addition to categorical eligibility for food stamps and medicaid benefits for dependent family members. There is no limit on the duration of AFDC–UF benefits. The average AFDC–UF cash benefits are about the same as the average monthly benefit to a worker under unemployment compensation; but for low-wage fathers, particularly in families with several children and no other income,

AFDC–UF benefits could be substantially greater than unemployment compensation.

The June 1975 decision can be expected to increase AFDC–UF participation. This may create problems because of the potential work disincentives for low-income, intact families. In addition, some of the cost of unemployment will be shifted from the employer-financed trust funds to general Federal and State revenues. However, the opportunity for this aid does provide more ample income maintenance for more low-income, intact families.

FOOD PROGRAMS

Concern about hunger or inadequate nutrition has led to the development of an array of programs which supplement income by providing either meals or vouchers to buy food. Benefits from these programs are not counted as income either by the Bureau of the Census in its income and poverty statistics, or in determining eligibility for other income maintenance programs. Spending on the major food programs has increased from $365 million in 1960 to about $6.4 billion in 1975, with the most rapid increases occurring since 1970 (Table 30).

Food Stamps

The food stamp program is the largest of these programs. It was set up in 1964 as an alternative to the direct distribution of surplus food commodities. The stated intention was to provide for "improved levels of nutrition among economically needy households." Because of the difficulties in estimating nutritional levels, the effect of the program on the health of the poor has not been established. Food stamps have, however, become an important part of our income maintenance system.

In fiscal 1965 the food stamp and food distribution programs together served a monthly average of 6.2 million people at a total Federal cost of $262 million, or a cost per participant of $41. By calendar 1975, the food stamp program alone served a monthly average of close to 19 million Americans at a total Federal expenditure of about $5 billion and a subsidy per participant of $270. A major factor in the growth of program participation has been its expansion by 1975 to all counties and U.S. territories.

Eligibility for food stamps is based on the "net income" a household expects to receive during the coming month (prospective accounting). A family's net income is its gross income less Federal, State, and local income taxes, social security taxes, retirement contributions, and union dues. Some other allowable deductions are medical expenditures exceeding $10 a month; child care when needed for work; expenses related to fire, theft, or other disasters; educational expenses for tuition and fees; alimony, rent, and utilities; and mortgage payments above 30 percent of income after all other deductions have been subtracted. A household is excluded if it has liquid assets or certain property valued at $1,500 or more. The asset limitation is $3,000 for house-

TABLE 30.—*Federal food programs, selected fiscal years, 1950–75*

Program	Unit	1950	1960	1965	1970	1974	1975 [1]
Food distribution program for needy families:							
Number of participants	Millions [2]	0.2	4.3	5.8	4.1	2.4	0.3
Federal cost:							
Total	Millions of dollars	6	59	227	289	189	36
Per participant	Dollars	24	14	39	70	80	120
Food stamp program:							
Number of participants	Millions [2]	.....	.....	.4	4.3	12.9	17.1
Federal cost:							
Total	Millions of dollars	.....	.....	35	550	2,728	4,396
Per participant	Dollars	.....	.....	76	127	212	257
National school lunch program:							
Number of children participating	Millions [3]	8.6	14.1	18.7	23.1	25.0	25.4
Percent of enrolled children:							
Total number of participants	Percent	34.1	35.0	39.2	44.4	48.7	49.1
Participants receiving free lunches or lunches at reduced prices	Percent	3.4	3.5	3.9	9.2	18.1	19.5
Federal cost	Millions of dollars	120	226	403	566	1,377	1,702
Special milk program:							
Federal cost	Millions of dollars	.....	80.3	97.2	101.5	61.4	124.1
School breakfast program:							
Number of children participating	Thousands [3]	.....	.....	.....	536	1,550	2,000
Federal cost	Millions of dollars	.....	.....	.....	10.9	70.1	85.0
Special preschool food service program:							
Number of children participating	Thousands [3]	.....	.....	.....	93.4	346.4	440.0
Federal cost	Millions of dollars	.....	.....	.....	6.3	30.0	47.2
Special summer food service program:							
Number of children participating	Thousands [3]	.....	.....	.....	461.9	1,415.2	1,810.0
Federal cost	Millions of dollars	.....	.....	.....	6.5	36.1	53.6

[1] Preliminary estimate.
[2] Monthly average.
[3] Daily average.

Note.—Federal cost excludes administrative expenses.

Source: Department of Agriculture.

holds with a member aged 60 years or more. The value of a home, a car, and any other personal effects is not considered in determining eligibility.

The stamps are vouchers which can be used to purchase most food items sold in grocery stores. The stamp allotment for a family is based on the current market cost of the foods that make up the Thrifty Food Plan developed by the Department of Agriculture to meet their nutritional standards. The cost of this food plan, and therefore the food stamp allotment, is equivalent to about 80 percent of expenditures made by the average U.S. consumer for food at home. The allotment is changed twice a year to reflect changes in the price of foods that make up the food plan. The permissible amount of stamps a household can purchase varies with the number of household members. In January 1976, the allotment for a four-person household was $166 a month in food stamps.

The amount a household pays for the stamps depends on its net monthly income. The difference between the food stamp allotment and the purchase price is the "bonus" or Federal subsidy. Families with less than $30 net in-

come pay nothing; that is, their bonus is equivalent to the entire food stamp allotment. Households of four receiving AFDC or SSI are automatically entitled to a monthly subsidy of at least $24 regardless of their income.

On the whole, the food stamp program reaches relatively low-income households (Table 31). It is estimated that the benefits have been sufficient to raise the mean income of the recipient families by about 10 percent. The food stamp program, however, has been criticized because it provides income supplements for some who do not have low income, and because it distributes resources in a way that many consider inequitable. The deductions allow some families to qualify who have large discretionary expenditures on items such as housing, education, and child care, while other families with the same income but with different consumption patterns for deductible items do not qualify.

Another important inequity follows from determining eligibility on the basis of income in a single month. As a result, some households qualify during a portion of the year, although their income over the year as a whole is sufficiently high to exclude them by any comparable annual standard (Table 31). For example, while only 1 percent of households in the program had a monthly income of $1,000 in July 1975, 3 percent had annual incomes of $12,000 over the year ending in July 1975.

Because of the 1-month accounting period, the food stamp program provides benefits to both the long-term poor and those whose incomes are temporarily low because of unemployment, sickness, a strike, or other reasons. The food stamp program provides countercyclical income maintenance benefits for the unemployed and participation rises with seasonal unemployment.

TABLE 31.—*Distribution of food stamp households by annual and monthly income, July 1974 and March and July 1975*

Income class	Percent of total food stamp households		
	July 1974	March 1975	July 1975
Annual income [1]:			
Total food stamp households	100.0	100.0	100.0
Less than $6,000	88.4	78.1	82.8
$6,000–$7,499	5.2	7.3	6.8
$7,500–$9,999	3.2	6.9	5.0
$10,000–$11,999	1.2	3.2	2.5
$12,000 and over	2.0	4.6	2.9
Monthly income:			
Total food stamp households	100.0	----------	100.0
Less than $500	90.2	----------	87.7
$500–$599	4.7	----------	6.1
$600–$749	2.9	----------	3.2
$750–$999	1.2	----------	1.9
$1,000 and over	1.1	----------	1.1

[1] Annual income is for 12 months ending in July 1974, March 1975, and July 1975. Households include single-person households. Annual income shown here may be understated compared to data derived from more detailed surveys of income.

Note.—Monthly income data were not collected for March 1975.
Detail may not add to totals because of rounding.

Sources: Department of Commerce (Bureau of the Census) and Department of Health, Education, and Welfare.

Although the family income of many of the unemployed may be low enough to qualify for food stamps during a month of unemployment, their income over a longer accounting period, covering months with employment, may be substantially above the food stamp eligibility level. The annual income of food stamp recipients in March 1975 was higher than in July 1974 or July 1975, partly because March was a month of high cyclical as well as seasonal unemployment.

