Achievements and Problems of Medicaid

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THE MEDICAID PROGRAM, initiated in 1966 under the Johnson Administration, was one of many programs designed to help the poor and disadvantaged enjoy the fruits of a growing and prosperous economy. Among all of the Great Society programs, those devoted to financing medical care—Medicaid for the poor and Medicare for the elderly—received the largest and most rapidly growing share of budgetary resources. For fiscal year 1976, governmental expenditures under the Federal-State Medicaid program were an estimated $14 billion, providing medical care services for an estimated 23 million low-income persons (*1*).

Dissatisfaction with the unanticipated high cost of Medicaid has plagued the program from its inception. Within a few years after its implementation, many State governments moved quickly to cut its cost. Some State governments sought to limit the drain on their budgets by tightening eligibility requirements, reducing the scope of benefits, and cutting back reimbursement levels to providers of medical care services (*2–4*). Beginning in the fall of 1974, unemployment rose rapidly and income and sales tax revenues declined. State governments experienced a fiscal squeeze, and once again severe pressures were put on them to make cuts in their Medicaid programs.

These actions, in turn, have contributed to the inability of the program to live up to the high expectations of low-income persons hoping to receive high-quality medical care and of providers hoping to receive suitable compensation for delivering it. Thus, Medicaid has cost more than was anticipated, while at the same time it has fallen short of providing all the benefits that were expected from the program.

In an atmosphere of frustrated expectations and seemingly unrestrainable high costs, it is perhaps not surprising that the Medicaid program has been subjected to numerous charges and accusations. Each affected group has pointed to others as the villains responsible for "the mess of Medicaid." A lot of myths and excessive rhetoric surround the program, hindering a dispassionate, objective appraisal of its effectiveness.

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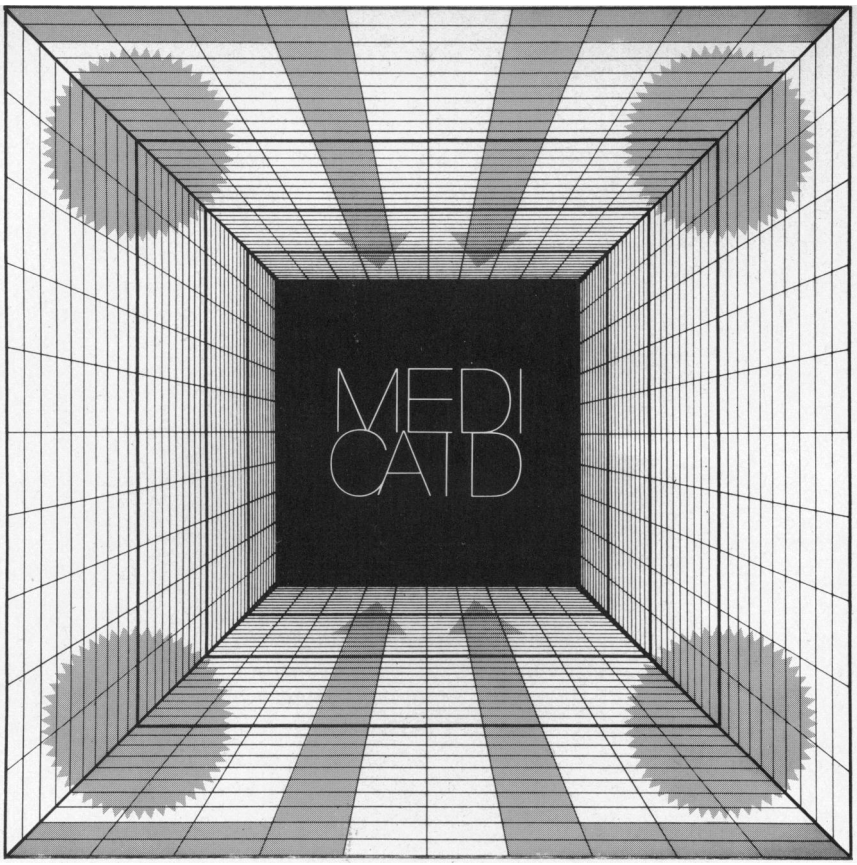

Some claims regarding the inequities, inefficiencies, and spiraling costs of the program are true, but they are often exaggerated or taken out of context; others are blatantly false or misleading. Genuine reform of Medicaid is sorely needed, and a reassessment of an overall strategy for health care for the poor is in order. But these actions can best be undertaken in an atmosphere devoid of charges and countercharges.

