

The 2008 Fedele F. and Iris M. Fauri
Memorial Lecture

*The Impact of the “Aging of America”
on Children’s Health*



M UNIVERSITY OF MICHIGAN
School of Social Work

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The Fedele F. and Iris M. Fauri Memorial Lecture in Child Welfare is presented annually in recognition of former University of Michigan Dean and Vice President Fedele F. Fauri and his wife. Dean Fauri's leadership and accomplishments in the field of child welfare spanned nearly 50 years. Much of the current social welfare legislation at both the state and federal levels is the product of Dean Fauri's activities, first as Director of the Michigan Department of Social Services, and then through his years in Washington, DC, where he held numerous leadership positions including Senior Specialist in Social Security for the U.S. Senate, Social Security Advisor for both the U.S. House of Representatives and the U.S. Senate, Social Security Advisor to President Kennedy, and Chair of the Advisory Council on Public Welfare for the U.S. Department of Health, Education, and Welfare. His accomplishments in the field of child welfare and social work education brought national and international acclaim to Dean Fauri, the School of Social Work, and the University of Michigan. This lecture series is made possible by gifts from alumni, faculty, and friends, and is intended to serve as a forum for the discussion of ideas and proposals to enhance further the well-being of young people.

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2008 Fedele F. and Iris M. Fauri Memorial Lecture
University of Michigan School of Social Work

October 27, 2008

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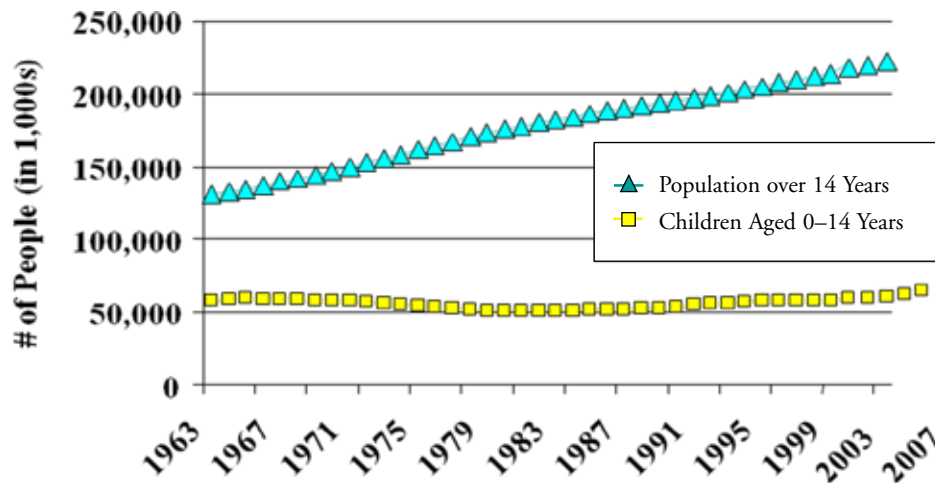
It is an honor to be asked to give the Fauri Lecture and to attempt to further the mission that the Fauris had when they began this school and the impact that they had together and individually on behalf of children and on behalf of the School of Social Work.

Today I am going to speak to you about the impact of the aging of America on children's health. I want to say first of all that I am not a senior, but I will be speaking about seniors. I am not a child, although my wife could tell you she sometimes mistakes me for one of ours. I am aging, and I am in America. I am not trying to foment age warfare; many of you may have a stake on one side of this equation or the other. But, what I will try to get across in this lecture is that I believe that society needs to make conscious decisions regarding resource allocation and that a better informed society is going to make better decisions. What I hope to do today is to try to provide you, as part of the public, with real information to be able to better understand both what is happening now, and will continue to happen, if we continue on our current path. It may well be that our current path is what our society wants, but I think we need to understand where we are going so that we can collectively and consciously make the decisions for the kind of society that we want to have going forward.

I am going to show you the current spending patterns in the United States for children and for others in this country. I will also show you current Medicaid spending, how it is proportioned, and its impact on state budgets. I will also review some issues within the private sector regarding the way in which we both finance and construct health care delivery, and also some mechanisms about the manner in which we value health care in this country. Then I will attempt to put it all together and look at some future directions and policy suggestions for your consideration.

One of the things that prompts this discussion is the change in the population of the United States. What you see in Figure 1 is a dramatic change in the relationship and the ratio of population in this country from the early 1960s until today. Children, those 14 and under, back in the early 1960s made up around 40 percent of the population. By 2007, the *proportion* of children in the population has actually shrunk to around 25–27 percent. You can see that the *absolute number* of children has remained the same. The difference is the growth in the number of people over 14, and the fastest growing segment of that population is seniors. And for the foreseeable future, we will continue to see this trend. We will have roughly the same number of children in this country, but a smaller and smaller proportion of children of our general population.