In 1975, the President proposed the National Food Stamp Reform Act which directs the program benefits toward those with low income over a period of time and curtails the provision of benefits to higher-income families. The proposal would change the method of determining eligibility by averaging actual income received over the past 90 days, rather than using the applicant's estimate of next month's income. It is estimated that the change from prospective to retrospective monthly accounting would save about 5 percent of the program's cost because of a better reporting of income. Lengthening the accounting period would save an estimated additional 4 percent of program costs, since families with high income over 90 days, but temporarily low monthly income, will not participate. Families with a 90-day income just above eligibility levels would quickly qualify in the event that their income deteriorated. Families whose usual incomes are sufficiently high that they would not qualify if their income declined for only 1 month are more likely to have assets that they can draw upon.

Another proposed change is to replace the present itemized deduction for determining net income with a single standard deduction of $100 a month, except for households with a member 60 years old or more, when the deduction would be $125 a month. As a result of the standard deduction, some families will be ineligible who now qualify because of large expenditures on certain deductible items. However, the deduction of $100 is higher than the present total deduction for the average family. This will benefit families with low incomes who formerly did not have many itemized expenditures.

Another feature of the proposal is to cut off all benefits for families whose income over the past 90 days, after the standard deduction, exceeds the equivalent of the poverty line. Thus, under this proposal, a family of four with a 90-day income in excess of $1,675 would be ineligible in 1976.

The proposed National Food Stamp Reform Act is expected to result in reductions of Federal outlays of $1.2 billion (21 percent) compared to present levels. Approximately 26 percent of the current monthly case load would become ineligible, and another 28 percent would receive reduced subsidies, chiefly those at higher income levels and those who tend to receive small subsidies. However, benefits will increase for approximately 24 percent of present participants, mainly at the lowest income levels.

There had been substantial concern that youths from high-income families were qualifying for food stamps while they were away from home at a college or university. A new regulation requires that when a student's parents claim him as a deduction on their Federal income tax, the family, not the student

himself, is the relevant filing unit for food stamp purposes. In addition, the proposed changes from itemized deductions, including school fees and tuition, to a standard deduction will provide a more equitable treatment of families.

Food Programs for Schoolchildren

The Federal Government provided about $2 billion in fiscal 1975 in subsidies for meals provided to children in nursery, primary, and secondary schools, and in some summer programs. These programs are implicitly based on the two presumptions that an adequate diet for children is important for their ability to learn and that many children are not able to obtain a nutritionally adequate diet at home.

In 1947 the Government contributed 8.2 cents in cash and 1.1 cent in commodities for each lunch served to any child, regardless of income. About 25 percent of all schoolchildren participated in the program, of whom about 12 percent received a free lunch subsidized by State and local sources. Until the middle 1960s, program growth was due mainly to increases in school enrollments and less to increases in participation rates. The Federal share in funding dropped during the period, while State, local, and student shares increased.

Starting in 1970 the Federal Government began additional subsidies to the lunch program targeted to children from lower-income families. As a result, the share of Federal funds increased sharply, and the percentage of students in the school lunch program increased. In fiscal 1976 the Federal Government contributes 12.5 cents in a cash grant and 11 cents in a commodity grant to all school lunches, regardless of the family income of the children. In addition, the Federal Government contributes almost 57 cents per lunch in cash for children who receive a free lunch and 47 cents for children receiving lunch at a reduced price.

The lunch program provides a free lunch to children from families whose income is at or below 125 percent of the poverty threshold. In 1974, about 17 percent of all schoolchildren received a free lunch.

Several new and potentially expensive programs have been introduced recently to expand the child nutrition programs. The Government school breakfast program is one example. It now provides an average subsidy of 31.4 cents per breakfast. If all eligible students participated, the annual cost would be $0.9 billion. Another is the Federal subsidy of 75.5 cents per lunch and supper provided to summer camps and day care institutions on the condition that the children come from an area defined as one where at least 33⅓ percent of the children are eligible for free or reduced-price school meals. Since 38 percent is the national average, a substantial proportion of institutions will qualify for the subsidy, regardless of the family income of the participating children.

Legislation enacted in 1975 would further increase Federal expenditures on the programs. Eligibility for the reduced-price lunch was extended to 195 percent of the poverty line (the equivalent of an income of $9,800

for a nonfarm family of four, using the 1974 poverty threshold), and it was made mandatory that all schools receiving Federal lunch money provide such a program. As a result, about 38 percent of children would become eligible for a free or reduced-price lunch. Participation is also likely to increase because of the mandatory provisions of the program. As a result of the new legislation, Federal expenditures are expected to increase by $0.5 billion more in fiscal 1977 than the $2.3 billion that was anticipated under the old legislation.

It is estimated that 31 percent of the Federal expenditures of $1.8 billion on the programs went to children from families above 125 percent of the poverty line in 1975. In addition, there is duplication of Federal benefits, with different programs subsidizing the same meal.

To provide for a more rational distribution of child nutrition funds, the Administration is proposing a single block grant to the States to replace the programs discussed above, as well as several other categorical food programs for children and mothers. The proposed legislation would eliminate food subsidies to children above the poverty line, allow the States greater flexibility in determining the needs of the children from low-income families, and simplify program administration.

UNEMPLOYMENT COMPENSATION

The recession of 1974–75 has again demonstrated that the unemployment compensation system is one of our most effective countercyclical tools. As workers are placed on a layoff, benefits begin immediately, thereby providing financial assistance to those families most severely hurt by the fall in employment. This provision of purchasing power to the unemployed is of substantial importance in promoting economic recovery and in more equitably distributing the economic hardships of a recession. As the unemployment rate increased from the second quarter of 1973 to the second quarter of 1975, for example, the average weekly number of beneficiaries under all unemployment compensation programs increased from 1.5 million to 5.4 million. As the recovery continues, the size of the unemployment compensation programs will decrease when persons receiving benefits gain employment.

This section reviews the main features of the unemployment compensation system and considers some of its implications for income maintenance and efficiency in the long run.

Program Characteristics

The nationwide unemployment compensation system had its origins in the 1935 Social Security Act. It is a joint program administered by the States within Federal guidelines. In addition, direct Federal unemployment programs cover four special groups: railroad workers, recently discharged members of the Armed Forces, Federal civilian employees, and those unemployed as a consequence of imports. A temporary federally funded program, special unemployment assistance (SUA), was introduced in January 1975

to provide benefits for wage and salary workers not covered by a regular Federal or State program. In addition, temporary Federal programs to extend the duration of benefits have been in effect in all recessions since 1958.

The legal rules and administrative practices of the unemployment compensation system vary substantially from State to State. There are, however, certain basic features. Generally, to be eligible for benefits a person must have had sufficient work experience and earnings in covered employment in a recent 1-year period prior to the onset of unemployment. As a result of the work experience requirement, new entrants and most reentrants to the labor force do not qualify for benefits. Nearly all workers on a job layoff but with work experience in a covered industry can qualify, so that total expenditures for unemployment benefits are highly sensitive to cyclical movements in the economy.

Eligibility also depends on the cause of unemployment. In all States persons unemployed because of a job layoff are eligible for benefits. Persons who voluntarily quit without "good cause" are subject to disqualification; however, the definition of good cause varies substantially among the States. For example, mandatory retirement, loss of transportation to work, or a change in location because a spouse changes jobs constitute good cause in some States, but not in others. Unemployment without good cause can still lead to compensation under the program in 31 States, but only after a disqualification period, and the length of the period varies widely. Strikers can receive unemployment benefits in New York and Rhode Island after a disqualification period. Thirteen States reduce or deny benefits to persons receiving social security retirement benefits.

As a further condition, to receive benefits the unemployed claimant must be able to work, be available for and actively seeking employment, and cannot reject a "suitable" job offer. The administration of the work test varies among the States. It also varies over the business cycle. The work test is harder to administer during a recession than when jobs are plentiful. Some States require weekly or biweekly visits to the local unemployment office to file a claim and collect benefits, and the claimant must present specific proof of job search. Other States require periodic interviews, ask for little or no documented proof of job search, and permit the mailing of benefit checks to the claimant's home.

In 43 States the duration of benefit entitlement under the regular program increases with the amount of work experience during the base period, generally up to a 26-week ceiling. Weekly benefits for these States are about one-half of the worker's pretax wage, up to a ceiling that varies among the States from $60 in Indiana to $139 per week in the District of Columbia as of January 1976. The other seven States have a fixed-duration program in which all eligible persons receive benefits for the same number of weeks, but the weekly benefit is itself determined by work experience and weekly earnings prior to unemployment. States where the maximum is $90 a week or more contain 70 percent of covered workers. Twelve States supplement

the benefit check with a small dependency allowance for a spouse or dependent children who are not working.