Concern with the cost as well as disappointment that the program has not fulfilled our high expectations, however, should not obscure the genuine accomplishments of Medicaid. Substantial progress has been made over the last 10 years toward its goals of insuring that needy persons receive adequate access to high-quality medical care and of relieving poor patients and their relatives and friends from the financial burden of medical expenditures. Any reform or replacement of the Medicaid program should be built on its achievements and accomplishments, so that the progress of the past will continue into the future.

Why Does Medicaid Cost So Much?

Perhaps the best known fact about the Medicaid program is that the cost of the program has grown rapidly throughout its history—far outpacing original cost estimates. Combined Federal, State, and local expenditures increased from $3.5 billion in 1968 to an estimated $14 billion in fiscal year 1976 (see table). This sixfold increase in Medicaid expenditures has been a major source of dissatisfaction with the program.

The fear, however, is unfounded that welfare costs and medical care costs for the poor are threatening to bankrupt State and local governments as well as to take over the Federal budget. Medicaid payments in recent years have not risen much faster than governmental expenditures generally. Medicaid accounts for roughly 2 percent of the Federal budget and 2 percent of State and local government expenditures, and this share of total expenditures has not changed markedly for several years. Thus, the cost of Medicaid is growing rapidly, but no more so than everything that governments pay for. Medicaid represents a fairly small, although politically vulnerable, part of overall government budgets.

Surprisingly, little is yet known about the reasons for the unanticipated high cost of Medicaid and its continued growth over time. Was the original cost estimate (of $1.5 billion combined Federal-State expenditures) totally unrealistic? Did providers of medical services take unfair advantage of the program to increase their incomes to exorbitant levels? Did beneficiaries of the

Medicaid payments adjusted for increases in recipients and prices, fiscal years 1968–76

Fiscal year [1]	Medical payments (in billions)	Medicaid recipients (in millions)	Payments per Medicaid recipient	Medical care price index [2]	Payments in constant dollars per recipient
1968	3.45	11.5	$300	100.0	$300
1969	4.35	12.1	361	106.9	338
1970	5.09	14.5	351	113.7	309
1971	6.35	[3] 18.0	353	121.0	292
1972	7.35	17.7	414	124.9	331
1973	8.71	18.5	472	129.8	364
1974	9.74	21.1	461	141.8	325
1975	12.09	22.5	538	156.2	344
1976	14.06	23.2	606	170.8	355

[1] For 1968–70, table includes payments and recipients under the Kerr-Mills program.
[2] Medical care price index of Bureau of Labor Statistics with adjustment to make 1968 equal to 100; estimated for fiscal year 1976.
[3] Includes some recipients of aid under nonfederally matched assistance programs.

SOURCE: Data on the Medicaid Program: Eligibility, Services, Expenditures, Fiscal Years 1966–76. Reported in U.S. House of Representatives, Committee on Interstate and Foreign Commerce, Subcommittee on Health and the Environment. Medical Services Administration, Social and Rehabilitation Service, Department of Health, Education, and Welfare. U.S. Government Printing Office, Washington, D.C., January 1976.

program use medical care services excessively? Was the program incompetently administered? Or did the program serve far more persons than had been originally anticipated?

Accounts in the media have focused attention on the charges and counter-charges of different groups affected by Medicaid. Physicians earning $300,000 a year have been blamed by some as responsible for high costs. Exorbitant nursing home profits and kickbacks to State officials have been cited by others. Medicaid patients have come in for their fair share of attack—they have been accused of taking joyrides in ambulances, obtaining prosthetic shoes for normal feet, and having extensive gold dental work done. Arrangements between laboratories and physicians for fraudulent billing or overbilling for laboratory services have been uncovered.

These abuses and inefficiencies are inevitable in a program as large as Medicaid, and corrective actions should be taken to uncover and eliminate them. But fraud and abuses account for only a small fraction of total Medicaid costs. To achieve effective control of them, we must look to the genuine causes of the increased costs.

