Introduction: Health Care Reform for an Aging Population

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The need for change in the system of health care delivery in the United States has finally emerged as a political issue alongside continuing budget deficits, a growing national debt, declining educational outcomes, and decreased competitiveness of American business in the global economy. The two most pressing health care problems at the present time are rapidly increasing costs and lack of access to the system. A more distant but potentially more recalcitrant problem is the aging of our population. Early in the new century the proportion of retired citizens to workers will increase sharply. Soon thereafter the number of frail elderly will burgeon (see fig. 1). The result may be an unprecedented allocation of social resources to the very old. A lasting solution to the present crisis in health care must accommodate these demographic changes, and it must take account not only of the health of individuals but also of the common good and the vitality of society as a whole.

The essays in this volume explore the kinds of changes necessary to meet our long-term health care needs within a just and vibrant society. A focal point is a proposal by Daniel Callahan in his book *Setting Limits: Medical Goals in an Aging Society* to withhold life-prolonging treatment at public expense from the very old. Several of the papers explore Callahan's rich philosophical account of the meaning of aging, the role of the elderly in society, and obligations between generations, as well as his controversial proposal to limit medical spending. Other essays look more broadly at the transformations required to meet both current and future problems and the values that should guide our attempts at comprehensive change. But first a word about the immediate need for health care reform.

The Current Problem

*Rising Costs.* Health care expenditures have increased over the last two decades an average of 11.6 percent per year, considerably higher than the overall rate of inflation of 8.7 percent. Health care spending in the U.S. for 1992 was $838.5 billion, more than 14 percent of our gross domestic product (GDP). The previous director of the Office of Management and Budget testified before Con-
FIGURE 1

U.S. population aged 85 years or older, 1900 to 2050, in millions
(from the US Bureau of the Census).


...gress that without serious structural changes, health care would account for 17 percent of the GDP by 2000 and 37 percent by 2030. These estimates now appear conservative. Citizens on fixed incomes are hit hardest by rising costs. Older Americans spent 10.6 percent of their after-tax income for health care in 1961, before the enactment of Medicare (which provides most of the cost of health care for all citizens after the age of sixty-five). In 1991, even with the help of Medicare, out-of-pocket expenses consumed 17.1 percent of their income.

Individual consumers are not the only ones affected by escalating health care costs. Increased government outlays through Medicare and Medicaid (the federal health care assistance program for the poor) exacerbate the federal deficit. To control expenditures the government has reduced Medicare benefits, paid only a portion of Medicaid bills, and imposed a prospective payment scheme based on averages rather than actual costs. The real cost of providing care has not diminished in proportion to the lower levels of reimbursements to physicians and hospitals. Consequently the surplus costs have been shifted from public to private payers. Such cost shifting has further accelerated the increasing cost of health insurance for individuals and the cost of health coverage for businesses, putting them at a competitive disadvantage. Chrysler Corporation estimates that health care...
costs, including those of its suppliers, added $700 to the cost of each vehicle in 1989, about three times the added cost in Japan ($246) and Canada ($223). Ford Motor Company spends much more for health care than for steel.\(^6\) As more of our money goes to health care, less is available for other critical social needs, such as education and economic investment. (Fig. 2 shows the change in outlay for some of these items.)\(^6\)

There are many reasons for this relentless rise in the cost of health care. Malpractice insurance premiums continue to climb, reflecting increasing litigation and higher awards. Many physicians practice so-called defensive medicine, ordering tests and procedures of negligible benefit only to protect against a potential malpractice suit. A recent study concluded that about $10 billion is spent every year in this manner.\(^7\) Patient education and preventive medicine receive little reward under the current system, which focuses on curing rather than avoiding illness. The cost of care is not addressed in medical education, so that physicians rarely know the cost of a test or procedure they order. This fact reflects a more pervasive attitude. As consumers we expect and demand the highest level of care available, which we equate with the most intensive, extensive, or expensive. We tend to think of medical care as an absolute priority, not subject to the cost-benefit comparisons that usually structure our economic choices (a point James Buchanan makes elegantly in his essay). Moreover, since our bills are usually paid by third parties,

**FIGURE 2**

Trend of Health Care Costs and Other Sector Expenditures as a Percentage of GNP.