Benefits have increased at about the same rate as wages in covered employment. There has, however, been an increase over time in the extent to which income maintenance benefits from other programs, particularly food stamps, are available to supplement unemployment compensation. Some unemployed fathers in low-income families will receive larger benefits because of the June 1975 court decision which allows them to accept AFDC–UF benefits instead of unemployment compensation.

From the worker's point of view, the fact that unemployment insurance benefits are not subject to payroll or income taxes (as they are in some other industrial countries such as Canada and the United Kingdom) increases their value. For household heads earning $150 per week, unemployment benefits replace about 60 percent of wages (net of taxes) and fringe benefits lost because of unemployment, while for those earning $400 per week the replacement rate is about one-third. The replacement rate can be very high (close to 100 percent) for low-wage workers in high-income families: for example, when the wife has low earnings and the husband has high income and they are in a high marginal tax bracket.

Benefits under the State unemployment insurance system are funded by taxes levied on employers in proportion to workers' base wages, equal in most States to the first $4,200. In principle, the tax rate varies according to employers' experience ratings, which are based on the extent to which their workers draw benefits from the system. However, because the variation in tax rates is usually within narrow margins, many firms with very high or very low unemployment experience relative to their industry often realize no change in their tax rates as a result of changes in their unemployment experience. Because the unemployment insurance funds in many States have been seriously depleted by the recent recession, the Administration has proposed increases in the taxable earnings base and in the Federal component of the tax rate.

Potential coverage of workers has been extended under the regular programs, from 59 percent of all workers in 1950 to 81 percent in 1974, because industrial coverage was made broader in 1954 and 1972 and because of a decline in the proportion of the labor force in the major remaining sectors not covered: agriculture, self-employment, and unpaid employment in a family business. As a result of special unemployment assistance, coverage was extended to the approximately 12 million wage and salary workers not covered by a regular program, primarily State and local government, farm, and domestic workers. Only the 8 million self-employed and unpaid workers in family businesses are not now covered by a regular or temporary program. The Administration has proposed legislation that would bring 6 million additional wage and salary workers, now covered by SUA, under the regular State programs so that their employers will contribute to the unemployment insurance trust fund.

In spite of the increased coverage there has been a decline over the past 20 years in the proportion of the unemployed receiving benefits under the regular State programs. This is probably due to the change in the composition of the labor force. Because of the eligibility requirements, many unemployed youths and women with weak labor market attachment do not have sufficient work experience to qualify for benefits. As these groups have increased in relative importance both in the labor force and among the unemployed, the proportion of the unemployed receiving benefits declined. Among the group with a more stable labor force attachment, men aged 25 and over, there has been a secular increase in the proportion of the unemployed claiming benefits. For example, this proportion declined from 54 percent in 1960 to 41 percent in 1973 for all unemployed persons, but for men aged 25 and over it increased from 63 percent to 72 percent.

Temporary programs to extend the duration of benefit entitlements in a recession have become more common. Prior to 1970, benefits were temporarily extended to 39 weeks in 1958 and 1961–62. A 1970 law permanently authorized an extension of benefits to 39 weeks in times of high State or national unemployment. In 1975, there was an unprecedented temporary extension of benefits in all States to a maximum duration of 65 weeks through the 26 weeks of federally funded benefits provided under Federal supplemental benefits (FSB).

Under current legislation, FSB and SUA benefits are scheduled to terminate in March 1977, or earlier if there is a sufficiently low State or nationwide unemployment rate. The purpose of this phasing out is that unemployment compensation should not discourage workers from actively seeking employment when job possibilities improve.

Some Effects of the Program

In recent years there has been considerable research on how the availability, potential duration, and size of unemployment benefits affect the measured unemployment rate. Although their estimates must be interpreted with caution, the studies are suggestive of the general impact of the program.

Several studies have used individual data to examine the effect on unemployment of the potential duration and level of benefits. The quantitative findings vary from study to study, in part because they differ in methodology, data, and time period. However, they all tend to indicate that the duration of actual unemployment is greater the higher the benefit level and the longer the potential duration of benefits. There is evidence, moreover, that the duration of benefit entitlement may be even more important than the level of benefits in explaining unemployment duration.

One study examined the effect of covering agricultural wage and salary workers (who had previously been covered in only two States) with the introduction of special unemployment assistance in January 1975. The study developed equations to predict agricultural unemployment rates and employment on the basis of cyclical and other factors. Seasonally

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adjusted data were used to compare the observed and predicted values before and after the introduction of SUA. After SUA, seasonally adjusted employment was lower during the off-season, presumably because of the availability of unemployment compensation. The seasonally adjusted unemployment rate increased by about 20 percent (2 percentage points) in the off-season, but did not change in the on-season. Apparently because of the SUA benefits, in 1975 the annual unemployment rate of agricultural wage and salary workers seems to have been about 10 percent greater than that predicted on the basis of cyclical and other factors. However, one year's experience may not be sufficient to estimate the long-term magnitude of these effects.

The extent to which States engage in eligibility screening can affect the amount of observed unemployment. The proportion of claims for unemployment compensation under the State programs that are rejected on the basis of individual State administrative decisions regarding eligibility can be called a "denial rate." Using State data for 1971, one recent study found that this denial rate had a significant impact on the State unemployment rate. It was estimated, for example, that at the margin a 10 percent increase in the national denial rate from the observed 25 per 1,000 claimant contacts would lower the national unemployment rate by 0.14 percentage point. It appears that a higher denial rate may not only decrease the period of unemployment among those denied benefits but may have an even larger impact by discouraging unemployment among others. Eligibility screening is subject to administrative control. Greater administrative expenditures and more time devoted to eligibility screening appear to result in a higher denial rate, particularly for reasons related to unavailability for work and the rejection of suitable employment. These effects are likely to be weaker during a period of high unemployment when job vacancies are more scarce. And, beyond some point, additional expenditures would have much smaller effects.

Certain categories of workers are more strongly affected by benefits than others. Those who have home responsibilities or are approaching retirement are more likely to remain unemployed until they exhaust their benefit entitlements. A study of the unemployment insurance system in Nevada in 1971–72, for example, found that a substantially larger proportion of exhaustees were either aged 55 or over or women, compared to those who stopped collecting benefits prior to exhausting their entitlement. Although greater difficulty in finding jobs may explain part of the differential, it cannot explain all of it. In this study, for example, 2 months after benefit exhaustion, 30 percent were employed, and another 30 percent had withdrawn from the labor force, primarily because of ill health, retirement, or family responsibilities. Similar findings emerge from other studies.

For most persons, however, the income support provided by the unemployment compensation system is a means of financing the search for a job. For these persons, if a longer period of unemployment facilitates job

search and leads to a job with higher wages and better fringe benefits, more pleasant working conditions, or a longer expected job tenure, it may represent a worthwhile investment. Thus far, however, studies of the effect of the additional job search stimulated by unemployment compensation have been inconclusive.

The unemployment insurance system also affects employers' behavior through the operation of the payroll tax. The tax levied on a particular employer does not depend strongly on the actual unemployment experience of his workers. Because of the weak experience rating the cost of a layoff is reduced. Partly because of the unemployment compensation benefits, workers would be less likely to seek other jobs during these periods of unemployment, particularly if unemployment is widespread. Thus the payroll tax subsidizes seasonal, cyclical, and casual unemployment relative to stable employment. This greater frequency of unemployment thereby leads to an increase in the unemployment rate. Data from a variety of sources indicate that much of the unemployment arising from job layoffs is temporary and does not involve a change in employer. For example, since 1960, manufacturing establishments had an average of 1.5 layoffs per 100 employees per month. During this period their rehire rate was 1.3 workers per 100 employees per month. Thus, on average, 85 percent of layoffs resulted in reemployment by the same establishment.

Results of various studies of the effects of unemployment compensation indicate that it is our most efficient tool for quickly providing financial help to those who lose a job. However, and to a large extent unavoidably, the existence of this automatic aid makes it easier for employers to lay off workers and for workers to prolong their period of unemployment. One implication is that the unemployment rate is affected by the amount and duration of unemployment compensation benefits. As a result of these and other issues that have been raised about the unemployment insurance system, the President has proposed the establishment of a National Commission on Unemployment Compensation to study alternatives and make recommendations.