Since Medicaid is a Federal-State program and most decisions are left to State governments, some sources of the growth in costs are undoubtedly more significant in some States than others. On the whole, however, three factors are almost totally responsible: (a) the increase in the number of Medicaid recipients covered under the Aid to Families with Dependent Children program, (*b*) the rise in medical care prices, and (*c*) the high cost of nursing home care for an impoverished aged and disabled population.

Annual Medicaid payments per recipient in constant 1968 medical dollars (expenditures divided by the consumer price index for medical care services) averaged $344 per person in fiscal year 1975, compared with $338 in 1969 (see table). That is, from 1969 to 1975, all of the growth of Medicaid costs could be traced to the rise in medical care prices and the provision of services to more and more people. On the average, Medicaid recipients were receiving approximately the same real services in 1975 as in the early years of the program.

When looked at in relation to what is spent on medical care for the average U.S. citizen, Medicaid recipients do not appear to be getting more care or averaging higher medical bills than anyone else. In fiscal year 1973 the average expenditure for personal health care services by all Americans was $384 per person—compard with $320 for Medicaid welfare recipients and $749 for medically needy and institutionalized Medicaid recipients (*5, 6*). The average payment for services received by a child Medicaid recipient was slightly less than the average payment for a child in the U.S. population. Similarly, for adults 19 to 64 years, the average Medicaid payment of $349 compared reasonably with the average $386 spent by all Americans in that age group. Even among the aged, Medicaid expenditures for those receiving welfare payments were about the same as the direct costs for the elderly who were not covered by Medicaid; each elderly person on welfare received medical services costing on the average $436, a figure that corresponds roughly to the amount the average elderly person paid for medical care in addition to what Medicare paid. Only for the elderly who were in nursing homes or who were medically needy, were the costs considerably higher—averaging $1,742 per person.

In summary, Medicaid costs are high not because people get too much care or because the Government pays exorbitant rates for it, but because (*a*) 23 million people receive Medicaid services each year, up from 9 million in 1967, (*b*) medical care costs in the United

States are generally high, whether the patient is covered by Medicaid or not, and (*c*) Medicaid has assumed the responsibility for meeting the health care costs of many elderly and disabled persons confined to nursing homes. To place any significant restraints on future Medicaid costs, these underlying causes must be addressed.

Progress Toward Medicaid Goals, 1964–74

From its initiation, the Medicaid program has had two major objectives: insuring that covered persons receive adequate medical care and reducing the financial burden of medical expenditures for those with severely limited financial resources. Before the introduction of Medicaid, most poor persons had little or no private insurance, and many went without needed care. Some appealed to charity—either from the physician, public hospitals, or friends and relatives. Others attempted to pay all or part of their medical costs despite great hardship to the family. Medicaid attempted to alleviate this situation—if not for all poor persons, at least for those on welfare and the medically needy.

Although it is difficult to separate the effect of Medicaid from other health programs for the poor or from other changing conditions that affect the poor, recent evidence suggests that the program has had considerable success in meeting its original objectives. In fiscal year 1964, persons with high incomes saw physicians about 20 percent more frequently than did the poor (*7*). By calendar year 1974 (according to unpublished data from the 1974 Health Interview Survey), the long history of lower utilization by the poor had been reversed, and the poor overtook persons with higher income in the use of physicians services. Persons with low incomes saw physicians 13 percent more frequently in 1974 than did persons with high incomes. Poor children increased their use of physician services from 3.3 visits in 1964 to 3.7 visits in 1974. Children from higher income families reduced their use of physician services over this period, thus reducing the differential in use of such services on the basis of income. While in 1964 children from higher income families had 66 percent more physician visits than children from low-income families, by 1974 they had only 15 percent more visits (reference 7 and the unpublished 1974 Health Interview Survey data).

Major gains were made by the poor between 1964 and 1974, particularly in the percentage who had seen a physician in the previous 2 years. In 1964, 28 percent of the poor had not seen a physician over the 2-year period; by 1973, 17 percent of the poor had failed to visit a physician for 2 years or more. Progress in this dimension was particularly evident for poor children, a third of whom had not seen a physician for 2 years or more in 1964. By 1973, this figure had been reduced to one-fifth of all poor children. Despite this gain, however, poor children were still 57 percent more likely not to have seen a physician in the 2 prior years than nonpoor children (*8*).

