Conference Report

The United States Confronts The Policy Dilemmas Of An Aging Society

What population aging means for the bottom line of the U.S. economy, and how to address the problems.

by David Shactman and Stuart H. Altman

The united states and virtually all other industrialized countries are confronting the policy implications of aging populations. Thus far, the response has been to increase spending on entitlement programs for the elderly at a rate that many consider to be unsustainable. From 1980 to 1995 the percentage of gross domestic product (GDP) spent on the elderly in Organization for Economic Cooperation and Development (OECD) nations rose by almost 25 percent, while the proportion of elderly in the population rose by less than 20 percent.[1]

The U.S. population is younger than that of most industrialized nations and will remain so even after the retirement of seventy-eight million baby boomers. However, this phenomenon, beginning in 2012, will cause the ratio of persons age sixty-five and older to those ages twenty through sixty-four to increase by 66 percent during 2010–2030.[2]

Aging will not be the major factor driving future U.S. spending, however. Although aging is the primary determinant of the long-term shortfall in Social Security, experts agree that the gap is fairly predictable and that a modest increase in revenues (or reduction in benefits) could solve the problem. Budgeting for future health care spending, however, is far more difficult. Victor Fuchs has concluded that the cost of the increasing technological capabilities of medicine, not the aging of society, is the primary budget problem.[3] He predicts that if medical spending on the elderly continues to increase at past rates, it could reach 10 percent of GDP by 2020—more than double what it was in 1995.[4]

Given these forces and their fiscal consequences, there will be much political debate about what priorities to set and what courses of action to follow. The U.S. tendency has always been to approach health and income-security policies program by program; rarely have we taken a wider perspective, considering the needs of the elderly in a coordinated fashion or in light of others' experiences.

To provide this broader view, we synthesize the lessons of an intensive three-day conference held at Lansdowne, Virginia, 21–23 October 1999, supplementing its proceedings with our own views. The conference included eighteen scholarly papers presented by leading national experts on social policy and economics. We begin by posing some basic questions about the economic implications of increased spending on the elderly. We then address some basic issues of social policy that affect the way health and income-security programs are structured and financed. Finally, we recommend some programmatic changes for consideration in the near term.

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Questions About Economics

■ **If other countries are able to devote higher proportions of their GDP to social programs, why can't we?** Most other industrialized countries have higher proportions of both taxes and government spending relative to GDP than the United States has. In 1998 the U.S. proportion of total taxes (not just federal) to GDP was 34.4 percent, and total government spending to GDP, 32.8 percent. Those constitute the lowest proportion of taxes of major OECD countries, with the exception of Australia, Japan, and South Korea, and the lowest proportion of spending outside of South Korea.[5]

If the United States continued its current health and income-security programs through 2060, the proportion of federal spending to GDP would increase from 19 percent to approximately 22 percent of GDP.[6] Economists disagree on specific implications for our economy, but there is evidence that the U.S. economy has weathered other major changes in federal spending. For example, Wendell Primus pointed out at the conference that the economy absorbed an increase in the proportion of government spending to GDP by 3 percent in only three years between 1965 and 1968. Federal spending in 1999 was 18.7 percent of GDP, down from 23.5 percent in 1983, and the Congressional Budget Office (CBO) predicts that it will fall to 15–17 percent by 2010.[7]

Despite these optimistic findings, Rudy Penner warned participants that if such spending increases are not matched (or mostly matched) by increased revenues, a disastrous debt spiral will wreak havoc upon the economy. Long-term projections by the CBO indicate that current policies (for example, existing benefits and tax rates) will result in a ratio of public debt to GDP that rises from 16 percent in 2040 to 53 percent in 2050 and to 129 percent in 2060.[8]

If, on the other hand, we assume that this additional spending is largely financed through taxes, the U.S. economy can likely support its current programs despite the projections of increased cost. However, such increases in spending will require increased taxes and result in some "fiscal drag" on the economy. Americans must decide if they are willing to accept higher taxes as well as a modest decline in the rate of economic growth in order to fund current programs. Many conference participants believed that at least some of the increased expenditures would be financed by reducing the rate of growth of other discretionary programs. That leads us to the next question.

■ **Given the limited proportion of national income that the public seems willing to spend through the public sector, to what extent does spending on one sector (the elderly) crowd out available spending for other purposes?** There is considerable evidence from home and abroad that increased entitlement spending on the elderly has already crowded out or reduced spending growth in other areas (Exhibit 1). Total spending for Medicare, Medicaid, Social Security, and retirement and disability nearly tripled as a proportion of federal spending between 1962 and 1999. While discretionary spending increased in nominal terms over the same period, its proportion of total federal outlays was cut in half.