SOCIAL SECURITY

The old-age, survivors, and disability insurance program, generally referred to as social security, is the largest income transfer program, in terms of both funds and number of recipients. In 1975, 32 million persons received cash benefits of $67 billion, which was 19 percent of the Federal budget and 4.5 percent of GNP (Table 32). Growth in the program has been extraordinary during the past 5 years. The number of recipients increased by 22 percent, and after adjusting for the increase in prices over this period, the average monthly benefit for retired workers increased by 26 percent.

The social security system has been successful in raising the income levels of a large proportion of the elderly who otherwise would have been impoverished. However, because of the sheer size of the program, there is a

TABLE 32.—*Beneficiaries and cash benefits in the old-age, survivors, and disability insurance program (OASDI), selected years, 1950–75*

Beneficiary or benefit	1950	1960	1965	1970	1974	1975
Number of beneficiaries (millions) [1]:						
Total	3.5	14.8	20.9	26.2	30.9	31.9
Retired workers, dependents, and survivors	3.5	14.2	19.1	23.6	26.9	27.6
Retired workers only	1.8	8.1	11.1	13.3	16.0	16.5
Disabled workers and dependents	----	.7	1.7	2.7	3.9	4.3
Annual cash benefits (billions of dollars)	1.0	11.3	18.3	31.9	58.5	67.1
Average monthly benefits (dollars):						
All retired workers [1]	44	74	84	118	188	206
Maximum to men retiring at age 65 [2]	45	119	132	190	[3] 305	[3] 342
Maximum to women retiring at age 65 [2]	45	119	136	196	[3] 316	[3] 360
Minimum to persons retiring at age 65 [2]	10	33	44	64	[3] 94	[3] 101

[1] As of December of each year.
[2] Assumes retirement at beginning of year.
[3] As of June.

Source: Department of Health, Education, and Welfare.

need to evaluate recent developments in the pattern of expenditures and of the taxes required to fund them.

Program Characteristics

The first social security legislation of 1935 intended that the program operate on a self-financed and actuarially sound basis. Contributions from the payroll tax were to exceed benefits in the early years so that a substantial trust fund relative to annual benefit outlays could be accumulated. Individual benefits were to be closely related to each individual's prior earnings except for preferential treatment at the base (minimum) amount. The amendments of 1939 changed the character of the program by stipulating that individuals retiring early in the life of the program would receive benefits greater than the actuarial value of taxes paid, and that dependents of retired workers would also receive benefits without any additional tax payments required. The 1950 amendments moved still farther away from a fully funded trust to the "pay-as-you-go" system which prevails today, under which those currently working essentially pay for the benefits of those who are retired.

As of January 1976, OASDI benefits are funded from a tax of 9.9 percent levied on the first $15,300 of wages, the maximum taxable earnings, with the payments shared equally by employer and employees. The self-employed pay a tax of 7 percent. (An additional tax of 1.8 percent for wage and salary workers and 0.9 percent for the self-employed is for medicare hospital insurance.) Tax payments are paid into separate trust funds, one for retirement and survivors, and one for disability. About 90 percent of all wage and salary earners and the self-employed are covered by the program and subject to mandatory contributions. The major exclusions are Federal civilian employees, who are under a separate Federal retirement program, and some State and local employees. In the past, increases in benefits and taxes have been legislated by the Congress periodically. Starting in 1975, on the basis of the 1972 amendments, benefit levels were "indexed" or linked

to the consumer price index so that they rise automatically depending on increases in prices. Similarly, the maximum taxable earnings base was roughly indexed to changes in average covered wages, and hence it also

Social security is designed as a replacement for earnings lost because of increases automatically over time.

a worker's retirement, disability, or death. Eligibility for benefits depends on work in covered employment for a minimum period as well as on age, disability, or survivor status. Although there are no restrictions on the amount of income that may be received from property, other pensions, or any sources other than work, individual benefits may be reduced if the beneficiary has earnings from employment and is less than 72 years of age. In 1976 beneficiaries can earn $2,760 without any reduction in benefits, but for each $2 in earnings above $2,760, benefits are reduced by $1. The amount of a worker's basic monthly benefit (before any reductions) depends on the worker's record of covered earnings, averaged over a specified number of years (at present 20 years for retirement benefits). Dependents and dependent survivors receive payments tied to the benefit level of the primary beneficiary. Workers choosing to retire between ages 62 and 65 receive a permanently reduced benefit. Disabled workers under the age of 65 have been eligible for benefits since 1957.

Table 33 shows the relation between the size of the benefit awarded and preretirement earnings for hypothetical male workers at different earnings levels, as calculated by one study. Examples are given for men retiring at age 65 and age 62, for single men, and for married men whose wives did not work in covered employment. The social security formula for determining benefits is scaled progressively so that benefits as a proportion of earnings fall as the benefit base rises. The benefit base, in turn, is calculated from prior earnings. For example, a male worker with a low-wage history culminating in $4,000 in annual earnings in the year before retirement would receive 55

TABLE 33.—*Social security benefits for single men and for married men with a dependent wife retiring at age 65 years and age 62 years, 1974*

1973 earnings before taxes and marital status	Men retiring at age 65 years		Men retiring at age 62 years	
	Amount of tax free benefit (dollars)	Benefit as percent of 1973 earnings before taxes	Amount of tax free benefit (dollars)	Benefit as percent of 1973 earnings before taxes
$4,000:				
Single	2,197	54.9	1,758	43.9
Married	3,296	82.4	2,582	64.5
$8,000:				
Single	3,349	41.9	2,679	33.5
Married	5,024	62.8	3,935	49.2
$12,000:				
Single	3,644	30.4	2,916	24.3
Married	5,467	45.6	4,282	35.7

Note.—Benefits are based on average amount of a worker's wages over a 19-year period. Wage histories for each category of wage earners were simulated by assuming that their wages grew at the same rate as that of the average wages of nonsupervisory personnel. The wife is assumed to be same age as worker and to have no covered earnings.

Source: Department of Health, Education, and Welfare (Office of Income Security Policy).

percent of his preretirement earnings in benefits if he is single, 82 percent if he is married. But a male worker making $12,000 before retirement would receive only 30 percent of such earnings if single and 46 percent if married. Because benefits are tax free and taxes are relatively more important at higher earnings levels, however, the decline in after-tax replacement rates as earnings rise is somewhat less than indicated here.

Income of the Aged

Social security is an important source of income for the aged. Largely because earnings decline with age, and because women are less likely to work than men, and earn less if they do, social security increases in relative importance with age and is relatively more important for households headed by a widowed woman (often single-person households). In 1973, among households headed by a widow aged 70 or older, the average annual income was $2,819, of which social security accounted for 57 percent. By contrast, among households headed by a married man aged 65 to 69, the total mean income was $9,694; social security on the average accounted for 25 percent of income, and wages and self-employment earnings accounted for 46 percent. In 1974, 23 percent of all persons 65 years old and over were women living alone, while 60 percent were married and living with a spouse.

The rapid increases in social security benefits of recent years have made a substantial contribution in improving the income status of the elderly. In 1966, 28.5 percent of those aged 65 and over were below the poverty level compared to 14.2 percent for all persons; in 1974, 15.7 percent of the elderly were in poverty compared to 11.6 percent of all persons. In addition to cash income, many of the elderly have imputed income from owner-occupied homes for which they are no longer making mortgage payments (70 percent of elderly households own their own homes). Virtually all of those aged 65 and over receive medicare or medicaid benefits, and many also finance some of their consumption out of their assets. These additional sources raise the relative level of consumption of the aged.

Work Incentives

Social security has created incentives for the aged and disabled to reduce their work during the year. The availability of the pension itself is an inducement to work less and take more leisure. In addition, the earnings test which applies up to age 72 restricts the amount that can be earned without forfeiting any benefits.