Figure 1
Population of the United States Adults versus Children, 1963–2007



Source: U.S. Census Bureau

So, when we look at health care financing, why is this important? Right now health care is around 16 percent of our gross national product. Even before the recent meltdown in our financial markets, it was unlikely—or very questionable—how much more of our GNP could go to health care. It is also very possible that the GNP itself may shrink over the next couple of years. If that is the case, simply by the math alone if we have a relatively stagnant amount of money going into health care, but a larger and growing proportion of one segment of the population, the very nature of that change will require a shift of resources. This is the concept of proportional spending by age. As a given proportion of society increases, a greater proportion of our dollars will go to that segment of society. As I said, the growing segments of our society are adults and seniors. What this means is that although there are the same number of children in the United States, as they become a smaller proportion of the population, we will likely see, in very real terms, actual decreases as well as proportional decreases in the amount of resources directed to them. I am not saying that is right, and I am not saying that is wrong. I am just saying that is the reality of our current medical expenditure process.

In our public sector, we have a few basic areas that finance health care for people 65 and older. We have Medicaid, which pays for health care for poor children, for blind and disabled adults, and also for seniors in long-term care facilities. There are also state programs that pay for different aspects of health care, and there are federally funded and state-funded research programs. In the private sector, there is private insurance. And we will talk about how that works for both adults and for children. We also have a private market for research and we will examine population-directed changes in where those research dollars are directed.

So what do I mean? Well let's just look at an example in Table 1 of what has already occurred. In 1987, there was per capita health care spending for those less than 6 years of age of around \$1,033. For those greater than 65 years of age, per capita spending in 1987 was around \$3,800. If we just jump ahead one decade, we see that inflation-adjusted per capita spending for those less than 6 years of age actually decreased over the course of that decade. In contrast, inflation-adjusted spending for adults over age 65 almost doubled. Taking into account the population data presented earlier, an increasing number of those over 65 means that not only are we spending more per person, but there are more people on whom we are spending that greater amount.

Table 1
Health Care Spending Per Capita

Age	1987	1998
<6 years	\$1,033	\$905
>65 years	\$3,858	\$6,265

Now let us jump ahead to 2004. This is the last year for which we have data on personal health care spending. And we'll look at this a little bit finer. See Table 2. For those who are 0–17 years of age, the annual spending per capita is approximately \$2,600. This is in contrast to over \$14,000 for each person greater than 65 years. When we look at the total distribution of personal health care spending in the United States, we see that around 13 percent goes to children 0–17 years of age, 52 percent goes to those 18–64 years of age, and 35 percent goes to those greater than 65 years of age. Thus, we have a growing segment of the adult population, and the adult population costs more. I am not saying this is good or bad; I just want people to know what is going on so that when we begin to deal with budgetary constraints we can make informed decisions about where we want our resources to go.

Table 2
Personal Health Care Spending, 2004

<u>Age</u>	<u>Annual Spending</u> (per capita)	<u>Total Distribution</u>
0 – 17 years	\$2,650	13%
18 – 64 years	\$4,511	52%
≥ 65 years	\$14,797	35%

Now we will examine more current data in Table 3. In the last fiscal year, 2006–07, our GNP increased by 2.3 percent. The children’s budget—and by that I mean all children’s entitlements, including health care—increased by 0.7 percent. In contrast, adult entitlements—specifically, adult Medicaid, Medicare, and Social Security—increased by 5.2 percent, a little over double the increase in GNP. Please remember, there are no fewer children, they are only representing a smaller and smaller proportion of the United States, and, in this case, receiving a smaller proportion and a smaller percentage increase of the increase in the GNP. And again, this is important, because we have an increase in the proportion of the population that costs the most. Thus, adults cost more and we will continue to see a faster rise in that proportion of the population.