Improvements in the prenatal care of low-income women were also noticeable between 1964 and 1974. The percentage of low-income women seeing a physician early in pregnancy increased from 58 percent in 1963 to 71 percent in 1970. However, in 1970 high-income women were still 20 percent more likely to have seen a physician early in pregnancy than low-income women (*9*).

Although there are many conceptual and data difficulties in showing the effects of this greater medical care utilization on the health of the poor, there was considerable improvement over the 10 years in those dimensions of health status that are typically worse for the poor than for others and that are sensitive to improvements in medical care (*8*). Infant mortality declined 33 percent from 1965 to 1974, and there were somewhat more rapid reductions in the postneonatal rates, rates which have historically been much higher for infants of low-income families. Declines of 50 percent or more were recorded for infant deaths from gastrointestinal diseases, influenza and pneumonia, and immaturity. The death rates for young children declined 14 percent from 1965 to 1973, particularly those for malignant neoplasms (26 percent decline) and those for influenza and pneumonia (48 percent decline). Age-adjusted death rates for the entire population declined by 10 percent between 1964 and 1974; deaths from diseases of the heart declined 16 percent, cerebrovascular diseases 18 percent, diabetes mellitus 7 percent, and arteriosclerosis 37 percent. Although a great many factors undoubtedly contributed to these gains, it is at least plausible that increased attention to medical care played a part in achieving this improvement in health. For better evidence we will have to await followup studies in which death certificate information is linked with other sources of data on income.

These trends in the patterns of medical care utilization and health status are encouraging, but five major qualifications should be made about the progress of the last decade:

1. Most important—differences in the use of physician services are not adjusted for the health needs of the poor, which continue to exceed those of other groups (*10, 11*).

2. The increase in the use of services has not been shared by all of the poor; those who fall between the gaps and are unserved by either private insurance or public programs lag well behind other poor persons in the use of physician services (*11*).

3. Trends for increased use of services by the poor have not been accompanied by a movement of the poor into "mainstream medicine" of comparable quality, style, and convenience to that received by the nonpoor (*11*).

4. Averages for the poor as a whole conceal significant disparities for particularly disadvantaged groups such as the rural poor or minorities (*12*).

5. Medicaid appears to have had only limited suc-

ss in reducing the financial burden of medical expenditures for all poor persons (*13*).

Inequitable Distribution of Medicaid Benefits

Perhaps the greatest deficiency in the Medicaid program is that it does not treat people in equal circumstances equally. The inequitable distribution of Medicaid benefits is caused in part by the joint Federal-State nature of the program and its tie to the welfare system. Other inequities arise because Medicaid is a financing program and therefore is less effective in overcoming the nonfinancial barriers to medical care that certain disadvantaged groups face.

Eligibility for Medicaid is linked to welfare eligibility, and thus the program shares the complexity of the welfare system. States must cover all families with dependent children that are receiving public assistance (AFDC). States may also cover all the aged, blind, and disabled recipients of supplemental security income (SSI), or they may restrict Medicaid coverage to those SSI recipients who would have met the more restrictive State Medicaid eligibility requirements of January 1, 1972, that were in force before the implementation of SSI. All but 14 States have elected to cover all SSI recipients.

In addition to covering recipients of cash assistance, States may also provide Medicaid coverage to the medically needy, defined as persons who would be eligible for cash assistance if their incomes were somewhat lower. Twenty-eight States and four jurisdictions (the District of Columbia, Guam, Puerto Rico, and the Virgin Islands) extend such coverage to the medically needy.

Twenty-five States and two jurisdictions restrict eligibility for AFDC to families with only a mother present. Twenty-three States and three jurisdictions also extend AFDC and Medicaid coverage to families with unemployed fathers who are not receiving unemployment compensation. A limited number of additional States cover the children of families with an unemployed father, but not the parents. Thirteen States and three jurisdictions cover all children in families with incomes below the AFDC eligibility level—regardless of the employment status of the parents or the family's composition.