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there is little incentive for either consumers or providers to control spending. As a result, our hospitals spend vast amounts building, remodeling, and purchasing the latest technology in competition for patients. There are ten thousand mammogram machines in the United States, while only two thousand would be necessary to meet current demand, and five thousand would screen the entire population. A more rational deployment of resources would significantly reduce total health care outlay.

**Limited Access.** Americans who can afford it receive the technologically most advanced medical care in the world. Our formidable challenge is to preserve the quality of available care while gaining control over runaway costs and at the same time including all of our citizens in the system. It is clear that the problems of cost and access are related. Most obviously, fewer are able to afford insurance as the cost rises (fig. 3 illustrates this correlation). A recent study by the Agency for Health Care Policy and Research of the Department of Health and Human Services has found that 20 percent of the population of the United States had no health insurance for some or all of 1987. More than twenty four million were uninsured for the entire year, and another twenty three million for part of the year. An estimated fifty million more are underinsured, with policies that provide inadequate coverage (a major illness could produce bankruptcy). Medicaid, the public assistance program for indigent patients, covers only the poorest of the poor in most states. The majority of these people without coverage are the working poor and their dependents. Many small businesses cannot afford to offer health insurance, and several larger and more prosperous companies avoid the expense by hiring mostly part-time workers. Self-employed, seasonal, and temporary workers also may lack coverage.

The uninsured often receive inadequate care under humiliating conditions. Many physicians refuse to take uninsured patients, and some even refuse to take patients with Medicaid coverage. Individuals may not be able to obtain important elective procedures until their needs become acute. At this point they may go to expensive emergency rooms where they cannot be turned away. If they are unable to pay for their care, the cost is shifted to insured patients, further increasing the cost of premiums—another example of the inextricable link between cost and access.

**Proposed Solutions**

**Incremental Revision.** A conservative approach to reform might attempt to control costs and increase access by modifying the present patchwork system and encouraging individuals to be more circumspect and parsimonious in their consumption of health care services. To expand access, underwriting practices could be
regulated so that fewer individuals are denied coverage or thrown into prohibitively expensive risk pools. Medicaid could be extended to cover the "uninsurable" (those who are already in poor health). Managed-care options in the private sector, such as health maintenance organizations or preferred provider arrangements, could be promoted in an effort to control costs. Individuals could be encouraged to accept more modest levels of care rather than demanding the best and most expensive care available. Advance directives could be promoted as a way of controlling wasteful end-of-life expenditures. In addition to the usual language that refuses life-prolonging treatment, clauses could be added to directives authorizing physicians and family to consider the cost of treatment and might explicitly reject expensive procedures that do not have corresponding benefits. Discounts might even be offered by insurance companies as an incentive to complete an advance directive.

It is highly doubtful, however, that sufficient savings could be realized from managed care and voluntary restraint to offset the added cost of extending access. Managed care has not had great success thus far in containing health care costs. Increased use of advance directives is unlikely to help significantly; patients who receive sustained intensive care before death account for only about 1 percent of total annual Medicare cost. Volume appears to be much more important than acute intensity of services in determining overall health care costs. Rather than so-called heroic medicine, it is repetition of comparatively "small ticket" items and the needs of chronic illness that are largely responsible for rising expenditures.11 Concerning
medical care in general, it seems naive to expect most Americans to request or voluntarily to accept a lower level of care than their coverage allows. Indeed, it seems unfair to reduce costs by encouraging sacrifice from the altruistic while others continue a more extravagant consumption of resources.

In the long run we must moderate our strong individualist orientation and embrace a more communitarian ethic, but reform of the health care system cannot wait for such a conversion. We must revise the system now so that cost-conscious choices are encouraged and rewarded. This might be attempted within the present market-oriented system by relying more heavily on private health insurance. All citizens would be encouraged through tax incentives to purchase their own health care policies on the private market. Subsidies for those with low incomes would be provided in the form of vouchers or tax credits. Rather than being expanded, Medicaid could be cut back to serve only as a safety net for individuals who cannot obtain private insurance because of a current illness or poor overall health. Cost-conscious consumers would encourage competition among insurers and providers to control costs. Cheaper policies with large deductibles might also help control costs by discouraging overuse of the system and rewarding “healthy behavior.”