Table 3
Changes in Fiscal Years 2006–07

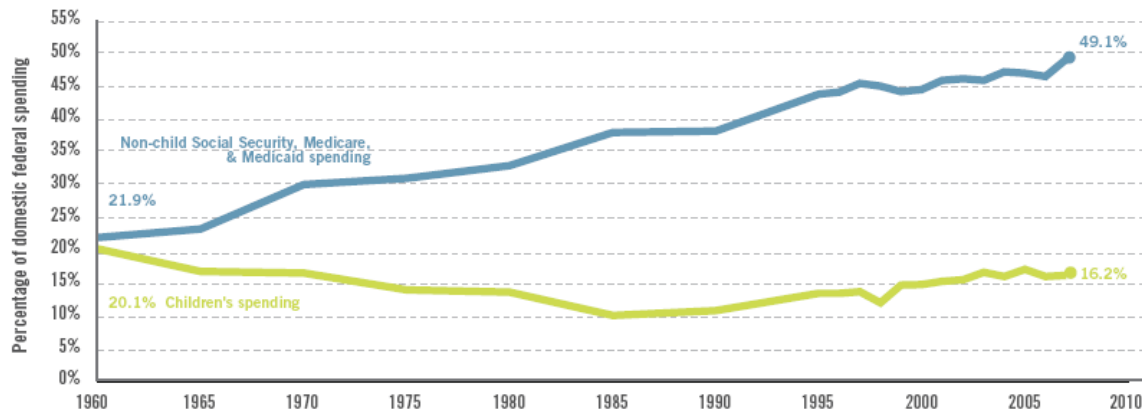
- GDP 2.3%
- Children’s budget 0.7%
- Adult entitlements* 5.2%

*Medicaid, Medicare, Social Security

Now, what is, then, the children’s share over time of overall domestic federal spending? Of the largest federal programs classified as spending on children, two are tax credits given to their families (one of them is a child tax credit, and the other is earned income tax credit), and the third largest is Medicaid. In 1960, spending on children was around 20 percent of the domestic federal budget. By 2007, that had fallen to 16 percent of the domestic federal budget. Domestic spending excludes military spending and foreign aid. By 2018, remembering the demographic changes I showed you before, you can calculate that children’s spending will decrease to a little under 14 percent of all domestic federal spending if our current spending patterns stay true. Again, these things are all happening just based on our current way of doing business. The question I want to continually pose to you during my talk today is: is the way we are doing business the way we want to continue to do business?

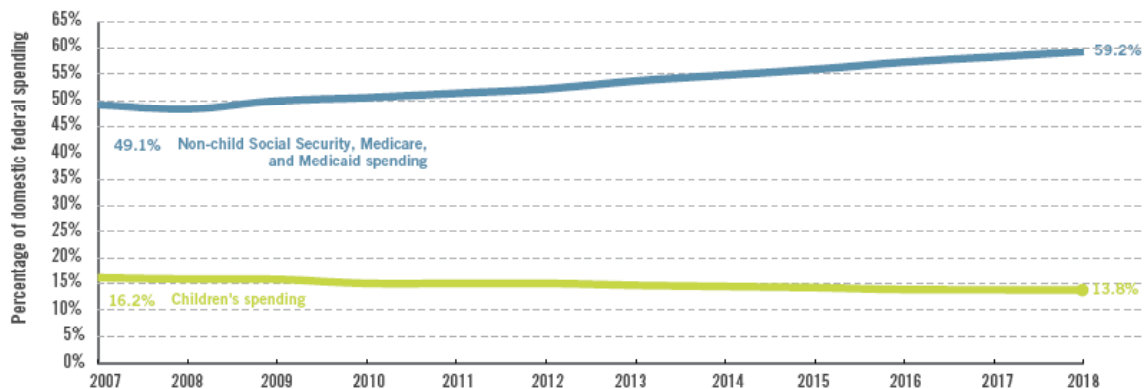
Back in 1960, children made up around 20 percent of federal domestic spending, and adults around 22 percent. By 2007, domestic spending on adults has now reached 49 percent of all domestic spending, whereas the spending on children is now down to 16.2 percent. The slopes of these two lines in Figure 2 actually look very similar to the slopes I showed previously regarding the changes in population age proportions. That is not just a coincidence. Looking at predictions for the year 2018 in Figure 3, we see that 49 percent of domestic spending on adults in 2007 will increase to 59 percent. For children, spending will fall from 16 percent to a little over 13 percent.

Figure 2
Federal Spending on Children and Major Entitlements as a Share of Domestic Federal Spending: 1960–2007



Source: The Urban Institute and The New American Foundation, 2008. Estimates and projections developed using the *Budget of the United States Government, Fiscal Year 2009* and CBO's *Budget and Economic Outlook: Fiscal Years 2008–2018*.
 Note: Children's tax expenditures are included in children's spending and domestic federal spending for this exercise.