To be eligible for welfare, families must have incomes falling below a need standard established by each State. Need standards established by the States range from $2,208 for a four-person family in North Carolina (as of July 1974) to $5,472 in Wisconsin (slightly above the poverty level of $5,038 for a nonfarm family of four in 1974). Each State also may set limits on assets (homes, automobiles, savings, and so forth) in determining eligibility.

States covering the medically needy also establish tests for income, assets, and family composition similar to those for public assistance recipients. The income levels for a medically needy family of four as of December 1974 ranged from $2,200 in Tennessee to $5,600 in parts of Wisconsin. Families with incomes above these levels may also be eligible if their incomes fall below this level after incurred medical expenses are deducted (the so-called "spend-down" provision).

As a result of this complex set of restrictions, the following low-income persons are not eligible for Medicaid assistance:

1. Widows under age 65 or other nonelderly single persons
2. Most two-parent families—which account for 70 percent of rural poor family members and almost half of poor family members in metropolitan areas
3. Families with a father working at a marginal, low-paying job
4. Families with an unemployed father in the 26 States that do not extend welfare payments to this group and families with an unemployed father receiving unemployment compensation in other States.
5. Medically needy families in the 21 States that do not voluntarily provide this coverage
6. Women pregnant with their first child in the 27 States that do not provide welfare aid or eligibility for the "unborn child"
7. Children of non-AFDC poor families in the 36 States that do not take advantage of the optional Medicaid category called "all needy children under 21."

Given all the holes through which a needy family can fall in trying to obtain assistance to meet their medical care costs, it is not surprising that a large number of poor people are not covered by Medicaid.

The magnitude of these gaps in coverage is not well known. There are few estimates of the proportion of Medicaid recipients with incomes above or below the poverty level; there is little information on the number of Medicaid eligibles at any given time. In fiscal year 1975, an estimated 22.5 million persons received Medicaid services—a figure that is similar in magnitude to the population below the poverty level, estimated as 24 million persons in that year. Some Medicaid recipients, however, have incomes above the poverty level, because of income standards being set above that level and because of the spend-down provision. The Council of Economic Advisers estimates that 30 percent of all Medicaid recipients have incomes above the poverty level (*14*). This proportion suggests that 15.8 million poor people were covered by Medicaid in 1975, or two-thirds of the poor. Thus, approximately 8 million poor people were excluded from Medicaid coverage. This estimate may be somewhat conservative, however, since the data on Medicaid coverage are for persons covered at any time during the year, while those for the population below the poverty level are based on the number covered at a given time. Counts of Medicaid recipients over the period of a year therefore overstate the number covered at any given time. If the movements in and out of Medicaid are adjusted over time, the results suggest that perhaps 40 to 50 percent of the poor population is not covered by Medicaid at any given time.

For some States, coverage of the poor is particularly restricted. In 1970, only 1 poor child in 10 was covered by Medicaid in the States of Alabama, Arkansas, Louisiana, Mississippi, South Carolina, and Texas. According to an estimate by the Medical Services Administration, Department of Health, Education, and Welfare, less than one-third of the poor in 17 States—Alabama, Alaska, Arkansas, Florida, Idaho, Indiana, Louisiana, Mississippi, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Virginia, and Wyoming—received Medicaid assistance (*1*).

Medicaid represents almost exclusively a financing approach to health care for the poor. It pays for services that the covered recipients are expected to seek out and obtain. It was hoped that this approach would enable the poor to use private mainstream health facilities rather than being segregated in public hospitals or clinics. For some groups, however, removal of the financial barrier to medical care services is not sufficient to facilitate a use of medical services that is commensurate with their health needs. Instead, other nonfinancial barriers to care—such as transportation, long distances involved in obtaining care, discrimination on the part of existing health facilities and personnel, disregard for the patient's circumstances and the patient's dignity, limited patient education and limited information concerning the desirability and efficacy of medical treatment, and the persistence of past attitudes and past patterns of medical care use—frequently prevent the appropriate use of medical services, even when these services are provided free of charge.

Such nonfinancial considerations are particularly strong for residents of rural areas and for minorities in both urban and rural areas. Deterred from seeking medical care by nonfinancial barriers, these groups are more likely to receive less than their proportionate share of Medicaid benefits and to continue to use medical services that are less adequate for their health needs than other covered Medicaid recipients.