But it is difficult to see how this consumer choice or market approach could solve the dual problems of access and cost. If the incentives to purchase insurance are large, they will greatly increase the budget deficit, offsetting any savings on Medicaid. If they are small, then many individuals and families will not purchase insurance or will purchase only limited coverage. When they need care it will be provided in the expensive emergency room setting, and the resulting cost shifting will make insurance more expensive. Moreover, a more competitive free-market approach to insurance will intensify risk pooling and the other underwriting practices the place coverage out of reach of the people who need it most, throwing them back on the public sector. A private insurance solution might work if universal coverage could be achieved, but that would entail forcing individuals to purchase insurance and prohibiting discriminatory underwriting practices, neither of which would be attractive to civil libertarians or proponents of free markets. Finally, that competition and enlightened choice would control costs is dubious, since there seems to be little disincentive to develop and use increasingly expensive technology. As we have seen, competition in the health care industry as it is currently structured tends to increase costs rather than diminish them.

Comprehensive Reform. The only effective way to resolve the current crisis in health care is to develop a system that features both universal coverage and budget limits. Universal coverage is necessary, not only because social justice requires it but also because it is the only way to stop cost shifting. Budget limits are likewise necessary to develop and enforce cost-control mechanisms and to maintain a pre-
dictable level of spending. The challenge is to design a program that preserves the present system's quality of care, is achievable politically, and is congruent with basic American values of professional autonomy, market economics, and consumer choice. (Reinhard Preiser carefully explores these and other basic American values that are likely to shape health care reform.) Socialized medicine, for example, in which physicians are salaried employees of a comprehensive, centrally budgeted and administered system, would provide the most reliable control of costs, but it is neither socially nor politically acceptable at the present time. By general agreement the two most realistic possibilities for attaining universal coverage and budget limits within a largely private system of health care delivery are mandated employment-based coverage and national health insurance.

*Mandated Employer Coverage.* The politically easiest means to universal coverage is some kind of mandated employer coverage, since it would build on the present system and would preserve the private insurance sector. Most Americans receive their health insurance as an added benefit of employment. We tend to think of workplace coverage as part of the natural order of things, but our system actually took root during World War II, in large part because health benefits were exempt from wartime wage controls and thus could be offered (or demanded) in lieu of a raise in salary. After the war and the lifting of wage controls, the IRS ruled that the cost of health insurance was deductible from taxable income, and the popularity of employment-based coverage was more firmly established. 12

One basic problem with this arrangement is that it has never covered everyone. Not all businesses offer health insurance, and the unemployed are left with inadequate public programs such as Medicaid. Since it does form our largest base of coverage, however, it seems to many the easiest route to universal coverage. We could simply require every business to provide a minimum level of coverage, with defined benefits, to all its employees. Or we could adopt a so-called play-or-pay system that would require businesses to provide the minimum level of coverage (“play”) or pay into a public fund from which the uninsured would be covered. Small firms could pay the same rate at large ones, since the employees of many small firms would be combined to form large pools. The unemployed would still need to be covered, either by extending Medicaid or by including them in the large insurance pools with government subsidy.

The principal organized opposition to mandated coverage comes from small businesses. Among firms with fewer than ten employees, less than half offer health insurance. 13 Many fear that this added cost could not be absorbed, especially at current prices for small-group coverage. For this reason mandated coverage must be accompanied by measures to reduce and control those prices. In addition to pooling of coverage for small-business employees we might do away with current practices of risk rating, that is, varying the cost of coverage according to the health status of the individual, and return to "community rating," that
is, basing a single price for a given level of coverage on the average health care costs for an entire community (not just healthy employed people). This would be good for the unemployed as well as for small businesses, since everyone could purchase coverage at the same rates. It would not be good, however, for large business, whose favored rates would rise. More large firms could convert to self-insurance to preserve their advantage, skimming the cream and militating against the concept of community rating.

