inflation of the 1970s, and to be in the maximum liquid asset position to capture most fully the benefits of high real interest rates and the stock market boom of the early to mid-1980s.

But this suggests too rosy a scenario. There are several reasons for caution in assuming ever-rising increases in economic status for the elderly. The rate of growth of Social Security benefits has already slackened, and the slow growth in average wages for current workers will limit their benefits as retirees. Income from private pensions, which has shown rapid growth in recent years, now seems to be leveling off. The proportion of the population receiving pensions will not grow as rapidly in the future.

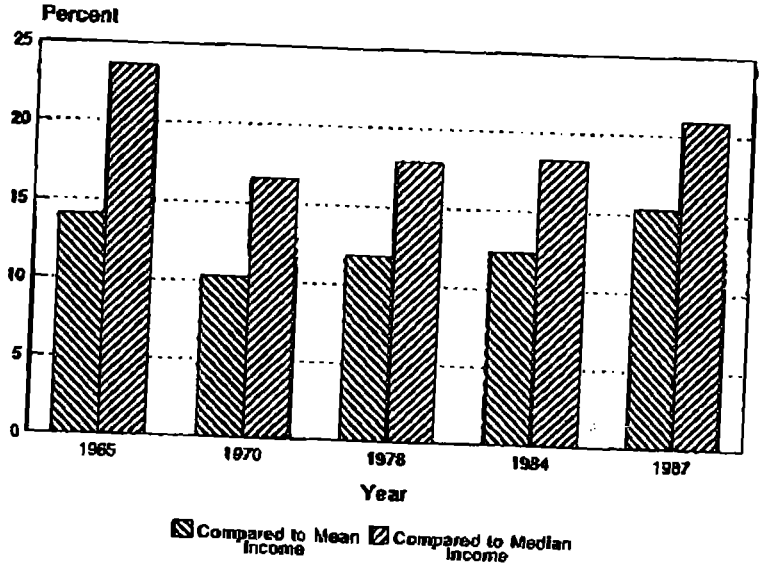
The changing age composition of the elderly will also retard the extent to which incomes grow over time. The very old will increase as a proportion of the elderly, and their lower average incomes are likely to help hold down overall rates of growth in income as compared to the growth of the 1970s. The younger old will be better off, but the over-85 age group will constitute an increasing share of the elderly population. In the near future, as the elderly population grows more as a result of longer life spans than because of new "entrants" to the 65 and over category, income growth will tend to be slower. In the 1990s, growth in the numbers of persons 65 and over will be concentrated in the over age-85 category, reflecting increased life expectancies. Individuals reaching retirement age will have been born in the 1930s, a period when birth rates were very low. Between 1990 and the year 2000, the population between the ages of 65 and 74 will grow by only 1.2 percent, while the group of those aged 85 and above will grow by 34 percent (Ways and Means 1992).

If these moderating influences on growth hold and the economy experiences relatively rapid real growth in the next decade, the status of the elderly relative to the young could again decline. More likely, however, the economic position of the elderly will stabilize relative to their younger counterparts. Growth in incomes for both the elderly and the young will likely average out to a moderate pace over the near term. This relative status of the elderly is likely to be important in any political debates over who should pay for Medicare, since many of the potential policy alternatives involve trade-offs between burdens on the old and the young.

Burdens from Health Spending

The percentage of income spent on healthcare by persons over age 65 is at an all-time high and will increase further. And as figure 1.4 indicates, whether compared to mean or median income, this spending now represents a critical burden for the elderly.[6] Incomes have risen rapidly for this age group, but out-of-pocket health costs have simply risen faster.[7]

Figure 1.4 HEALTHCARE SPENDING IN THE UNITED STATES AS SHARE OF INCOME, PERSONS 65 AND OLDER, 1965–87



Sources: Waldo et al. (1989); U.S. Bureau of the Census (1990 and unpublished data).

Analyses of the acute-care portion of these expenses reveal considerable burdens on those with low or moderate incomes. The low rates of private health insurance purchased by this group also leave them vulnerable to very high potential healthcare liabilities. For example, in 1986, elderly persons with a hospital stay and incomes of less than $10,000 spent 18.3 percent of their own income for acute healthcare services (Feder, Moon, and Scanlon 1987b). Since this is an average, it understates the level of burden for a considerable minority of this group.