Poor people in rural areas are further disadvantaged because of the restrictions on eligibility for Medicaid. Only 40 percent of the poor in nonmetropolitan areas are elderly or members of one-parent families—the groups most likely to qualify for Medicaid. In metropolitan areas, 55 percent of the poor fall into the typical aged or one-parent welfare-eligible category.

In calendar year 1969 Medicaid payments per white recipient were 75 percent higher than payments per black recipient (*12*). Although part of this difference reflected the greater concentration of blacks in the States with limited Medicaid programs, even within broad geographic regions, blacks lagged substantially behind whites in the receipt of benefits. For example, in the Northeast, whites received on the average $362 in Medicaid payments while blacks received only $205. Differences among races, however, were most extreme in rural areas, where whites received more than double the benefits received by blacks. Disparities in Medicaid benefits on the basis of race were smallest for children and largest for the elderly. For nonaged adults, payments for whites were more than 33 percent higher than payments for blacks.

The lower benefits per black recipient were somewhat offset, however, by the tendency of poor blacks to qualify for Medicaid to a greater extent than poor whites. Since 65 percent of the poor blacks were either aged or members of one-parent families, compared with 43 percent of the poor whites, the poor blacks, particularly in the urban northern States, were somewhat more likely to be eligible for Medicaid. Seven of 10 poor blacks received Medicaid services in 1969 compared with slightly more than half of poor whites. The average Medicaid payments per poor person, therefore, were 36 percent higher than the average payments per black person.

For those eligible for Medicaid, the disparity in benefits was particularly marked for nursing home care. The average nursing home payments per white person covered by Medicaid were almost five times as high as the average nursing home payments made on behalf of the blacks covered by the program. Most of this difference is related to the higher proportion of white Medicaid recipients placed in nursing homes. For persons admitted to nursing homes, average payments for whites were $2,375 in 1969, compared with an average expenditure of $1,857 for blacks. The rate for black patients in nursing homes was lower than the rate for whites partly because blacks die younger. Therefore fewer black Medicaid recipients were elderly and in need of nursing home care. But there also appears to have been substantial discrimination, both overt and institutional, in nursing homes in 1969. Some nursing homes refused to accept black patients. More commonly, however, blacks failed to get into nursing homes because of institutional discrimination arising from segregated housing patterns and physicians' referral of patients to only a limited portion of all nursing homes.

Payments for general hospital service did not differ greatly by the race of the Medicaid recipient. About 17 percent of the white Medicaid recipients were hospitalized, compared with 14 percent of the blacks. However, the average payments per person hospitalized were slightly higher for blacks. The reason may be that blacks were more likely to be treated in city-county public hospitals, where costs were higher and stays longer.

Payments for private physician services were 40 percent higher for white than for black Medicaid recipients. Sixty percent of the white Medicaid recipients saw a private physician during the year, compared with 52 percent of the blacks. The average payment for physician services was also higher for whites, either because they visited physicians whose fees were higher or because they went more frequently.

These higher payments to private physicians for white Medicaid recipients were offset, in part, by the greater use of hospital outpatient departments as a source of medical care for blacks. Thirty-eight percent of the

black Medicaid recipients received care from hospital outpatient departments, compared with 26 percent of the whites. The average cost of care for those going to hospital outpatient departments appears to have been much the same, regardless of the race of the recipient.

Some caution should be exercised in extrapolating these data on Medicaid payments by race to current conditions. The data are based on the experience of 24 States reporting Medicaid data by race in calendar year 1969. Since that time, national statistics on medical care utilization indicate that blacks have made some gains in the use of physician services relative to whites, although they still lag behind whites in the number of physician visits per person. In 1969, many States in the South with high concentrations of poor blacks did not have Medicaid programs. Benefits for blacks, therefore, may have become more extensive in recent periods.

Data from the Georgia Medicaid program, however, reveal that differentials by race have not evaporated over time (*15*). In fiscal year 1974, white Medicaid recipients in Georgia averaged payments of $587 per person, compared with $271 for black recipients—more than twice as much for whites as for blacks. Poor blacks were somewhat more likely to be covered than poor whites. Georgia Medicaid covered 54 percent of the poor blacks and 43 percent of the poor whites.