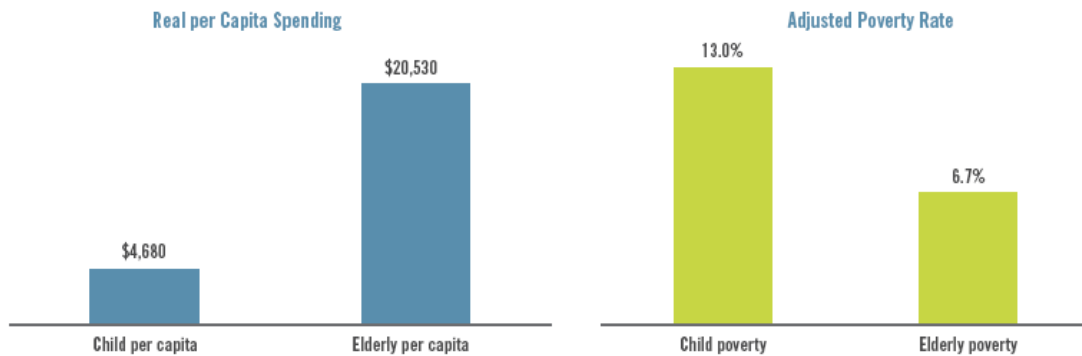
Figure 3
Federal Spending on Children and Major Entitlements as a Share of Domestic Federal Spending: 2007–18



Source: The Urban Institute and The New American Foundation, 2008. Authors' projections, based on the *Budget of the United States Government, Fiscal Year 2009*; CBO's *Budget and Economic Outlook: Fiscal Years 2008–2018*; *Treasury's General Explanations of the Administration's Fiscal Year 2009 Revenue Proposals*; and Urban-Brookings Tax Policy Center Microsimulation Model (version 0308-1).
 Note: Assumes the 2001–03 tax cuts are made permanent and that full AMT relief is provided in each year.

Now some might say that makes sense, because they believe more seniors are living in poverty and that is why the social welfare health spending needs to go more specifically to seniors. Notice in Figure 4 that per capita spending in 2005 in social welfare and health programs was a little under \$5,000 per child; for the elderly it was about \$20,000 per individual. However, if you look at the adjusted poverty rates, we actually see a higher poverty rate among children of around 13 percent versus an elderly poverty rate of a little under 7 percent. So we cannot explain the variation in funding and the patterns of funding by a greater poverty rate in the senior population relative to the child population.

Figure 4
Per Capita Federal Spending and Poverty Rates in 2005: Children versus the Elderly



Source: The Urban Institute and The New American Foundation, 2008. Authors' estimates based on the *Budget of the United States Government, Fiscal Year 2009* and past years; and U.S. Census Bureau, *The Effects of Government Taxes and Transfers on Income and Poverty, 2005*, table A-2, March 2007.
 Note: This figure uses an alternative measure of poverty that is post-transfer (does not include the cash value of health care transfers, however). Elderly spending only includes Social Security, Medicare, and Medicaid.

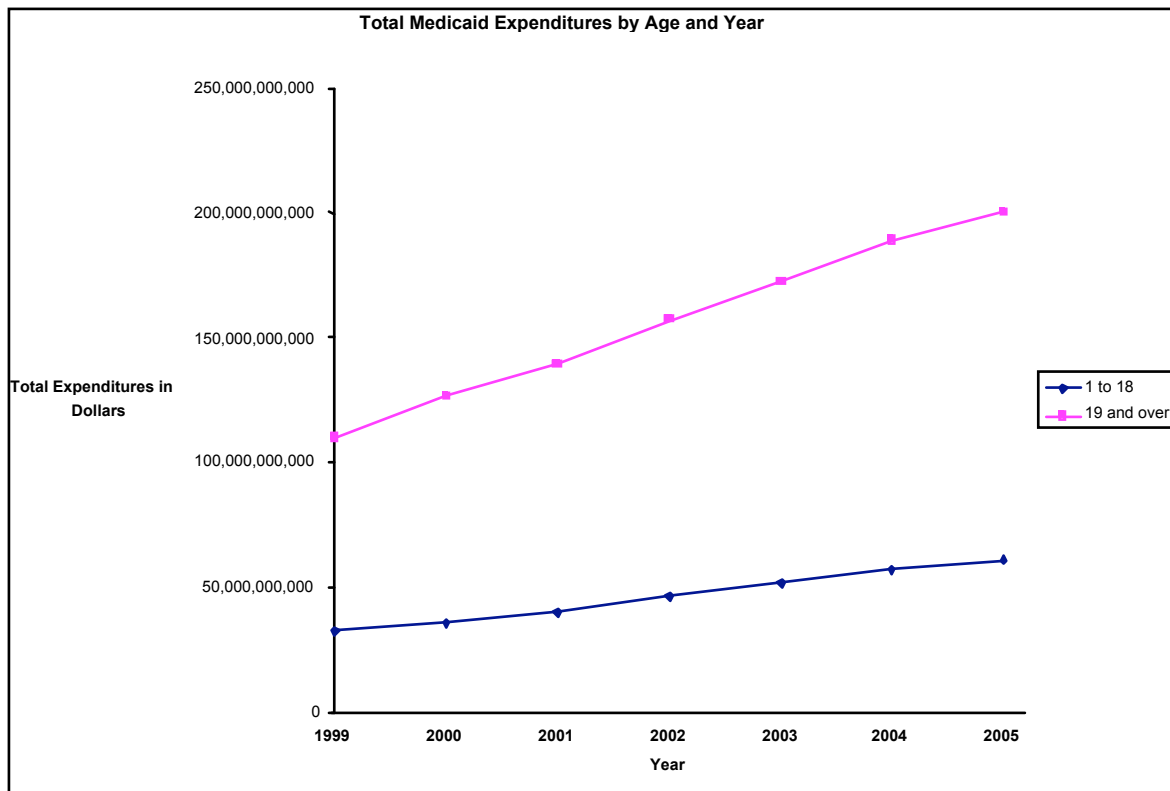
Now, what factors are accentuating and motivating these changes? And, when I show you the projections out to 2018 and to 2030, why do I think those trends are going to continue? It is simple; we are going to have a growing retirement of the baby boom generation. More and more individuals are moving not only into Social Security but also onto Medicare. We also have the political power of our ever-growing senior population: the Gray Panthers, Elders Vote, and AARP. I have no problem with the strength of the voting block, but that is the reality of the situation. Elders vote and children don't. If you have more people in a group, they expect a greater share of the resources. And the other factor, again, which accentuates these trends, is the fact that not only do we have a growing number of elders, but they also have a higher cost per person with regard to either social spending or health spending.