The purchase of private supplemental coverage, often termed "Medigap," is not a solution, since it tends to raise the average spending on healthcare. Since many older Americans pay fully for this insurance, they are effectively still bearing the burden of healthcare costs, plus paying an additional amount to cover the often substantial administrative costs of the insurance (Feder et al. 1987a). Beca so

benefits in the future that will be funded by future workers. To maintain fairness, a major restructuring of Social Security would still have to pay benefits to current beneficiaries for some time period to fulfill the original promise of the program. Such a transition could be costly and result in lower rates of return during the transition for those who must contribute for their own benefits and to pay for the phase-out of the existing program.

The Social Security program is not and should not simply be thought of as a pension system. It has many other goals that take priority over a simple calculation of the benefits that can be achieved compared to benefits paid in. First, it is a program intended to offer a floor of protection for qualifying Americans. This means that some redistribution must occur, paying higher benefits relative to contributions for those with the lowest resources. In addition, Social Security offers disability and survivor protections that also need to be funded before considering giving individuals more flexibility over their own contributions.

It might be possible to achieve higher returns through privatization, but the complexities and uncertainties associated with such a major change need careful scrutiny. The serious attention being given to such proposals suggests, however, that they may well become part of a long-run strategy for change. Clearly, the practical concerns raised here need to be explored further before such major reform is undertaken.

ADEQUACY OF MEDICARE AND MEDICAID

Another continuing challenge to the well-being of older Americans is the burden of health care spending by individuals. Despite the introduction of Medicare (for the elderly) and Medicaid (for those with low incomes) in 1965, the percentage of income spent on out-of-pocket, unreimbursed health care costs by persons over age 65 is at an all-time high and is projected to increase further (Moon 1993). Incomes have risen for this age group, but out-of-pocket health costs have simply risen faster. At the same time, overall spending on Medicare and Medicaid has also increased sharply. Both the government and individuals are feeling the pinch of higher health care spending.

Analyses of the acute-care portion of h expenses reveal considerable burdens on those with l or moderate incomes. We have estima that by 1994, s] ding acute-care out-of-pocket servi

and premiums averaged 21 percent of the incomes of *all* the el and if we look at average out-of-pocket burdens for the poor persons over the age of 60, the percentages rise to 30 percent or (see table 2.11). Premiums are lower as a share of income for hi income persons both because they pay the same dollar premiu Medicare as those with lower incomes and because they are likely to receive subsidized premiums for supplemental covera part of their retirement benefits. This also factors into the age d ences shown in table 2.11. Younger households are considerably likely to have retirement benefits, as well as higher incomes. Very income families are eligible for special protections under Med but the overall shares are still high because of low participation

How much of this growth simply reflects older persons' desi finance health care spending rather than other consumption a ties? Certainly some growth in spending over time reflects suc sires working in concert with incentives for consuming more h care because of the subsidies that insurance provides. And t extent that these changes are discretionary, they may not be vi as fully reducing standards of living for the elderly. On the other

Table 2.11 HEALTH CARE SPENDING OUT-OF-POCKET AND ON PREMIUMS *SHARE OF INCOME*

	Percentage of Elderly	Per Capita Spending ($)		Expendi Share of Income
		Out-of-Pocket	Insurance Premiums	
Poverty Status:				
Under 100%	12.1	913	653	3
100–125%	6.0	1,047	1,069	2
125–200%	20.5	1,456	1,268	2
200–400%	35.1	1,486	1,200	1
Over 400%	24.4	1,509	1,199	1
Age:				
65–69	33.7	972	1,078	1
70–74	26.5	1,121	1,143	1
75–79	19.9	1,357	1,231	2
80–84	11.5	2,296	1,193	3
85 +	8.4	2,700	1,082	2
Total	—	1,382	1,137	2

Source: Authors' simulations using NMES (National Medical Expendi

a. Although the dollars shown in this table are per capita, the shares of inc estimated by family, recognizing that it is family budgets combined matter.