Military expenditures also increased, but the proportion of total federal outlays devoted to the military fell significantly. Had this not been the case, the growth rate of spending in other areas would have been further reduced, or taxes to support entitlements would have risen more than they did. Given that comparable reductions in military spending are unlikely to continue, future increases in elderly entitlements will have to come from other social programs or increased taxes, a policy direction that will meet with greater political resistance. This effect has also been seen in other industrialized nations.[9]

Although the proportion of our national income allocated to government spending is not fixed, it is certainly limited. Spending (as a proportion of GDP) on such areas as education, the environment, housing, and defense is likely to be reduced if spending on the elderly continues to rise. The major economic ques-

EXHIBIT 1
Changes In U.S. Federal Spending, In Nominal Dollars And As A Proportion Of Total Federal Outlays, Selected Years 1962–2010

	Billions of dollars					
Program	**1962**	**1970**	**1980**	**1990**	**1999**	**2010[a]**
Medicare	$ 0	$ 6.8	$34.0	$ 107.4	$ 209.3	$ 434.0
Medicaid	0.1	2.7	14.0	41.1	108.0	264.0
Other retirement and disability	2.7	6.6	32.1	59.9	85.3	125.0
Social Security	14.0	29.6				
Total health, disability, Social Security	16.8	45.7				
Discretionary spending, including defense	72.1	120.3				
Defense only	52.6	81.9				
Total outlays, including all other spending	106.8	195.6				
	Percent of federal budget					
	1962	**1970**	**1980**	**1990**	**1999**	**2010[a]**
Medicare	0.0%	3.5%	5.8%	8.6%	12.3%	18.8%
Medicaid	0.1	1.4	2.4	3.3	6.3	11.4
Other retirement and disability	2.5	3.4	5.4	4.8	5.0	5.4
Social Security	13.1					
Total health, disability, Social Security	15.7					
Discretionary spending, including defense	67.5					
Defense only	49.3					

SOURCE: Authors' calculations, based on Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2001–2010* (Washington: CBO, January 2000).
[a] Estimates.

tion confronting Americans is how we want to prioritize government spending among the various needs.

■ **If budget deficits are thirty years away, do we have to worry about them today?** Today's budget picture is brighter than it has been in many years. The CBO now projects that the government will accumulate a budget surplus of 3–5 percent of GDP by the year 2010 (the higher figure if discretionary spending is held within the budget caps and the lower if discretionary spending increases at the rate of inflation).[10] At that point, however, the baby boomers will begin to retire, and the funds needed to support current programs will rise dramatically. By 2030 the surplus will be depleted, and by 2040 there will be a deficit of 3 percent of GDP.[11] Three percent sounds small, but in 2040 it will represent about $1.3 trillion. Every surplus dollar that is saved now will reduce the magnitude of the otherwise steep adjustment later.

Despite this fact, however, there is good reason not to make radical or inflexible adjustments exclusively on the basis of long-term economic forecasts. Eugene Steuerle and Paul Van de Water pointed out the enormous uncertainty involved in long-term economic and budget projections. In May 1996 the CBO estimated that the long-term fiscal gap was 5.4 percent of GDP. That was revised successively downward to 4.1 percent in March 1997, 1.6 percent in May 1998, and 0.6 percent in January 1999.[12]

Henry Aaron strongly cautioned participants about making policy changes based on such uncertain long-range forecasts. Aaron and many others at the conference recognized the usefulness of long-range forecasting but distinguished between programmatic policy and fiscal policy. They recommended that major reforms be based on sound program structures and well-constructed social policies. Fiscal and budgetary planning based on long-term forecasts, they contended, should not be the basis for irreversible changes in the basic structure of our programs for health and income security.

■ **Can we get more out of our current programs for the same amount of money, and what might we have to give up in return?** Since U.S. policymakers ordinarily take a program-by-program approach, most political and policy debate has focused on individual program reform. However, fundamental social policy issues determine how these programs are structured and financed, and potential cost-saving efficiencies may often come at the expense of societal ideals. We identify some of the more salient issues.

Universal social insurance versus means-tested benefits. Most industrialized countries have universal social insurance programs for the elderly. The U.S. Medicare program is universal in that it provides benefits to any citizen age sixty-five or older regardless of income. The Medicare trust fund is now projected to run out before 2020, and it is clear that it could be extended longer if benefits were means-tested (or taxed) so that wealthier persons received few or no benefits and limited government resources were reserved for the poor.