So now let's turn to Medicaid. Many people think of Medicaid as a program for children. And in fact, there are many children who are enrolled in Medicaid. But, Medicaid is complex and you have to be very careful when looking at the different issues that surround it. For example, let's look at the total number and proportions of Medicaid enrollees. Around 51 percent of all Medicaid enrollees nationwide are between the ages of 1 and 18. However, when we look at Medicaid expenditures, we find a very different story. Only 22 percent of Medicaid expenditures are going to children 1–18 years of age, while 73 percent of Medicaid expenditures go to people over 18 years of age.

When we look at that in actual dollar terms nationwide for FY04, the resource allocation was about \$57 billion for those 18 years and under, \$121 billion for those 19–64, and almost \$68 billion for those greater than 65 years of age. In fact, there are more dollars spent for our seniors than for our children in the Medicaid program. Those are the expenditures.

Where is the growth happening in the Medicaid program? Over the two decades of 1978–98, there was an average annual 2.8 percent increase in Medicaid expenditures for children, and a 3.7 percent increase for adult blind and disabled beneficiaries. But the highest growth in the Medicaid budget was actually long-term care for seniors, almost 5 percent on an annual basis. This is almost twice the rate of increase for children. So then when we look at total Medicaid expenditures, by age and by year, from 1999 to the year 2005, we see another interesting pattern. See Figure 5. This pattern parallels the same graph I showed previously regarding the changes in age demographics. There is a faster rate of growth and expenditures for adults and the elderly. Many of you in the audience may be thinking, “So what? So what if more and more of the Medicaid resources are going to the adult population? Or to seniors? Why does that matter? What is the issue that we need to address?”

Figure 5
Total Medicaid Expenditures by Age and Year



Well, Medicaid is not, even though it is an entitlement, a limitless pool. And increasingly, as you read about in the newspapers—whether it be in our state of Michigan, or another state—states have budget problems. And one of the first places states look to cut their budgets is within Medicaid. Although the costs are increasing for all the eligibility categories, as I showed you a moment ago, the expenditures are not increasing evenly. In fact, expenditures for seniors are increasing at almost twice the rate they are for children, and—here is the common theme—the demographic changes will create increasing budget pressures.

So what happens? Well, states have to try to control their costs, and so they try to control their costs with a variety of different mechanisms. Specifically, with Medicaid, there are most often changes in eligibility requirements and changes in benefit packages and payments. And finally, there are changes in the provider reimbursement, which affects access to care.