Between 1940 and 1950 only about a third of men aged 65 and over were eligible for social security benefits (Table 34), and benefits were low and declining in real value. After 1950 there was a sharp increase in the percentage eligible for social security—to 81 percent in 1960 and 93 percent in 1975. Benefit amounts also increased sharply, even after adjusting for inflation. After remaining stable from 1940 to 1950 the labor force participation of men at 65 years of age and over declined sharply. Hours worked per week for men 65 years of age and over also fell, from 42 in 1950 to 34 in 1970.

TABLE 34.—*Labor force participation rates and social security benefits for men 60 years of age and older, selected years, 1940–75*

Age group	1940	1950	1960	1970	1970	1975
Percent of men in labor force [1]:						
60–64 years	79.0	79.4	77.8	73.2	75.0	65.7
60–61 years	81.7	81.8	82.0	80.3	78.7	75.2
62–64 years	77.0	77.7	74.7	67.9	69.8	58.8
65–69 years	59.4	59.7	44.0	39.3	41.6	31.7
70 years and over	28.4	28.3	21.9	16.6	17.7	15.1
70–74 years	38.4	38.7	28.7	22.5	25.2	21.2
75 years and over	18.2	18.7	15.6	12.1	12.0	10.2
Percent of men eligible for social security benefits [2]:						
62–64 years	([3])	([3])	([3])	93.8	----	96.4
65 years and over	[4] 10.9	32.4	80.7	91.0	----	92.5
Average monthly primary social insurance benefit for men filing for benefits in given year:						
Current dollars	23.26	31.88	92.03	146.99	----	263.53
1975 dollars [5]	89.81	71.80	168.24	205.12	----	263.53

[1] Data in the first four columns are from the "Census of Population." Data in the last two columns are from the "Current Population Survey"; they exclude institutional population and are for April.
[2] Based on number of persons eligible at beginning of year.
[3] Not eligible for social security benefits.
[4] Data are for 1941.
[5] Deflated by the consumer price index.

Sources: Department of Commerce (Bureau of the Census), Department of Labor (Bureau of Labor Statistics), and Department of Health, Education, and Welfare.

The same relation between benefits and retirement behavior is evident for the group aged 62–64, who became eligible for retirement at reduced benefits in 1961. Although their labor force participation rate had been fairly stable until 1960, it declined markedly after benefits became available. One recent study finds that for every 10 percent increase in social security benefits relative to average wages, the number of male beneficiaries aged 62–64 increases by 2.8 percent in the first quarter after the increase, and by 6.0 percent after 5 quarters.

Persons eligible for social security have also been found to adjust their work behavior to avoid losing benefits under the earnings test. Thus, following a liberalization in the earnings test during 1966, over 10 percent of the working beneficiaries raised their earnings from $1,200 to $1,500, the new ceiling. The earnings test does not apply to those aged 72 and over, who may earn any amount without forfeiting benefits. For this reason many of those with high earnings wait until age 72 to start collecting benefits.

Although social security appears to have been an important factor in the decline in employment among those of retirement age, other factors were operating as well. Increases in earnings and income over time enabled workers to save more in order to enjoy more years of leisure at older ages, and a larger proportion of the elderly now have asset holdings and private pensions. The decline in self-employment on the farm and in nonfarm industries also contributed to declining work at older ages, since the self-employed retire at a later age than employees. Studies indicate that in years of relatively high unemployment retirement is accelerated. Compulsory retirement practices may also have had an effect. However, the spread of compulsory retirement

may itself have been stimulated by the availability of social security and the development of private pension systems.

There were additional incentives for the elderly to work longer, however, which have probably served to prevent labor force participation at older ages from falling even faster. Most notable may be the increase in the availability of white-collar employment, which tends to make less demand on physical strength. Increases in part-time employment opportunities have made work more feasible for those wishing a limited schedule, although the increase in part-time jobs may itself have been partly stimulated by the supply of older workers.

Short-Run and Long-Run Financing Problems

Issues have arisen with respect to both the short-run and long-run financial situation of the social security system. The Administration is proposing measures to deal with both of these problems.

Legislation has resulted in increases in benefit awards as a percentage of preretirement earnings, from 32 percent in 1965 to 43 percent in 1975 for the median wage earner aged 65 years and over. Other liberalizations in benefits have occurred, such as the increase in the dependent widow's pension from 82.5 percent to 100 percent of the husband's benefit if neither claimed benefits before age 65. Increases in early retirements have also contributed to rising outlays. Despite increases in the payroll tax rate (from 8.4 percent in 1969 to 9.9 percent in 1975) and in the maximum of earnings to be taxed (from $7,800 in 1969 to $15,300 in 1976) receipts have not risen as rapidly as benefits.

The tax shortfall has been exacerbated by the high levels of unemployment and the relatively slow growth of earnings in the past few years. Preliminary figures for 1975 indicate that expenditures exceeded payroll tax receipts by $2.6 billion, or 4.2 percent of tax receipts. Total expenditures, including administrative costs, exceeded total receipts, including interest on assets, by $1.6 billion, or 2.4 percent. The cyclical component of the problem will eventually diminish with the economic recovery, although a $4.4-billion deficit is forecast for 1976, and the trust fund will be permanently reduced. In response to the decline in the trust fund the Administration is proposing to increase the combined social security tax rate paid by employers and employees by 0.6 percentage point as of 1977. This increase will enable the trust fund to be maintained at a level of at least one-third of outgo for at least the next 5 years.

Projections of the social security system indicate that program costs relative to payroll receipts, under present law, are likely to escalate considerably. The size of the projected shortfall depends on assumptions about the birth rate, the rate of inflation, and the growth rate of real wages. Under commonly used assumptions (births per woman of 2.1, a 4 percent rate of inflation, and a 2 percent growth rate in real wages), expenditures would rise to 22 percent of taxable payroll by the year 2030, an amount which, if benefits were to be matched by tax receipts, would imply a social security tax rate about double today's level. However, with a lower fertility rate

(1.7) and more pessimistic assumptions about inflation (5 percent) and real wage growth (1.5 percent), social security expenditures would require taxes of 32 percent of payrolls by the year 2030. Optimistic economic assumptions, on the other hand, combined with a projected increase in the fertility rate to 2.5, lead to payroll taxes of 15 percent of the total payroll by 2030. Even this would represent a 50 percent increase in the present tax rate.

One reason the long-run social security projections described above are so high is that 1972 legislation provided for the double-indexing of social security benefits. Under the legislation, once a person starts getting benefits the amount is kept constant in real terms through automatic adjustments tied to increases in the CPI. However, the legislation inadvertently provided for a second effect of inflation on future benefits for those who are now working, since the schedule that relates retirement benefits to past earnings was also tied to the CPI. In this way replacement rates, the ratio of retirement benefits to average wages in the year before retirement, can automatically rise as a result of inflation. It has been estimated that, under current law, if nominal wages increase at 6 percent and the CPI at 4 percent per year, replacement rates for the median wage earner at age 65 would increase from 43 percent in 1976 to 59 percent in 2030. For low-wage workers, the increase would be from 63 percent to 99 percent over the same period and would exceed 100 percent by the year 2040. This rise in replacement rates for those retiring in the future is estimated to add about 26 percent to program costs by the year 2030, compared to a system in which replacement rates remain at the 1975 level.

The Administration will propose a specific plan to modify the system so that benefit levels will rise at the same rate as average wages. The goal is to make a person's benefits rise solely in accordance with wages during his working years and in accordance with the CPI in years after his retirement.

MEDICAL CARE

The provision of medical care services in the United States is largely private, but government plays a major and increasing role in the financing of medical expenditures. Between fiscal 1950 and fiscal 1975 total health expenditures rose from 4.5 percent to 8.3 percent of GNP (Table 35). During the same period the Federal share of the total health bill rose from 12 percent to 29 percent, an expenditure in fiscal 1975 of $34 billion. Federal funding of the hospital component of health expenditures has increased even more dramatically, paying 39 percent of the Nation's hospital bill in fiscal 1975. As a result of the expansion of Federal and State funds and of private insurance, consumers directly paid only 8 percent of all hospital expenditures. Consumers paid nearly all of the remainder indirectly through taxes and insurance premiums.