Racial differences by type of medical service were much the same in Georgia as for Medicaid as a whole. A higher fraction of whites than blacks were hospitalized in 1974, but blacks tended to have somewhat more expensive hospital stays than whites. White Medicaid recipients in Georgia were almost six times as likely to receive nursing home services as were black recipients. Slightly more white recipients received private physician services, and the payments per person receiving physician services were 28 percent higher for whites than for blacks. Blacks in Georgia tended to receive more dental care than whites in 1974, but this benefit has since been discontinued by the State. Blacks in Georgia made relatively greater use of hospital outpatient facilities in 1974 than did white Medicaid recipients.

Rural residents, whether white or black, also face special barriers to receiving medical care services. Frequently, Medicaid does not cover rural families, since in typical poor rural families both parents are present, and hence the families do not qualify for AFDC in most States. Limited availability of medical personnel and transportation barriers also deter some of the rural poor from seeking needed medical services. Rural blacks may be even more affected by racial discrimination than urban blacks, since they have fewer alternative sources of care.

Again, the Medicaid program has not collected extensive data to document the distribution of benefits. Data for 1969 for 28 States reveal that Medicaid payments per poor person were 70 percent higher in metropolitan than in nonmetropolitan areas. Most of this difference reflects the greater coverage of the urban poor by the Medicaid program. Sixty-three of every 100 poor metropolitan residents were covered by Medicaid in 1969, compared with 38 of every 100 poor persons in nonmetropolitan areas. Thus, the metropolitan areas in the 28 States had 1.5 times as many poor people as the nonmetropolitan areas but 2.4 times as many Medicaid recipients.

Directions for Change in Medicaid

The Medicaid program has had a major impact on the health care of the poor in the past decade. Its many achievements have gone unheralded and largly unappreciated—obscured by an all-consuming concern with its unanticipated high cost. But there is little doubt that Medicaid has fallen short of our original high expectations. It continues to be afflicted by a host of problems. Reform is clearly needed.

Four problem areas should be addressed by a far-reaching reform of the program: the sources of rising costs, the gaps in coverage of the poor and needy, the limits on benefits and the limited participation in the program by mainstream medicine (private health facilities, physicians, and other health professionals), and the inequitable distribution of benefits by State, urban-rural residence, and race.

In seeking solutions to the seemingly unrestrainable increase in health care costs for the poor, we should look to underlying causes. Over the first 10 years of the program, three factors played a central role in rising costs. The first was the increased eligibility under AFDC (which was brought about by an increase in poor one-parent families), the increasing tendency on the part of the poor to register for the benefits for which they were eligible, and the high unemployment. The second factor was the generally rapid increase in medical care prices. The third was the high cost of caring for aged, disabled, and seriously ill persons who could not care for themselves or meet their own medical expenses.

Lesser factors that have added to Medicaid costs—and which have received the largest amount of press and public attention—include fradulent practices (such as billing for services that have not been rendered, or that have been provided by ineligible providers, kickbacks to physicians for referrals to laboratories or other providers, and the sale by patients of prescriptions or supplies obtained through the program); abuse of the program (such as by excessive hospitalization, excessive surgery, lengthy hospital stays, excessive laboratory services, injections in physicians offices, excessive prescriptions for drugs, physicians' mass visits to nursing homes, the padding of physicians' incomes through proliferation of services and repeat visits); and poor administrative mechanisms for checking and periodically reviewing eligibility and identifying abuses. Although the magnitude of the dollars involved in these abuses has never been demonstrated to be substantial, actions should be taken to eradicate the more costly or harmful aspects of fraud, abuse, and administrative inefficiency.

The second area of needed reform relates to the exclusion from the Medicaid program of many poor persons. The categorical restrictions on eligibility, the varying tests for income and assets, and State administrative actions to curtail costs by restricting eligibility have served to exclude many poor persons from the program. Estimates indicate that at any given time from one-third to as many as one-half of the population below the poverty level does not receive Medicaid benefits. These poor persons continue to lag well behind the rest of the poor in access to decent health care.