Across the United States, most commonly, these changes in eligibility and reimbursement focus on children's services. So we see that even though the greatest rates of increase are not happening for kids, that is where states look to cut their Medicaid expenditures. There is a disconnect between where the expenditures are rising and where states look to make those cuts. States also put a proportion of their budget toward immunization programs for children. When state budgets get really tight, that is also a place where cuts are made. And we see nationwide that over ten states have decreased their access to childhood immunizations for all children, and over half of the states have decreased access for immunizations to at least a certain segment of the pediatric population. This includes not providing access for new vaccines, and also not providing vaccines for children ineligible for Vaccines for Children, a program run by the federal government. It covers some kids who are poor and don't have access to care, but not all children. Many states have now cut back on providing immunizations for those children because of budget pressures.

So states have also responded to these fiscal pressures in other ways: ten states charge Medicaid premiums to families with incomes as low as 101 percent of the federal poverty level; thirty-four states have imposed premiums, or enrollment fees, on child health coverage. Again, these are the states' responses to a growing Medicaid cost, but the growing cost is not in the pediatric age range. Further, twenty-one states have now implemented co-payments for prescription drugs for children in state insurance programs. More specifically, child health insurance, provided through either Medicaid or through the state health insurance programs, has dramatically undergone increases in costs to families. For those at 101 percent of the federal poverty level, the cost per month to families is now ranging between \$8 to \$40. For those families who are at 200 percent of the federal poverty level, costs are now ranging from \$10 to \$250 per month for state-supported health insurance for indigent children. Again, these changes have significant impacts on the pediatric population, but this is not where the greatest increase in growth and costs on states is occurring. Further cutbacks on children have resulted in ten states limiting or reducing their provision of vaccines to the uninsured population: seven states for new vaccines and three states for all vaccines.

Now, one thing that has happened for the benefit of children, in the late 1990s, was the State Child Health Insurance Program, or SCHIP, that many of you have heard about. However, because of budget problems, many states have attempted to have these resources not only go to children but also actually help cover some of the adult health care costs within their state. Four states cover childless adults with money from the Child Health Insurance Program, eleven states cover parents, eleven states cover pregnant women, and overall nationwide, 10 percent of all covered lives in the State Child Health Insurance Program are adults. And as many of you know, the expansion of the SCHIP was vetoed by President Bush earlier this year.

What about private sector insurance? What's going on with that? Private sector insurance covers employees, and it covers their dependents. This is the main source of private insurance for children. There is an increasing focus in our society toward disease management, most of that being for adults. And that makes sense, because the primary purpose of employer-based insurance is to keep workers healthy. There is an increasing emphasis on investment to try to develop programs to keep workers healthy. Again, not a bad thing. It is just where the money goes. However, certainly even before the recent economic problems, there has been an erosion of employee/employer offerings in terms of both the breadth of coverage provided to the employees and also the breadth of coverage provided to dependents.

There has also been a disconnect of the prevention of adult diseases in childhood. In fact, if we actually make an effort to prevent some diseases in childhood, we will have much healthier adults. But that is not necessarily, or even often, the way we structure private insurance in this country. In fact, we are much more likely to have private insurance that covers secondary prevention for adults rather than primary prevention for children.

So, how much does this private insurance actually cost? And what is the proportion that the employee pays for different kinds of coverage? Well, overall, the employee share, that means the worker share of employee coverage, is about

16 percent. However, employees pay a much greater proportion of dependent coverage: 28 percent of the coverage for dependents is paid for by the employee. Interestingly, for those in low-wage jobs nationwide, again we have around 16 percent of the employee cost borne by the employee him- or herself, but 34 percent of the cost of dependent coverage is borne by the employee. Where do children get their private insurance? As dependent-covered lives. As the costs or the proportion of costs for dependent coverage rises, more and more families will be priced out of being able to afford that dependent coverage. This impacts the ability of children to access private insurance.

What about investment in research? Well, public investment in research provided by the NIH, the CDC, the Health Resources and Services Administration, and other federal agencies is responsive to political pressure. This is true for prostate cancer or breast cancer or any other disease that affects particular populations or specific age groups. It is no secret that the National Institute on Aging is funded at a fairly significant level with regard to research in this country. I am not saying that is bad, but as the elder segment of the population grows, there will be even greater political pressure to increase funding on research to be able to provide new therapies and treatments for our aging population.

At the same time, there is a lot of private investment in research in this country, both in pharmaceuticals and in medical devices. But those of you who are invested in the private sector know very well that private funding follows growth. And the real growth in our economy is among elders. So, increasingly, private capital is going into drugs and devices that assist elders. Again, I am not saying this is bad. It all makes sense. The question is what happens to the children in society as capital in the private sector flows more and more to seniors where the growth opportunities are for return on that investment.