The two major Federal programs are medicare and medicaid, which were enacted as part of the Social Security Amendments of 1965. Medicare is a

TABLE 35.—*Total health expenditures and personal health expenditures by source of funds, selected fiscal years, 1940–75*

[Fiscal years; percent, except as noted]

Type of expenditure and source of funds	1940	1950	1960	1965	1970	1975
Total health expenditures:						
Amount (billions of dollars)	3.9	12.0	25.9	38.9	69.2	118.5
Percent of GNP	4.1	4.5	5.2	5.9	7.2	8.3
Percent funded by public	20.2	25.5	24.7	24.5	36.5	42.2
Personal health expenditures:						
Amount (billions of dollars)	3.4	10.4	22.7	33.5	60.1	103.2
Percent distribution by source of funds:						
Total	100.0	100.0	100.0	100.0	100.0	100.0
Direct payments	82.0	68.3	55.3	52.5	40.4	32.6
Third party payments	18.0	31.7	44.6	47.5	59.7	67.4
Private insurance	-------	8.5	20.7	24.7	24.0	26.5
Other private	2.7	3.0	2.3	2.0	1.5	1.2
Federal	3.9	9.4	9.2	8.5	22.3	27.7
State and local	11.4	10.8	12.4	12.3	11.9	12.0
Hospital expenditures:						
Amount (billions of dollars)	-------	3.7	8.5	13.2	25.9	46.6
Percent distribution by source of funds:						
Total funds	-------	100.0	100.0	100.0	100.0	100.0
Direct payments	-------	34.2	18.6	18.5	12.3	8.0
Third party payments	-------	65.8	81.4	81.5	87.7	92.0
Private	-------	20.1	39.4	44.0	36.9	37.0
Public	-------	45.7	42.0	37.5	50.8	55.0

Note.—Detail may not add to totals because of rounding.

Source: Department of Health, Education, and Welfare (Social Security Administration).

Federal program with uniform benefits available to the aged, to certain disabled persons covered by social security, and to those with end-stage renal (kidney) disease. Medicare includes hospital insurance financed through social security taxes, with benefits subject to a $104 deductible as well as various copayments after the 60th day of hospitalization. A physician reimbursement program is included which requires a monthly premium of $6.70, with benefits subject to a $60 deductible and 20 percent coinsurance. Federal expenditures on medicare doubled from 1970 to 1975. In fiscal 1976 they are expected to reach $17.4 billion. Fiscal 1976 Federal expenditures per enrollee are estimated at $717, but expenditures per beneficiary receiving hospital insurance benefits are estimated at $2,082 and for those receiving supplementary medical insurance benefits, $355.

Medicaid is funded by the States with Federal contributions accounting for from 50 to 78 percent of costs. The law provides categorical coverage of participants in the AFDC program; in 1974, 90 percent of AFDC recipients obtained medicaid benefits. Also covered are most of the aged, blind, and disabled in the supplemental security income program. Many States have also extended coverage to the medically indigent. Medicaid benefits and the population covered vary considerably across the States. In 1974, two States, California and New York, received 30 percent of all medicaid benefits, although they had only about 17 percent of the poverty population. Federal expenditures on medicaid have also increased rapidly and are estimated to be $8.2 billion in fiscal 1976, averaging $606 per participant. In

addition to medicare and medicaid the Federal Government provides health care for veterans and military personnel (costing $6.5 billion in fiscal 1976), as well as for Indians and other groups ($2 billion in fiscal 1976), and it subsidizes medical research and physician education ($3 billion in fiscal 1976).

The influence of government on medical care extends beyond its spending programs, however. For example, by exempting from taxable income an employer's contributions for health insurance, the government indirectly encourages the purchase of more insurance. Federal and State governments impose regulatory controls on hospitals, and States regulate the training and licensing of physicians and other health professionals. Thus government has considerable direct and indirect influence on the quantity, quality, distribution, and price of medical care in the United States.

This review of medical care and the role of Federal programs centers on: (1) The relation between changes in health status and changes in medical expenditures; (2) the personal financial impact of medical expenses; and (3) the relation between health insurance and resource allocation.

HEALTH STATUS AND MEDICAL EXPENDITURES

The medical care system is clearly important in maintaining the Nation's health. But the relation between various measures of health status and expenditures on medical care suggests that medical care is only one of a large number of factors affecting health.

Dramatic declines in mortality occurred during the first 50 years of this century mainly because of improved sanitation, heating, and other amenities, along with significant breakthroughs in medical technology. The development of vaccines, penicillin, and other drugs led to the control of many infectious diseases. Despite a relatively low level of medical expenditures and little public financing, access to medical care was apparently sufficient to ensure a general dissemination of these medical gains.

Since 1960 there have been substantial increases in expenditures on medical care. Infant mortality rates have declined—from 24.7 deaths in the first year of life per 1,000 live births in 1965 to 16.5 in 1974—partly because of the decline in high-risk births (e.g., births that are a mother's fifth or more). However, life expectancy at age one has barely changed for males since 1960, though for females there has been some increase.

Studies of the relation between income and mortality among the States indicate that higher income actually tends to be positively associated with higher mortality, even though expenditures on medical care increase with income. Many of the factors increasing mortality, such as pollution and sedentary white-collar work, are also associated with high income. Research studies show that, after controlling for these factors as well as education and income, increases in health expenditures are associated with declines in mortality, but the effect is very slight. Moreover, at the same level of income and health expenditure, increases in educational attainment are strongly associated with lower mortality.

Comparisons across developed countries also indicate that there is no simple relation between health and income or health expenditures. Among the OECD countries, life expectancy for males at age 10 tends to fall somewhat as income measured by gross domestic product (GDP) increases, even though health expenditures seem to be strongly related to GDP. A fairly strong negative relation is found, however, between infant mortality and income. These patterns are illustrated by the contrast between Greece and the United States. Although per capita GDP is about 4 times higher in the United States and per capita health expenditures are 10 times as high, life expectancy at birth is 72 years for Greek males and 67 years for American males. For females, the difference is smaller: 76 years for Greeks and 75 years for Americans. And infant mortality rates are higher in Greece: 25.3 in 1973 compared to 17.6 in the United States.

There are wide differences among the developed countries with respect to public funding and provision of care, which some believe has an important effect on health, particularly of the poor. The United States tends to rely more on private insurance or personal expenditures than do most developed countries. But there is no indication that access to physicians' and hospital services in the United States is actually more restricted than in countries with nationalized health insurance or health care. For example, one study of visits to physicians in 1964 compared the situation in the United States before medicare and medicaid with that in Sweden, where a substantially greater proportion of physicians' services are paid for by national health insurance. The incidence of reported symptoms of sickness was higher in Sweden, but the percentage who saw a doctor when they had a symptom was the same in both countries (46 percent). The ratio of visits to the incidence of symptoms was, however, somewhat lower in the United States for low-income persons (42 percent versus 46 percent for Sweden) and higher for high-income persons in 1964 (51 percent versus 48 percent in Sweden). In 1971 a second survey showed an increase in the ratio for all income levels in the United States (50 percent), with the lowest income group close to the level of the highest income group (52 percent and 54 percent respectively). No data are available for Sweden in 1971. These general findings—that in the United States there are a similar number of visits to physicians per reported symptom as in other developed countries with greater subsidization of medical care—are confirmed by other studies comparing a broader range of countries, including those with nationalized health services.

The United States, however, has high mortality rates despite seemingly low sickness rates and high utilization of medical resources. One possible explanation is that the higher mortality in the United States is not the result of chronic illness susceptible to medical treatment, but is due to illness less readily affected by medical technology. The unusually high rates of mortality in the United States from cardiovascular diseases give this hypothesis some

support. These diseases, it should be noted, are more likely to be influenced by life-style and environmental factors.

When health and income are compared across families in the United States, persons with low incomes are found to have poorer health, as measured by such indexes as days spent in bed and infant mortality rates, than those with high income who live in the same area. In part, the relation occurs because sickness can cause low income. But as was the case with international and State comparisons, detailed studies cast doubt that income or access to medical resources plays a significant role in explaining these differences in health. In fact, in recent years the poor have spent more days in the hospital and visited doctors at least as often as those who were not poor. Moreover, as noted above, a similar incidence of visits to physicians per reported symptom was found for high- and for low-income levels in 1971. Even taking account of differences in sickness, overall access to treatment seems fairly equalized.