The most important factor in controlling the cost of health insurance, of course, is controlling the cost of health care. Spending is more difficult to control under a fragmented system of employer-based coverage and private insurance than under a single-payer program of national health insurance. Nevertheless there are some successful models to examine. Hawaii has had a system of employer-based universal coverage for almost two decades. It combines mandated coverage with state subsidies and a state insurance pool for the unemployed. Insurers agreed to return to community ratings, and costs are controlled through annual fee-setting negotiations between insurers and providers. As a result, while everything else is more expensive in this island state, health insurance premiums in Hawaii are the lowest in the country. Germany provides another example of a decentralized system with effective cost control. Most coverage is supplied by a multitude of regional, not-for-profit insurance organizations known as “sickness funds.” All employers are required to contribute at rates determined by the various funds. Fees are negotiated with physicians’ associations, and rates are established with hospitals—the same daily rate for every patient, regardless of diagnosis. Under this system West Germany was able to restrict its growth in health care spending during the 1980s to the overall rate of growth of its gross domestic product.

**National Health Insurance.** An important element of the cost of health care in the United States is the expense of administering a diverse system of private health insurance. Under our present system insurance is provided by a multitude of companies competing on the private market, each with its own procedures and forms to complete for reimbursement. There are hundreds of kinds of policies and many levels of risk rating. Each company has its own administrative staff, and each provider must have several employees involved in keeping records and filling out various reimbursement forms. Add Medicare and Medicaid regulations and forms, and the result is that too much of our health care spending goes into administration and paperwork and too little into actual patient care. In 1987 the average overhead cost of private insurance carriers was 11.9 percent of premiums, compared to administrative costs of 3.2 percent for government programs (primarily Medicare and Medicaid). Administrative costs for public and private programs combined accounted for 5.1 percent of all health care expenditures in the United States. By contrast the cost of administering the public health insurance program

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in Canada was only 0.9 percent, and the figure for public and private programs was 1.2 percent.¹⁶

How do the Canadians keep administrative costs so low? They have a single-payer system of national health insurance, covering all citizens equally, administered by the government and financed by taxes in lieu of insurance premiums. Consumers have freedom of choice among private practitioners, but as the single payer the government can set budgets and negotiate reasonable fees with providers. Seventy-three percent of all health spending is public (compared to 42 percent in the U.S.). There is a small private-insurance sector, but it is restricted by law to benefits not included in the public program. Out-of-pocket payments are estimated to constitute 20 percent of all health expenditures (about the same as in the U.S.).¹⁷ In addition to universal coverage, administrative efficiency, and budgetary control, a system of national health insurance offers significant advantages. Since health insurance is uncoupled from employment, workers may change jobs without fear of losing their coverage. Dependents will remain insured if they become widowed or divorced from an employed spouse. Differential tax rates correlate coverage with ability to pay, avoiding inefficient and potentially humiliating means-testing for public subsidies. Businesses need no longer purchase insurance in an unpredictable market and administer their own benefit programs.

There are two large problems with instituting a system of national health insurance in the United States: an immediate surge in unemployment and an uncertain “utilization response” to the new system. First, it is obvious that large numbers of insurance company employees (as well as billing clerks in hospitals and doctor’s offices) would be out of work. Some, but not all, would find employment with the new public program, since the single-payer system would be more efficient. Most of these skilled workers would find jobs sooner or later, but the immediate effect on an economy just beginning to recover from stagnation could be very serious. For these reasons we might have to phase in the new system, thus producing no effective cost controls for several more years. A new administration pledged to all three goals of economic growth, deficit reduction, and immediate control of health care spending would face obvious political difficulties with a conversion to national health insurance. Although it seems to offer the best opportunity for long-term cost control and overall economic vitality, the short-term damage could be great.

The second serious concern is with the so-called utilization response to the new system: would the response to free care be a surge in demand? If so, savings in administrative efficiency could be more than offset by increased consumption of services. One study estimates that universal access to free care would inflate expenditures by $78.2 billion over 1991 levels while saving only $46.8 billion in administrative costs.¹⁸ This contradicts an earlier calculation that administrative savings would be sufficient to fund care for the uninsured and underinsured.¹⁹ All such predictions are generated from economic models that cannot adequately an-
ticipate the complex behavior of both patients and providers. We simply do not know what level of use to expect. Canada experienced no massive increase when its system was introduced, but as Barer and Evans aptly note, the United States of 1993 is quite different from the Canada of 1967.