So how does society value health care? How do we value it, and how do we decide what we are willing to pay for it? I am going to suggest that there are actually three mechanisms we use. One is how much does it cost for an additional year of life? This becomes an issue of how we think about philosophical issues and societal priorities. How do we value one person's next year of life versus another person's next year of life? And what is the impact of the influence of society? In a rich society, do we value health care more if we value another year of life more than we might in a poor society? Or do we value another year of life more now than we did thirty years ago, because society overall in this country is more affluent?

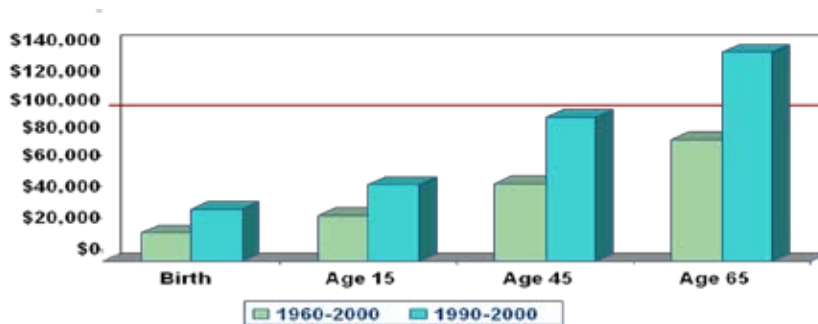
I want to now share with you a study that we have conducted where we try to look at what an additional year of life might cost us, right now, in this country. We looked at the marginal effect on health care relative to the marginal spending per year of life extended for the forty years from 1960 to the year 2000. We looked at life tables to see how much longer people are living now than they did forty years ago, and we just arbitrarily—and I say arbitrarily because we could pick whatever number we wanted—we assumed that around 50 percent of the improvement in lifespan was due to medical spending. You could pick 30 percent or 70 percent—we just picked 50 percent because the explanation would be the same no matter what percentage we took.

Take a look at Table 4. From life expectancy tables, at birth in the year 1960 you would expect to live 69.9 years. If you were born in the year 2000, you would expect to live 75 years. If you're 65 in the year 1960, you would expect to live another 15 years; and if you're 65 in the year 2000, you would expect to live another 18 years. Then we calculated the cost per each additional year of life that could be attributed to medical advances. See Figure 6. And we see that each additional year of life will cost a little less than \$20,000 if we took that whole period from 1960 to 2000, up to almost \$40,000 for each additional year of life from the decade of 1990 to 2000. If you're over 65, though, it costs a lot more for each additional year of life because you have many fewer of them.

Table 4
Remaining Life Expectancy

Age	1960	1970	1980	1990	2000
Birth	69.9	70.9	73.7	74.4	75.4
15	58.3	58.9	61.1	61.5	62.3
45	29.5	30.0	31.9	32.5	33.2
65	15.4	15.9	17.4	17.9	18.2

Figure 6
Cost per Additional Year of Life Attributable to Medical Advance



So then sometimes we try to value another year of life, or health, by societal preferences. We know that society has different preferences based on the age of the individual that we ask about. So this is just an example; I am not going to ask you to make this choice. Suppose a choice must be made between two medical programs. The programs cost the same, but there is only enough money for one. Program A will save 100 lives from diseases that kill 20 year olds; Program B will save 200 lives from diseases that kill 60 year olds. Increasingly we will be faced with some of these kinds of issues, especially when we are deciding to give or not give vaccines versus spending on other programs.

We know from our research of these societal priorities that actually the public, including the elderly, assign a higher priority to health gains for youth. The reason for that is that people value their longer life expectancy; they have the potential for greater productivity. There is also a fairness and equity argument. Children have not had a chance to live long enough. We need to make sure that they, just as the adults have done, have a chance to live a long and productive life. We also know that the societal value of health has increased over time, meaning that we value health more today than people did in the 1950s and in the 1940s. Our society places a higher monetary value, not just in terms of what we are willing to expend, but also in the perspectives of a previous generation. This is important for children because they are the ones who have the most to gain. And finally, in studies of societal priorities, there is increased value for longer life years, not a discount for future life years. This is important because traditionally many people who do these types of studies treat life like money. When we discount for the future, we discount future life years often at 2 percent or 3 percent, like we do the value of money. But in fact, life years, when looking at societal priority studies, are not discounted at 2 percent or 3 percent. If we continuously discount more and more years of

life saved—meaning 40, 50, or 70 years of life saved—we discount them to almost nothing. So the more years of life saved, the less they are worth in our traditional way of looking at things. I would posit that this actually stacks the deck against kids. In my opinion, it does not mean that the years from 70 to 80 for an infant are any less important than those for a senior living from 70 to 80 years of age. However, our current method of discounting does just that.

