



THE WAR ON POVERTY'S EFFECTS ON HEALTH CARE USE OF THE ELDERLY

A Russell Sage Foundation Policy Brief

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Introduction

The War on Poverty created two health insurance programs, Medicare and Medicaid, which have had profound effects on the health of the American population. The War on Poverty also created community health centers (CHC) to expand the supply of physicians, nurses, and dentists in rural and low-income areas where assuring financial access to health care would not be enough to increase use.

The most significant outcome of these programs is that they drastically reduced what had been a common fear for older people in the years before the War on Poverty: that they would not be able to obtain medical care because they could not afford it. Medicare also reduced younger as well as older individuals' risk of financial ruin due to high medical costs in old age. Substantially reducing the elderly's risk of financial ruin from expensive medical care is a profound change and one of the greatest effects of the War on Poverty for all Americans.

In her chapter in *Legacies of the War on Poverty*, Katherine Swartz reviews what is known about the effects of Medicare and Medicaid, with special attention to their effects on the elderly poor.

The volume is timely as January 8, 2014, will mark the 50th anniversary of the War on Poverty.

Differences in Access to Health Care by Elderly

With these programs, the War on Poverty's architects hoped to reduce disparities in use of care between the elderly and non-elderly, and between poor elderly and elderly with higher incomes. By providing insurance similar to that held by many non-elderly, Medicare was expected to provide the elderly with same access to health care that the non-elderly had and reduce income and racial disparities in the use of health care among the elderly.

Reducing income disparities in access among the elderly was achieved within a decade – poor and near-poor elderly were obtaining medical care at rates very similar to those of elderly with higher incomes. In 1964, low-income elderly had 22 percent

fewer physician office visits than higher income elderly; within ten years, they were as likely as higher income elderly to see a physician (Davis and Schoen 1978, 42). The narrowing of the income gap in access to physicians has continued in the decades since, although disturbing differences in the use of specific medical services have recently been documented. Such differences have raised concerns that the elderly poor now receive less care than higher-income elderly.

Racial Integration of Hospitals

Medicare produced a second significant outcome that is often overlooked: the racial integration of hospitals. Before 1965, virtually all the hospitals in the South and in many northern cities had separate floors for blacks and whites, and black physicians were often denied hospital staff privileges. By December 1966, six months after Medicare was operational, racially segregated hospital areas were nearly gone and staff privileges were granted to black physicians. The speed with which this transformation occurred is breathtaking—particularly in comparison with the much slower integration of schools and employment practices.

This outcome was produced by a combination of two forces (Reynolds 1997; Quadagno 2000): One was money—any hospital not in compliance with integration and civil rights guidelines would not be eligible for Medicare payments. The second was the persistence and hard work of key people within the Department of Health, Education, and Welfare who created a strategy of reaching out to hospitals and political leaders in southern states and pressured them to comply (Reynolds 1997; Quadagno 2000). The strategy worked—and it contains lessons for current efforts to implement the Affordable Care Act's insurance exchanges.

The Future of Medicare and Medicaid

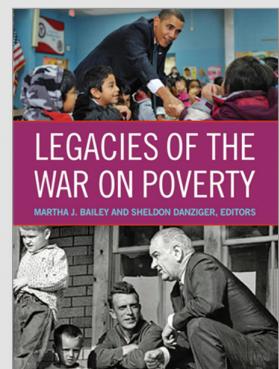
Making Medicare and Medicaid financially sustainable for future generations is an issue the country must now address if it wants to continue to help the elderly and elderly poor obtain health care. To ensure the financial sustainability of both programs involves both slowing the growth in health care spending and restructuring the financing of the programs.

LEGACIES OF THE WAR ON POVERTY

A new book from the Russell Sage Foundation

Many believe that the War on Poverty, launched by President Johnson in 1964, ended in failure. Historical and contemporary accounts often portray the War on Poverty as a costly experiment that left doubts about the ability of public policies to address complex social problems. Featuring a multidisciplinary team of renowned scholars, *Legacies of the War on Poverty* challenges and contests this conventional wisdom as too simplistic. The volume examines the empirical evidence accumulated over the past 50 years and offers a balanced and broad assessment of the long-term impacts of the War on Poverty.

(Available September 2013; visit russellsage.org/publications for more information)



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Conclusions and Recommendations

As another standout reform of the War on Poverty, Medicare has proven enormously beneficial to the elderly over the past fifty years.

- *Almost all the elderly have health insurance today, which almost certainly would not have happened if the elderly could purchase insurance only through the private insurance market that existed before 1965.* The health insurance provided by Medicare and Medicaid have removed most financial barriers to obtaining medical care, enabling the elderly to obtain treatments that are now regarded as standard care for many conditions. Without these programs, the elderly could not possibly afford such care.
- *Medicare also is associated with historic benefits for the country as a whole.* It fostered the development of numerous medical treatment options: some of these have transformed previously fatal conditions into chronic conditions; others have greatly improved the quality of life for millions of people, both elderly and non-elderly.

However, there are growing signs that the gains for the elderly poor are eroding. As the costs of health care continue to grow faster than GDP, Medicare's cost-sharing requirements are causing more lower-income elderly to face financial difficulties paying for care. Moreover, given the gains in life expectancy since 1965, a rising proportion of older people are at risk of not having enough income when they are eighty years old and older to pay for Medicare Part B premiums and long-term care services.

Swartz identifies two key issues in reducing these disparities in health care access and outcomes among the elderly:

- *The Affordable Care Act (ACA):* Under the ACA, almost all Americans under sixty-five will have health insurance by 2014. The expectation is that those with insurance will seek more medical care, especially preventative care, reducing future disparities in health and access to health among the elderly. Swartz notes that though the full repercussions of the ACA will not be known for at least another decade, it's possible that we may see some immediate ACA benefits for the elderly in the form of increased Medicare and Medicaid payments to primary care physicians, which will likely lead to better coordination of care for chronic health issues.
- *The financial sustainability of Medicare and Medicaid:* Swartz highlights the importance of slowing the growth of health-care spending, but notes that policy options for doing so are limited. Ensuring the financial stability of both programs requires reducing waste and inefficiencies, as well as restructuring the financing of the programs. Swartz maintains that this restructuring must contain mechanisms for prefunding a larger portion of Medicare's projected expenses in order to preserve it for younger generations, and further recommends raising taxes on unearned income as a funding option if income distribution continues to grow more unequal.

The information in this policy brief comes from the chapter "Medicare and Medicaid" in *Legacies of the War on Poverty*. Russell Sage Foundation, September 2013

About the Author: KATHERINE SWARTZ is professor of health economics and policy in the Department of Health Policy and Management at the Harvard School of Public Health.