A system that is awash with human and physical capacity and technical possibilities, and chafing under utilization constraints that, while ineffective in aggregate, are still onerous and offensive, might very well respond to the extension of coverage with a significant increase in recommended diagnostic and therapeutic interventions. After all, one of the most common arguments for a universal system is to provide "needed" care for those left out at present.29

Setting Priorities. Regardless of the direction health reform takes, moving from partial to universal coverage will be highly inflationary at the present rate of consumption. Reductions will be necessary somewhere—in fees, levels of coverage, or availability of services—to offset this inflationary pressure. Oregon has developed a plan for extending coverage to all citizens while holding spending to current levels. It includes a play-or-pay requirement for employers, a high-risk pool funded from public and private sources, and a redistribution of Medicaid funds. The last feature has drawn the most attention. Under the proposed plan Medicaid eligibility would be extended to everyone below the federal poverty level. In order to cover more people with the same amount of money, fewer services will be included in the Medicaid benefit package. A commission was created by the state legislature to develop, in the words of the authorizing legislation, "a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served." Services would be included in the package as far down the list as budgeted funds would allow. The state has finally obtained a waiver from the federal government allowing it to use Medicaid funds in the proposed manner.

A national system with universal coverage would obviate the need for Oregon to implement its own program, but its method of distributing scarce financial resources could be an important part of any national plan. While other schemes rely on some combination of fee negotiations, managed care, waiting lists, or triage, Oregon's plan is designed to control costs by explicitly limiting services. Prioritizing services could help determine minimum benefits for nationally standardized insurance policies. Prioritizing could also contribute to a single-payer system, since it would allow periodic adjustment in coverage to enforce limits on spending. In combination with negotiated provider charges and limited deployment of expensive technology, it could be a powerful and flexible tool for both setting and enforcing a global budget. Leonard Fleck's second essay provides a
detailed analysis of Oregon's approach and of its possible role in a single-payer system. He also provides a critical account of the managed competition version of employment-based coverage and suggests a hybrid version that would borrow some features from the Canadian model.

Planning for the Future

Our Aging Population. Lurking in the shadows of the debate on health care reform is a problem that threatens eventually to undermine any potential solution. Due in part to the postwar baby boom and subsequent steady decline in the birth rate, the average age of our population is steadily increasing. The trend will slow somewhat during the remainder of this decade, due to the relatively low birth rate during the Great Depression of the 1930s, but it will take a sharp upturn early in the next century. The first wave of the baby boom generation will reach retirement age (and eligibility for Social Security as well as Medicare) about 2011. By 2020, the elderly will account for approximately half of the nation's health care expenditures.21 By 2040, the average age of the baby-boom generation will be eighty-five. After eighty-five average health costs increase dramatically.22 Spending on hip fractures, for example, is projected to increase from $1.6 billion in 1987 to as much as $6 billion in 2040 (in constant 1987 dollars). More sobering still is the projection for the cost of care for demented individuals. The prevalence of dementia rises sharply after age eighty-five; those who reach eighty-five have better than a 1 in 4 chance of becoming demented (this estimate may well be too low). In 2040 the cost of caring for demented patients alone is projected to be greater than the current federal deficit.23

Hip fractures and dementia are only two of the age-related conditions that require long-term care. Any comprehensive reform, indeed any reform of the health care system that hopes to provide access to basic care and control costs, must include long-term care. There are more residents of nursing homes than patients in hospitals or even available hospital beds.24 Medicare does not include nursing home coverage, and the small number of private insurance policies available are of uncertain value. Nursing home stays are financed by personal savings and, when those are depleted, by Medicaid. Given current patterns of disability and nursing home use, the cost of long-term care could rise by 2040 to between $84 and $139 billion (in constant 1985 dollars).25 Long-term care is not synonymous with nursing home care, though currently they are largely the same. Most of the millions of individuals who need long-term care neither want nor need nursing home placement, but their options are limited. We must find ways to make nursing homes more humane and efficient, provide less dispiriting and expensive alternatives to nursing home care, and integrate long-term care—both structurally and financially—into a comprehensive system of health care delivery.
Robert Kane elaborates each of these goals and suggests ways we can assess and assure quality of care.

Even without additional spending on long-term care, the share of the federal budget dedicated to pensions and health care is projected to increase from a current 40 percent to 60 percent by 2040. Without a sizeable tax increase, which seems unlikely, the money to fund entitlement programs for the elderly may be taken from other sectors of the budget, such as education, public works, and public assistance. If taxes were increased to cover such costs, there might be little remaining in the way of private savings to invest in the economy. Thus, a poorly educated, economically stagnant and stratified society could be the consequence of meeting all the health care demands of our aging population.