Even for the poor covered by Medicaid, restrictions on the level of services and the low rates of reimbursement for physicians and for other providers impede access to adequate care. It is clear that Medicaid has not achieved its objective of bringing the poor into mainstream medicine and providing them with treatment by the same types of physicians, community hospitals, and other health facilities as other Americans. Instead, State Medicaid programs have discouraged many physicians from participating by low rates of reimbursement for services, extensive red tape, delays in payment, the need for prior authorization of services, and numerous restrictions on covered services. A third needed reform is the institution of adequate methods of providing the poor with higher quality care, care that is comparable to that received by all Americans.

Finally, serious inequities in the distribution of Medicaid benefits on the basis of State of residence or urban-rural residence within the State and on the basis of race need to be redressed through greater uniformity of benefits and coverage and through supplemental programs to encourage the establishment of health care delivery in disadvantaged communities.

A number of alternative directions can be taken to achieve some or all of these reforms. These include:

- Maintaining the present Medicaid program, with State governments continuing to exercise their current authority to expand or restrict eligibility, benefits, patient charges, and provider reimbursement
- Giving the State governments even broader authority to use Medicaid funds for health services for the poor—as President Ford's block grant proposal would do
- Providing for tighter cost control through Federal actions—as the proposed Talmadge Medicare and Medicaid Administrative and Reimbursement Reform Act would do
- Providing for federalization of the Medicaid program with uniform coverage of all the poor and comprehensive benefits—as in the proposed Long-Ribicoff Catastrophic Health Insurance and Medical Assistance Reform Act
- Integrating the financing of health care for the poor into the financing of health services for all Americans through national health insurance
- Reassessing the current financing-service delivery mix of health care programs and using financing mechanisms to promote the development of health services delivery

Debate on these alternative future directions for the health care of the poor should be a key focus in the period ahead. Recognizing the strengths and weaknesses of our current programs, we can build new ones on the past and continue our progress toward the goal of decent health care for all Americans.

References

1. Medicaid, 1977–1981: Major program issues. Medical Services Administration, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D.C., July 1975.
2. Holahan, J.: Financing health care for the poor: The Medicaid experience. Lexington Books (D. C. Heath and Company), Lexington, Mass., 1975.
3. Klarman, H. E.: Major public initiatives in health care. Public Interest No. 34: 106–123, winter 1974.
4. Stevens, R., and Stevens, R.: Welfare medicine in America: A case study of Medicaid. Free Press, New York, 1974.
5. Mueller, M. S., and Gibson, R. M.: Age differences in health care spending, FY 1974. Soc Security Bull 38: 3–16, June 1975.
6. Numbers of recipients and amounts of payments under Medicaid, fiscal year 1973. DHEW Publication (SRS) 76–03153. National Center for Social Statistics, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D.C., November 1975.
7. Volume of physician visits, by place of visit and type of services, United States, July 1963–June 1964. PHS Publication No. 1000, Series 10, No. 18. U.S. Government Printing Office, Washington, D.C., June 1965.
8. Health, United States 1975. DHEW (HRA) Publication No. 76–1232. U.S. Government Printing Office, Washington, D.C., 1976.
9. Andersen, R., Greeley, R. McL., Kravatts, J., and Anderson, O. W.: Health service use: National trends and variations 1953–1971. DHEW (HSM) Publication 73–3004. National Center for Health Services Research and Development, Health Services and Mental Health Administration, Rockville, Md., October 1972.
10. Aday, L., and Andersen, R.: Development of indices and access to medical care. University of Michigan Health Administration Press, Ann Arbor, 1975.
11. Davis K., and Reynolds, R.: The impact of Medicare and Medicaid on access to medical care. *In* The role of insurance in the health service sector, edited by R. Rosett. National Bureau of Economic Research, New York City, 1976.
12. Davis, K.: National health insurance: Benefits, costs, and consequences. Brookings Institution, Washington, D.C., 1975.
13. Anderson, R., et al.: Expenditures for personal health services: National trends and variations, 1953–1970. DHEW (HRA) Publication No. 74-3105. Bureau of Health Services Research and Evaluation, Rockville, Md., October 1973.
14. Council of Economic Advisers: Economic report of the President. U.S. Government Printing Office, Washington, D.C., January 1974.
15. Georgia Department of Human Resources: Medicaid report 2082, fiscal year 1974. Atlanta, Ga.