Medicare in the USA: a review of 45 years of health provision

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Introduction

Medicare, the federal health insurance in the United States of America for senior citizens 65 and older, and for disabled persons under 65, celebrated its 45th anniversary in 2010. 2010 also marked the introduction of major healthcare reform in the USA, the first significant overhaul since the 1960s. As part of the new healthcare reform, Medicare will serve as the laboratory for testing measures of efficiency and effectiveness in healthcare services, administration, and education. This paper reviews the policy, politics, and economics involved in the passage of Medicare legislation in 1965, and its proposed reformative role in healthcare in the coming years. Medicare serves not only as a provider of healthcare but also as a springboard for reform. Over the years, there have been successes and failures, based on the strengths and weaknesses of both the American healthcare system and the American political ethos. As an example of governance in the provision of healthcare, this paper discusses the Medicare model of incremental change as viable in American society. The discussion provides a historical and sociological review of a long-standing health programme designed to meet principles of equity and ethics, and to discuss how and if these goals are being met. As an expert on American education has written, "Large-scale, decentralized democratic societies are not very adept at generating neat, rational solutions to messy situations." (1) During the health reform legislative battle of 2010, heated exchanges among politicians, health providers and beneficiaries over every aspect of national healthcare goals were common (2).

The early years, 1965

"Medical care will free millions from their miseries. It will signal a deep and lasting change in the American way of life. It will take its place alongside Social Security and together they will form the twin pillars of protection upon which our people can safely build their lives and their hopes."

President Lyndon Baines Johnson, June 1966 (excerpt from speech prior to implementation of Medicare) (3).

Medicare legislation was passed in 1965, a period in US political and social history that witnessed the civil rights movement which had the objective of securing legal and civil rights for African-Americans, and the Great Society programmes, promoted by President Johnson, which had the goal of removing poverty in the US. At the time of passage, Medicare's beneficiary population was those aged over 65. Part of the impetus for Medicare's development and passage was research on poverty that found the aged were a significant segment of the population, impoverished largely by expenditures on healthcare. As a population viewed with special concern in the US, the aged were among the first to benefit from universal health coverage. "The outpouring of civil rights activity in the early 1960s spurred politicians to support Medicare as part of Johnson's War on Poverty, and major civil rights groups all endorsed the legislation." (4: 77)e Unions and retirees also supported Medicare (4: 77-78). Medicaid, passed in the same year, addressed the medical care needs of those under the US official poverty line for a family of four.

By July 1966, Medicare was an active programme for the 65 and over population, with an enrolment of 19.5 million (5: 471). Today, in the US, 12.9% of the population is over 65. There are 47 million enrolled in Medicare, and since the programme was expanded in the 1970s, this figure includes people with end stage renal disease, and the disabled of all ages who were added to the ranks of Medicare beneficiaries. It was believed in 1965 that Medicare would serve as a foundation for a national healthcare system; 45 years later, it remains as a health plan under federal auspices for the three categories identified here.

The federal government, often along with state governments, is involved in supporting several healthcare programmes in addition to Medicare. These are: Medicare covering 45 (now 47) million in 2008 (6); Medicaid covering 59 million in 2006 (7); the Children's Health Insurance Programme covering 4.9 million in June 2009 (8); Veterans Administration Health Affairs serving 5.5 million in 2008, with 3 million more, who did not use the system in that year, eligible for care (9); Tricare covering 9.4 million active and retired military and their families (10), and Indian (native American) Health Services covering 2 million (11).

Thus, approximately 127 million Americans are covered by government health programmes. Therefore, in a population of 310 million, 127 million are covered by federal health programmes, with Medicare accounting for 1/3 of these healthcare beneficiaries.