Education has been found to be strongly associated with health in the United States and seems to account for the positive relation between income and health among persons living in the same area. Even when health expenditures are held constant, the relation between education and health is important. Education could affect health because those with more education are more aware of the effects on health of smoking, diet, and exercise. Evidence suggests that people with more education are more skilled in using medical resources and are better able to detect warning signals of illness. Of course, to some extent the chain of causation may also run the other way: those with better health may also obtain more schooling.

These studies of the factors affecting health status suggest that large additional expenditures on medical care may be a very costly way of obtaining small improvements in measured health status for this country. Apart from medical care, there are other ways in which the Nation's health may be improved. New advances are likely to result from research on medical technology and drugs, as in the past. Rising levels of education should tend to improve the health of the population. More important may be further research on, and the spread of current knowledge about, the effect of life-style and environment on health status.

HEALTH INSURANCE, HEALTH EXPENDITURES, AND FAMILY INCOME

Given the current level of medical resources, it is important to distinguish between the effects on health of small changes in medical expenditures and the effects of the absence of any medical care at all. Because medical care is beneficial, and the incidence of serious illness is generally unpredictable, people prefer to have medical insurance so that large unpredictable expenditures can be more easily budgeted on a routine basis.

A large proportion of the U.S. population is covered by private health insurance. On the basis of a survey of households, it is estimated that about 78 percent of the population have private health insurance for hospital care and 76 percent have surgical benefits.

Virtually all persons 65 years old and over are covered by medicare. The percentage of this group with private insurance dropped from 54 percent in 1962 to 45 percent in 1967 after medicare was introduced. Since then, however, an increasing proportion have been purchasing private insurance which supplements medicare by paying for deductibles and coinsurance. The low-income elderly are eligible for medicaid, which supplemented medicare for close to one-fifth of the elderly in 1974.

According to household survey estimates, in 1974 about 38 million Americans under age 65 had no private insurance against hospital costs, and 41 million were without surgical insurance. An estimated 40 percent (15 million) of the uninsured under 65 years of age were from families with an annual income below $6,400.

However, an unknown proportion of the uninsured have other sources of coverage or access to free or low-cost care provided by public sources. No unduplicated count of those receiving benefits under all programs is available. In 1974, 23 million persons received medicaid benefits at some time during the year, of whom about 19 million were under age 65, including 14 million AFDC recipients. In fiscal 1975, Veteran's hospitals provided free hospitalization to 1.1 million persons and 14.8 million doctors' visits on an outpatient basis. The miliary provided care for the 2 million men and women in the Armed Forces; 7 million ex-military personnel and their dependents, and the dependents of current military personnel were eligible for care under the civilian health and medical care program for the uniformed services (CHAMPUS). Care was also provided to Indians and others through the Public Health Service. State and local government spending for health, excluding medicaid, exceeded $8.5 billion in 1975.

Another way to evaluate the extent of coverage for high-cost medical expenses among the poor is to examine the data on expenditures incurred and sources of payment. In 1970, persons in lower-income families (defined here as an annual income of $5,700 or less for a family of four) incurred expenditures of $229 per year on medical care, compared to expenditures of $254 by those who were not poor (Table 36). Sources of funding differed, however: medicare, medicaid, and other government programs paid for 46 percent of the expenditures of lower-income families, compared to 12 percent for other families, who, as expected, relied more on private health insurance. Out-of-pocket medical care payments averaged $77 for those with lower income and $127 for those with higher income.

Hospital expenditures are likely to be less discretionary than other medical expenses, and the poor incurred somewhat higher hospital expenditures than those with higher incomes. However, both groups were liable for only a small fraction of hospital bills. Mean out-of-pocket hospital expenses for those requiring a hospital stay were only $14 for the poor and $16 for others.

Although lower-income groups seemed to have obtained the same amount of health resources as others in 1970, mostly subsidized by public sources, outlays on health consumed a larger proportion of their income. Outlays includ-

TABLE 36.—*Expenditures per person for different health services by family income status and source of payments, 1970*

Type of expenditure and family income status [1]	Health expenditures (dollars)		Payment as percent of total health expenditures					
	Total	Out of pocket	Total	Medicaid and other free care	Medicare	Voluntary insurance	Out of pocket	Other sources [2]
Total expenditures per person	248	116	100	11	8	29	47	4
Below near poverty	229	77	100	28	18	16	34	5
Above near poverty	254	127	100	6	6	33	50	5
Inpatient hospital expenditures	104	16	100	17	15	46	15	6
Below near poverty	113	14	100	30	28	23	12	6
Above near poverty	101	16	100	13	11	53	16	7
Physician expenditures	65	33	100	8	6	31	51	5
Below near poverty	57	22	100	28	14	16	39	4
Above near poverty	67	36	100	1	4	34	54	6
Other health expenditures [3]	79	67	100	6	1	6	85	1
Below near poverty	59	41	100	22	2	3	69	3
Above near poverty	86	75	100	2	1	8	87	1

[1] Near poverty is a measure above the poverty threshold used by the Bureau of the Census. It was $5,700 for a family of four in 1970.

[2] Includes free and non-free care provided by Veterans Administration hospitals, workers' compensation, and military and civilian health and medical care programs for the uniformed services and their families.

[3] Includes expenditures on prescription and nonprescription drugs, dental care, appliances such as eyeglasses, care by nonphysician medical practitioners (nurses, psychologists, Christian Science practitioners), ambulance service, other outpatient services, and supplies.

Note.—Detail may not add to totals because of rounding.

Source: Department of Health, Education, and Welfare (Bureau of Health Services Research and Evaluation).

ing both out-of-pocket expenditures and payments for health insurance premiums were estimated to be 9 percent of income on average for lower-income families and 4 percent for higher-income families.

It appears that a small proportion of the population experiences catastrophic medical expenditures relative to their income in any year. In 1970, 1 percent of all families were estimated to incur medical and psychiatric expenditures of $5,000 or more. Eighty percent of the expenditures over $5,000 were paid for by private insurance, medicare, medicaid, and sources other than the family. About 8 percent of all families had outlays (out-of-pocket expenses plus insurance premiums) of $1,000 or more, of which 40 percent represented routine payments for insurance premiums. For lower-income families, 2 percent had outlays of $1,000 or more during the year; and at higher income levels, 10 percent had such outlays. These medical outlays which include out-of-pocket expenses and insurance premiums exceeded 15 percent of income for 10 percent of all families, and the proportion was 25 percent for lower-income families and 4.5 percent for higher-income families. These estimates overstate the relation between outlays and income, however, because lower-income families with large health outlays are more likely to have a current income that is temporarily depressed below the usual level because of the sickness of an earner.

The data reviewed on expenditures and outlays refer to 1970. Since then, medicaid has expanded: from serving 15.5 million persons, it served 23 million persons in 1974, and third-party payments (both public and private) have accounted for a larger share of all expenditures.

Most Americans do have some coverage for health expenditures through public or private insurance or publicly provided care. However, it is believed that a substantial proportion do not have coverage for very large medical expenses relative to their income and assets, although it is also believed that such coverage is spreading rapidly. The Administration has proposed providing catastrophic health insurance coverage for medicare participants. This proposal is discussed below.

RESOURCE ALLOCATION AND COSTS

One of the major concerns about medical care is the sharp rise in costs. Since 1950 the medical component of the CPI has increased much faster than the overall CPI (Table 37).

Prices of hospital services have increased at a much faster rate than physicians' fees or other medical services. In part this is the result of an increase in the quality of hospital services not fully reflected in the CPI. As indicated in Table 37, when total hospital expenditures per patient day are deflated by a crude price index for hospital inputs, it appears that increases in real resources explain a substantial amount of the rate of increase in expenditures per patient day. During the 5-year period since medicare and medicaid were introduced, 1965 to 1970, the rate of increase of real resources per patient day nearly doubled and accounted for about one-half of the nominal increase in hospital expenses per patient day.