So how can we modify cost-effectiveness analyses to reflect more accurately both society's evaluation of health improvement by age, as well as the reality of interventions we now have? And how does this modification affect results and conclusions of recently conducted cost-effectiveness analyses of vaccines that target young people? When we do not believe that saving each of the 70 years of an infant's life is valuable, then the intervention itself loses a significant part of its value when you conduct economic analyses.

So how can we modify this? Well, I posit that future health gains should be weighted more accurately toward society's increased willingness to pay for health. As opposed to discounting those future years, we must actually increase the value of life over time because we know that society has increased its value of life and health over the last generation.

We should also think about including net resource use in the cost side of the equation, meaning that children have a whole era of productivity ahead of them. They are not simply going to be consumers and use up resources. They will also, throughout their lives, give resources to society. Finally, younger life years should actually receive priority if for nothing else than equity and fairness reasons. Some have written about this as the "fair innings" argument; the young have not had their share of life to live yet, so it is actually those younger years that should be valued even more than those older years.

Now we do have some significant challenges ahead for our nation. We have the demographic challenges of which I spoke and their impact on budgetary constraints. This results in competing interests between different segments of our society.

I do not think it is bad that we have competing interests. We just need to make conscious decisions about how we are going to deal with those. So I would like to suggest three potential directions. One is to make transparent our societal priorities. If, in fact, we have decisions to make, we should lay all our cards on the table. No matter how we as a society decide where and how we are going to invest our resources, right now many of the patterns of spending that I showed you are happening without discussion. It happens because that is the way these programs were put in place a generation ago. However, fundamentally, our population is different than it was a generation ago. It is time that we start to decide if we still want to keep our current patterns of resource allocation. If that is what we as a society decide, then that is what we decide. But let's make conscious decisions.

I also believe we need to level the entire economic evaluation playing field. Right now, because of the manner in which we are discounting the value of future years, the process is not fair. We need to try to figure out a way that works for all of us to level that playing field.

Because of the way cuts are made in Medicaid right now, I believe we need reform. With societal priorities, we need to decide specifically whether we want proportional spending. There are definitely reasons why proportional spending may be a good idea. We will have a greater number of people that are going to require long-term care. But we also have to understand that there is a downside to this pattern of expenditures. We must make sure we do not diminish the priority of the segment of society—children—who actually are not decreasing in absolute numbers, only decreasing in proportion. We need to make sure that we are sensitive to the needs of seniors, but we also need to make sure that we are sensitive to the needs of children. These are difficult decisions, but I believe they must be decided in a context of public debate.

With regard to leveling the economic playing field, we need fair methods of evaluation; we have to cease devaluing long-term benefits. Importantly, we spend a lot of time talking about our future but we need to make sure we account for the future needs of our society. We hear a lot about mortgaging the future of our children, and all of these are very blasé kinds of statements. However, in fact, when it comes to health—it is really going on right now.

And what about Medicaid? Right now the Medicaid beneficiaries are at odds with each other in vying for payment in the Medicaid structure. Medicaid covers care for children, the blind and disabled, and the elderly. I will suggest that instead of seeing increases in one aspect of Medicaid, and making cuts in another aspect of Medicaid, that we conceptually, or in reality, divide Medicaid into three separate programs: one that covers elders, one that covers the blind and disabled, and one that covers children. Then, we can link funding with expenditures. If there is a cost overrun in one aspect of Medicaid funding, then maybe that is where we need to think about making those cuts. In reality, these are three separate populations that are being cared for through this program, but the money has all been jumbled together. We also need to reevaluate the state-by-state variability for each of these eligibility criteria—the children, the blind and disabled, and the seniors. It does not make good public health sense that a child or an elder is eligible for certain benefits in one state but not in another.

We do have some big challenges ahead of us: demography, budget constraints, and competing interests. We will struggle, if we allow ourselves to, over the coming decade to figure this out. I think there is valor in this struggle. I think the struggle is important. We cannot dodge difficult decisions, and we cannot dodge the debate we need to have to determine how best to provide for all aspects of our citizenry.

We can no longer afford to be ignorant about these issues. And we need to begin to take the risk of having real discussions. We have a lot of decisions to make and they are going to be hard, but I think that we as a society need to be transparent regarding how we determine the manner in which our society moves forward. We need to take care of all the vulnerable segments of our society. And I hope that we can now, at least at this university, if not in this state and this nation, begin that debate.

Bibliography

Freed, G. L., & Fant, K. (2004). The impact of the “aging of America” on children. *Health Affairs*, 23, 168-74.



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