In 1965-1966, the goal was health coverage at 65, with a long term goal of universal coverage for the whole population. The objective of complete coverage was not realised by the 1960s legislation, but the 2010 reforms opened pathways to more extended coverage for much of the US population in the coming years. In 1966, the beneficiaries who were registered for Medicare numbered 19.5 million people, 65 and over. In 2010, 47 million people were enrolled in the three eligible categories (over 65, disabled, and kidney dialysis patients), with benefit payments totaling 509 million dollars. Medicaid differs from Medicare in that it covers people in poverty, it is a combined federal and state programme and, in recent years,

states have introduced programmes designated for special groups, such as children in low income families, not at the official poverty level. As Stevens (5) shows, the 1960s and 1970s witnessed a proliferation of federal health agencies, causing the development of a healthcare industry (not systems) in which Medicare entered. Therefore, Medicare both pushed the development of many allied services, and attempted to control the growth and quality of these ever-multiplying health organisations and services. These tasks remain urgent ones for Medicare 45 years later because of ever exploding costs and expanding demand for medical services. As the healthcare debates of the post-2000 period show, the many players in healthcare (doctors, hospitals, pharmaceutical and medical technology companies) often see government as the adversary when it attempts to control costs, introduce efficiency, and rationalise services.

Developments in Medicare

Medicare legislation and implementation proceeded as it did for elders over 65 because this was a sympathetic group in the public and political view; the identification of poverty among the elderly, largely attributed to the high medical expenses they had to incur, clinched the passage of the bill. By twinning Medicare with Social Security old age pensions, politicians could declare they had ensured a package for old age security. However, the real hope was for a universal health coverage plan. Opposition came from the American Medical Association, a national organisation representing doctors. The AMA claimed that Medicare would "interfere with the doctor-patient relationship" and that doctors had already reduced or eliminated payments for elderly, poor patients. Therefore, the medical profession declared there was no need for this special insurance. This opposition led to the first provision of Medicare being for payment to hospitals, now known as Medicare Part A, thus bypassing doctor coverage although coverage for doctors' services, known as Medicare Part B, was introduced soon after.

However, because of the wish of politicians and policy makers to ensure acceptance of Medicare by both hospitals and doctors, cost restraints were not part of the immediate provisions. Instead of just being paid for the cost of services to patients, hospitals were permitted to factor in their overall operating costs into the bills of patients; doctors were not constrained by the cost of their services-they were allowed to bill "customary, reasonable costs" in their geographical areas, and they were paid more for hospital visits to patients. As can be imagined, this failure to stipulate regulations, led to the expansion of services, hospitals, and clinics, leading to the rising cost of medical care in the 1970s. This problem, in turn, led to multiple attempts to control costs throughout the 1970s by introducing health maintenance organizations (HMOs). in which doctors' groups provided services at fixed fees and to the development of DRGs (diagnostic related groups)., now a standard method of categorising diseases in order to estimate the length of hospital stay and treatment. One particular service offered through Medicare for patients with ESRD is cited by Paul Starr (12) as an egregious example of a new technology, kidney dialysis, achieving unique status. Reimbursement for dialysis led doctors, free-standing dialysis units and hospitals with these units to lobby for payment by Medicare for all patients with ESRD. Medicare used the hospitals/ health system in place as providers for ESRD. New hospitals were not created; however, the payment option for such specialised programmes pushed the development of for-profit hospitals, and a variety of free-standing speciality facilities which realised the revenue potential of dialysis and other specialised programmes.

By the 1980s, efforts to control costs became an incessant demand from health insurance companies, companies providing health insurance for employees, and government-sponsored plans such as Medicare, thus placing doctors and hospitals in the spotlight as the cause of runaway costs to the system.

"With a government program...public policy concerns such as cost and quality move front and center; in the case of Medicare, these concerns caused the programme to become a leader in the health insurance field." (13: 70) Thus, as mentioned above, the introduction of DRGs by Medicare was imitated by health insurance companies, thereby becoming a standard for the health system overall. And, in terms of standards of care, standards for pharmaceuticals and for medical technology, Medicare has increasingly become the reference point for the health insurance industry.