Age-Based Rationing. One way to deal with increasing expenditures due to the aging of the population is to limit care to the aged. In his book *Setting Limits* Daniel Callahan proposes that life-extending medical treatment not be provided at public expense after a certain age. This policy should be implemented in the context of an enriched understanding of the meaning of aging and of the role of the elderly in society. A special role—as conservators of the past and teachers of youth—ensures that their exclusion from certain benefits does not mean exclusion from the moral community. Furthermore, life-extending care should be rationed only when society commits itself to easing the suffering of old age and improving the quality of life of the elderly. He does not specify an age but suggests that by the late seventies or early eighties we have achieved, or had a opportunity to achieve, life’s important goals and rewards and face ever more costly and debilitating medical problems. Rather than prolong lives of increasing incapacity, society should use its resources to see that younger citizens have the same opportunity to live out a “natural life span.”

Several of the essays in this volume address the major themes of *Setting Limits*. Thomas Cole examines Callahan’s account of the meaning of aging and of fairness between generations from a social historian’s perspective. He believes that disputes about generational equity reflect broader social forces, such as the decline of American military and economic power, skepticism about the liberal welfare state, and the loss of a unifying conception of the life cycle. Stephen Post tries to modulate the adversarial tone of the intergenerational equity debate; he develops an image of mutual obligations based on the Judeo-Christian concept of ‘covenant’ and calls for a communitarian balance of rights with responsibilities. John Hardwig refocuses concerns about generational equity on individual families. Careers or marriages can be threatened by the demands of constant care for frail or demented parents. Savings may be depleted by lengthy hospital or nursing home stays. We currently authorize adult children to make health care decisions for their incapacitated parents but expect them to consider only the interests of the patient, however marginal, and never their own, however great. Hardwig argues for a more
balanced approach to such decisions, taking into account everyone’s interests and burdens.

The second part of the book is devoted to the difficult and painful issue of age-based rationing of medical care. Callahan’s proposal to limit public funding of life-prolonging treatment for the very old prompted immediate and widespread criticism. Janet Coy and Jonathan Schonsheck argue that much of the criticism is based on misunderstanding or a superficial reading of the book. They carefully reconstruct and elaborate Callahan’s argument and defend it against some of his leading critics. Leonard Fleck examines the charge that, because lifesaving treatment would be denied to identifiable individuals, Callahan’s proposal is not only unethical but also unworkable. As a society we tolerate the sacrifice of “statistical lives” resulting from public policy decisions (e.g., not to fund maternal health clinics or childhood inoculations), but we will spare no expense to save identifiable individuals whose lives are in danger—a trapped coal miner for example. Fleck analyzes the so-called rule of rescue and finds that the rescue analogy does not apply to age-based rationing of medical care. Howard Brody proposes an alternative to a government-imposed age limit, that the elderly consult a “peer network”—a group of respected close associates with whom one’s life plan has been developed—to consider whether or not life-extending treatment would be appropriate. Sharon Sytsma agrees with Callahan that rationing medical care will be necessary, but when she examines his position she finds the ultimate basis to be, not age, but quality of life, a criterion she herself finds preferable. Jecser and Pearlman formulate a number of arguments against age-based rationing and then explore some alternative criteria for allocating scarce medical resources. They conclude that basic health care should be available to all and that publicly funded nonbasic services may be allocated according to medical benefit.

The essays in part 3 that have previously been mentioned examine the more general problem of health care reform and explore some further alternatives to setting limits based upon age. The closing paper by Callahan is a response to his critics and a further elaboration of his views on the meaning of old age and its place in allocation decisions. He distinguishes between fixed and flexible categorical standards, assesses the merits of each, and closes with some thoughts about adopting and implementing his proposals in a democratic and pluralistic society.

Notes

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9. Shelton and Janosi, "Unhealthy Health Care Costs."


18. J. F. Shields, G. J. Young, and R. J. Rubin, "O Canada: Do We Expect Too Much from Its Health System?" *Health Affairs*, vol. 11, no. 1, (Spring 1992), pp. 7–20.


25. Schneider and Guralnik, "Aging of America."