Proponents of such a change cite not only targeting efficiency, but social equity. Former Colorado governor Richard Lamm argued, for example, that it is unethical for society to support wealthy seniors while forty-five million younger (and often poorer) Americans lack basic health insurance. More-liberal opponents, however, cited ideals of social solidarity and program stability to support universality (and many would support both current programs and universal health insurance). Theodore Marmor and Jerry Mashaw argued that the very nature of a social insurance program gives security to all who are younger because we know that some will need assistance when we are older. Furthermore, changing to an income-defined program stigmatizes beneficiaries as welfare recipients and diminishes the support of the program by the middle and upper class.

Defined benefit versus defined contribution. Medicare guarantees a defined benefit package, and the cost of that package has been growing much faster than the economy and faster than the funds earmarked for its support.[13] A defined-contribution program would control future government spending but would shift the risk of any increased costs greater than the defined formula from the government to beneficiaries. Such a change is controversial, as illustrated by the recent experience of the National Bipartisan Commission on the Future of Medicare. The commission first considered such a plan but rejected it early in its deliberations. It then considered a more expansive premium-support system in which the government would continue to pay for the growth in a defined-benefit package but would limit its payments to each individual to a fixed percentage of the benefit package. Even this plan was rejected, however, partly because the increased funds that would be necessary to maintain premium-support levels were not absolutely guaranteed.

Generational equity. How much should the younger generation, who are often struggling to get started, support the older generation, many of whom are financially secure? Both Medicare and Social Security are pay-as-you-go systems in which the younger working generation pays for those who are retired. Each generation could instead fund its own needs, accumulating funds during its working years. Proponents of prefunding argue that the current system will become more difficult to sustain as the dependency ratio (of dependents to workers) worsens. Furthermore, they contend, prefunding not only is more equitable across generations but also is more economically efficient and will result in greater economic growth. At its heart is the requirement of forced savings and the accumulation of interest income or equity growth.

One of the problems of a prefunded system is that making the transition from a pay-as-you-go system incurs a double burden for those paying during the transition. Thomas Saving, a strong advocate of prefunding, stated at the conference that there is no way to proceed without making some age group worse off. As a result, a change to this kind of system is politically difficult.

Many advocates of prefunding also believe that individuals should assume more respon-

sibility for their own income and health security accounts. Hence, there have been a number of proposals for privatized accounts. Medical savings accounts (MSAs) represent one type of private medical account, and individual retirement accounts (IRAs) and 401k plans are private income-security accounts. The issues pertaining to private accounts involve a trade-off between potential economic return and universality. Proponents favor privatization because of individual control, personal choice, and the potential opportunity to earn higher returns. Opponents, however, question what will happen to those who fare poorly with their investments, and they decry the loss of social solidarity that would result from a change to an individual system.

Protecting a budget surplus that comes from earmarked taxes—or in today's political parlance, "saving the surplus"—is one way to partially prefund the needs of the baby boomers without instituting structural changes in the underlying programs. "Saving the surplus" while the budget is balanced and while demographic factors are favorable will enable the country to avoid sharp increases in taxes and/or reductions in spending when the boomers retire and the trust funds are depleted. However, the temptation to fund discretionary programs or to provide tax cuts to citizens looms large compared with concerns about a budget deficit some thirty years in the future. This has been illustrated quite clearly with the recent congressional inability to stay within the budget caps. Americans would likely have to express a strong political consensus to stay this particular course.

■ **What programmatic changes should we consider in the near term?** We recommend four areas for immediate consideration.

Examine incentives to extend working lives. Research by Joseph Quinn has found evidence that Americans have recently begun to lengthen their working lives.[14] Although it is too early to predict with certainty, this could indicate that the long-term trend toward earlier retirement has reversed. With life expectancy increasing and age-specific disability decreasing, Americans will face a longer period of time after age sixty-five in which they can perform productive work. Increased longevity is often given as a reason why programs for the elderly will require more funding. However, if Americans work longer, pay more into retirement accounts, and claim benefits later, this would powerfully affect all current budget projections.

Whether it is a societal benefit to create incentives to work longer is a complex question. Recent studies show that Americans are already among the hardest-working people in the developed world.[15] Incentives to extend working lives would affect white-collar executives differently than poor or disabled workers, or those who work in physically demanding jobs. However, of all potential policy options, the impact of longer working lives yields perhaps the most attractive economic return relative to what must be traded off.

Change the age and eligibility rules for Social Security and Medicare. Clear financial advantages exist for raising the age of eligibility for Social Security to age seventy, if protections are added for those who cannot support themselves during longer working years. Medicare presents different issues, since raising the eligible age saves little and provides no incentive for employers to retain elderly workers who usually incur higher health costs. Here the government might subsidize employers to reduce the cost of insuring elderly workers or increase benefits in later life for workers who forgo earlier benefits because they choose to continue working. Such changes could have important budgetary consequences.