TABLE 37.—*Changes in prices of various medical and hospital services and expenses, 1950–75*

[Percent change; annual rate]

Period	Consumer prices					Hospital expenses and services per patient day [1]		
	All items	All services less medical care services	Medical care services			Expenses [3]	Real expenses [4]	
			All [2]	Semiprivate room	Physicians' fees		Assumption A [5]	Assumption B [6]
Annual average:								
1950 to 1955	2.2	[7] 3.8	4.2	6.9	3.4	8.2	3.3	4.3
1955 to 1960	2.0	[7] 3.3	4.4	6.3	3.3	6.9	3.3	3.5
1960 to 1965	1.3	1.8	3.1	5.8	2.8	6.7	3.3	4.2
1965 to 1970	4.2	5.4	7.3	13.9	6.6	12.7	6.0	7.4
1970 to 1975	6.7	6.3	7.6	10.2	6.9	12.5	4.8	5.1
Change from preceding year:								
1971	4.3	5.3	7.3	12.2	6.9	13.2	4.5	6.6
1972	3.3	3.8	3.7	6.6	3.1	13.4	6.5	7.8
1973	6.2	4.3	4.4	4.7	3.3	7.6	2.8	1.6
1974	11.0	9.2	10.3	10.7	9.2	11.2	3.7	2.5
1975	9.1	9.1	12.6	17.2	12.3	17.6	6.5	7.3

[1] Beginning 1965, patient days have been adjusted for outpatient visits.
[2] Includes some medical care services not shown separately.
[3] Based on data reported by the American Hospital Association for community hospitals for year ending September 30.
[4] Labor and nonlabor inputs adjusted for price changes.
[5] Deflated by a weighted average of the consumer price index and an index of hospital wages.
[6] Deflated by a weighted average of the consumer price index and adjusted hourly earnings index in the private nonfarm economy.
[7] Change for all services.

Sources: Department of Labor (Bureau of Labor Statistics), American Hospital Association, and Council of Economic Advisers.

Resistance by taxpayers to the increasing burden of medicare and medicaid, and pressures to restrain medical costs have led in the past to pressures for a more formal mechanism to control costs. During the period of the Economic Stabilization Program, starting in August 1971 and ending April 1974, the health industry was placed under more stringent price controls than most industries. In addition to price ceilings on individual services, controls were also placed on the increase in total annual hospital expenditures. These controls in effect curtailed the amount as well as the price of the service provided. From 1972 to 1973 increases in hospital resource use per patient day did slow. However, it is not clear whether the slower growth rate represented a gain in efficiency through a more careful use of resources, a curtailment of quality improvements that would have been desirable, or less efficiency through a greater rate of admission of less serious cases. Since the end of controls, real hospital resources have increased at a very rapid rate, partly to "catch up" and perhaps partly in anticipation of a permanent controls program. Hospital expenses per patient day increased at the very high rate of 18 percent from 1974 to 1975.

Some of this expansion in medical resources is probably a desired quality improvement. There is considerable evidence, however, that much is a consequence of the growth of private insurance and public funding, which has led to a system where "third parties" pay for an increasing share of medical services, particularly hospital services. The most common form of health insurance has low or no deductibles and low cost-sharing (coinsurance), especially for hospital care. This type of coverage has been shown to have a substantial effect on the price and quantity of services. For example, families with insurance have a greater number and longer length of stays in hospitals and more visits to physicians. The patients may themselves prefer this extra health care because the extra cost to them is small. In addition, hospitals and doctors, knowing that most of the costs will be paid by third parties who are not in a position to decide on what services should be provided, are also likely to expand the quality, quantity, and price of their services. As a result, patients receive services that they would not value enough to pay for if they were given additional income equal to the cost of the service. In this way too many resources, and probably not the optimal kind, are allocated to medical services. The system encourages the development and use of high-cost techniques and a reliance on institutional rather than home care.

Unlike most other forms of insurance, private health insurance is largely purchased through the employer in a group policy. This practice has been substantially encouraged by the income tax and payroll tax systems, which exempt from taxation the employer's contribution for this form of insurance even though it is really an addition to the worker's income. Up to a point, it is to the mutual benefit of employer and employee to favor wage increases in the form of untaxed fringe benefits rather than in cash. As workers have moved into increasingly higher marginal tax brackets, this incentive has increased. In 1953 employers paid all of the costs for health insurance

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premiums for 10 percent of employees and none of the costs for 41 percent. By 1970 employers paid all of the costs for 39 percent and none of the costs for only 8 percent. The Government further reduces the cost of insurance by allowing a deduction under the personal income tax of half the cost of premiums paid by the taxpayer up to $150. All medical expenditures, including the other half of the premium cost, that exceed 3 percent of income may also be deducted. Estimated tax losses in fiscal 1977 are $4.2 billion for exclusion of employers' contributions and $2.1 billion for itemized medical deductions, including insurance premiums.

As a result of these tax subsidies, the cost to the consumer of paying for medical care indirectly through insurance is sharply reduced. Indeed, it has been estimated that in 1975 the Federal Government paid 20 to 22 percent of the premium costs of insurance through forgone tax receipts. Even taking into account the insurance companies' administrative costs and the costs of induced additional medical care, a result of the tax subsidy is that families with group coverage, paid for at least in part by the employer, spend less on medical care by buying insurance than they would have done by paying directly. In an unsubsidized market, consumers would have the incentive to pay out of pocket for routine budgetable medical care and to confine their insurance to very large and unpredictable expenditures. Faced with insurance at a substantial discount, they are induced to buy more comprehensive insurance, covering expenditures from the first dollar.

The problems of insurance are exacerbated in the case of medicare and medicaid because the mechanism of higher premiums, which may provide weak incentives to economize in our subsidized private insurance market, hardly works at all in the public system. Although there are medicare deductibles, there is no copayment for the first 60 days of hospital care. Under medicaid there are generally no deductibles and no coinsurance for hospital and physicians' services.

Perhaps the main feature that fosters cost increases is the method by which medicare, medicaid, and most Blue Cross policies reimburse the hospitals. These insurers pay a share of the hospital's costs, based on the percentage of all costs accounted for by their respective beneficiaries. Because hospitals have the assurance that a large percentage of their revenues will be based on cost reimbursement, there is little direct restraint to keep costs down. The Federal Government is now experimenting with prospective reimbursement schemes, whereby hospitals are told in advance how much they will be reimbursed per unit of service provided (e.g., patient admissions, patient days).

MEDICAID AND MEDICARE PROPOSALS

Medicare and medicaid have an important role to play because many of the poor and aged have difficulty financing health insurance premiums, deductibles, and cost-sharing. In part, medicaid has expanded the use of medical services by the poor and has changed patterns of use from the public hospital or charity clinic to private doctors and nonpublic hospitals.

Medicaid benefits are unevenly distributed across States, however, with some of the wealthiest States receiving more than four times as much Federal money per low-income person as poorer States. In addition many other health care programs are funded under narrow categorical legislation which makes coordination difficult.

For these reasons the President has proposed to merge medicaid and 15 other programs, such as mental health services and neighborhood centers, to form a single State block grant for health services under the proposed Financial Assistance for Health Care Act. The grant would be distributed among States according to such specific measures of need as the number of low-income persons. This would replace the present method of determining the distribution of medicaid funds, and funds for other formula and project grants, which use a wide variety of often arbitrary criteria such as narrow categories of disease or family status. The new formula grant would redistribute Federal funds more equitably, since need would be the basic criterion. The new formula grant proposes Federal funding of $10 billion for fiscal 1977.

Under the proposed legislation, States would be provided with maximum flexibility to allocate their funds among programs. In addition, States would be required to undertake planning and cost control activities and would also be able to experiment with different forms of giving the aid—whether through insurance vouchers, Health Maintenance Organizations, or direct State provision. Thus some innovations in health financing which would have implications for slowing the increase in medical costs may be stimulated.

The Administration has also proposed the Medicare Improvements Act of 1976, which would provide better protection for the elderly and disabled from catastrophic health expenses and would also help to control costs. Under the cost-sharing reforms, beneficiaries would pay the deductible and 10 percent of hospital and nursing home charges until the proposed maximum of $500 in out-of-pocket expenditures is reached, after which the Government would pay all costs for covered services. For physicians' services, beneficiaries would pay a deductible of $77 per year and 20 percent of the charges, up to a proposed $250 of out-of-pocket expenditures. All expenditures above that would be paid by the Government. It is also proposed to limit annual increases in Federal reimbursements to medical care providers to 7 percent for a day of hospital care and 4 percent for physicians' services. These measures are expected to result in Federal cost savings of $2.2 billion in 1977 compared to expected costs under the current medicare provisions.