Positive outcomes of Medicare included (in the early phases in the 1960s): rapid desegregation of hospitals in the South, since Medicare would not reimburse for services in segregated facilities; funds for medical training of physicians; payments to doctors for services rendered in and out of hospitals (previous health plans limited payments to in hospital services) (14). Later developments included standardisation of efficiency measures, the development of DRGs, and hospice services for terminal illness. Negative outcomes resulted as well, such as the proliferation of free-standing facilities for specialised services like dialysis; excesses in end-of-life care; focus on drug, surgical and technology services for the older population, rather than earlier intervention through preventive services. A regressive feature of Medicare funding is that low wage workers pay the same rate of Medicare tax out of their salaries as upper income wage earners. (Information on Medicare payments and services are provided in slide 1. The current population served by Medicare is described in slide 2.).

Medicare in the age of health reform: 2010 and onwards

By the 1990s and later, Medicare had assumed a larger role in establishing standards of care, use of evidence-based medicine, limits on hospital stays, and encouragement of outpatient services where and when feasible rather than more costly hospital stays. These standards also became those, by and large, of many health insurance schemes, as the way to control costs by ensuring efficiency and efficacy in the delivery of healthcare. Problems facing Medicare included the provision of drugs, which were not covered by Medicare until mid-2000. Middle-

income recipients solved the shortfalls in coverage through so-called Medigap plans-insurance provided by their employer-sponsored retirement health plan, or supplemental private insurance paid out of pocket. For lower income recipients, many states supported drug coverage programmes based on income eligibility. To solve the gap in drug coverage, Medicare introduced this coverage for some beneficiaries, under Medicare modernisation in mid-2000. Even with new payment mechanisms for drugs, these costs remain out of control throughout the healthcare system, not only in Medicare. An initiative to use generic drugs and new agreements with pharmaceutical companies under recent healthcare reforms, project expectations of reduced costs.

Throughout their history, Medicare and Medicaid have faced problems of fraud perpetuated by hospitals, free standing clinics, durable equipment providers, pharmacies, doctors, and even by patients themselves. Over the years, increased fraud detection measures have lowered fraudulent activities. Under the recent healthcare reform, Medicare is introducing more fraud detection measures, including reminding recipients to review their quarterly service statements to see that they reflect the services they received.

Additional new benefits in Medicare under the 2010 reforms include free preventive screenings for colorectal cancer and free mammography; free annual physical examinations; increased training of primary healthcare doctors and nurses; development of community health centers; coordinated care between hospital stay and home care; and improved long term care choices.

Medicare : payments and services	
Part A	Hospital coverage 37% - payroll taxes (employers / employees/ self - employed). 13% - income tax paid on Social Security/trust fund investments interest/premium payments. 43% - general revenues
Part B	Doctors, lab services, durable equipment, etc.
Part D	Prescription drugs and administrative services.
Parts B and D	Paid by funds approved by Congress, premium paid by enrollees in B and D, interest on trust fund investments.
Part C	Medicare Advantage, allows enrollment in specified private health plans for Medicare beneficiaries

(Source: Kaiser Foundation September 2010)

Medicare : population characteristics
One half (47%) have incomes below 200% of the poverty line ($21,660 for individuals $ 29, 140 for couples in 2010)
More than one quarter of all beneficiaries have a cognitive/mental impairment
More than one quarter are in fair or poor health.
Eight million beneficiaries (17%) are nonelderly people with disabilities
Two million beneficiaries (4%) live in a long term care facility.

(Source: Kaiser Foundation September 2010)

Summary

From a review of the experience and history of Medicare in the US over these 45 years, politics and economics played a large role in its introduction, in the direction it took in its initial years, and more recently in the introduction of "donut hole" drug coverage. However, health planning and policy processes in federal and state agencies have grown, and by using data collected over the years on the Medicare programme specifically, and the health system more broadly, trial programmes to control costs and introduce efficiencies into healthcare have been and will continue to be undertaken. Those identified as workable and effective are then introduced as policy. For at least two generations now, in the US, the burden of health costs in old age, the period of greatest vulnerability to disease and chronic conditions, has been lifted, as foreseen by President Johnson in 1966.

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