Increase the scope of the elderly benefit package. Although budget projections provide reasons for reducing benefits to the elderly, the fact is that the scope of benefits in the United States is considerably narrower than it is in most other developed countries. The income replacement rate for Social Security (at early retirement age, that is, age sixty-two in the United States) is 41 percent in the United States, considerably below that of nearly all other developed nations.[16] And although many Americans have private pensions, Social Security represents 80 percent of total income for

the bottom 40 percent of households.[17] Although we do not recommend increasing Social Security benefits, they are not generous compared to other industrialized countries.

Relative to other countries, the U.S. Medicare program provides a particularly narrow set of benefits. In most OECD nations virtually all health care expenses are public, while for the average elderly American Medicare covers only about half of total expenses. A large gap exists in the lack of coverage for prescription drugs, which are the fastest-growing component of health care expenditures. Spending on prescription drugs increased at an average annual rate of 12.2 percent between 1993 and 1998, twice as fast as the rate of increase in total national health spending.[18]

Except for Americans who qualify for Medicaid, there is almost no public coverage for long-term care. By 2030 the number of Americans needing long-term care is expected to increase by 54 percent (over 1997 levels).[19] Furthermore, they will need care for a longer period of time. As a consequence, nursing home expenditures are projected to grow from $69 billion in 2000 to $330 billion in 2030.[20] The use of private long-term care insurance will increase, but it is unlikely to noticeably close this gap for health services.

This growth in demand is clearly the crux of future budgetary concerns. Nevertheless, pharmaceutical benefits and long-term care insurance are essential components that need to be at least partially included in the scope of elderly benefits. At the same time, however, Americans must confront the prospect that unlimited access to the capabilities of medical technology may crowd out these expansions as well as other spending priorities. The idea of limiting future medical technology, or limiting access to the fruits of that technology, has always been anathema to American thinking. However, it is a dilemma that we may well have to address.

Consider a more integrated approach to health and income-security programs. Considerable savings could be garnered by adopting a more integrated approach to health and income-security programs. By an "integrated approach" we refer to setting overall spending priorities and aligning incentives, as opposed to combining programs. Such an approach can accomplish the following three objectives: better assess the total costs of programs for the elderly in comparison to other societal needs; align conflicting incentives among existing programs; and eliminate rigidities so that streams of revenue can be more efficiently allocated across needs. The first of these is self-explanatory, but we briefly discuss the other two.

Programmatic changes should be encouraged to reduce conflicting incentives. The Social Security program has phased in reforms that have now largely eliminated the "tax" on early retirement. However, Medicare penalizes those who work longer by making the employer the primary health insurer and by giving nothing in return to the worker who forgoes otherwise free benefits. Tax exclusions for private pensions are given as an incentive to supplement Social Security with private savings, but allowing lump-sum withdrawals defeats that objective. Tax exclusions for employer-sponsored health insurance mostly benefit the upper middle class and wealthy, who are most likely to already be insured. In addition, age eligibilities for Medicare, Social Security, and pension withdrawals are all different. As a result, those wishing to work longer are often penalized, and those wishing to retire early often have less access to retirement income and health insurance.

Rigidities also should be eliminated so that streams of revenue can be allocated more efficiently. As policymakers have added tax incentives to encourage savings, the number of tax-advantaged accounts earmarked for specific uses has been rising. Hence, there are MSAs, IRAs, educational IRAs, Roth IRAs, and so on, each with its own restriction on how funds can be withdrawn. This increases the possibility that individuals will have more funds than necessary for some needs and not enough for others. Increasing the flexibility to apply restricted savings streams to other needs will increase allocative efficiency and provide incentives for different kinds of retirement savings. Lynn Etheredge pointed out

that if retirement accounts could be rolled over to purchase long-term care insurance, demand for policies would likely increase. Similarly, he recommends that those without employer-based pensions be allowed to increase their Social Security payroll deductions and have the added amounts directed to qualified pension plans.[21] These kinds of integrative policies can result in a more efficient use of existing revenue streams.

The United States can afford to sustain its current programs, even as it confronts the increased costs of an aging population. Those increased costs, however, must be paid for by higher taxes, slower economic growth, or reduced discretionary spending. As an alternative, programs can be reformed to cut expenditures, but often at the cost of reducing elderly security and social solidarity. Complicating the challenge is the need to expand access to such benefits as pharmaceuticals and long-term care. A broader, more coordinated view of elderly entitlements could better enable us to confront these challenges. In addition, programmatic changes such as encouraging longer work lives, adjusting age and eligibility requirements, and aligning incentives across health and income-security programs can increase our capacity to provide for our aging citizens.

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NOTES

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