Potential Medicare Coverage

Medicare represents the Federal Government's major financial and policy commitment to health care. In 1986, Medicare represented 58 cents of each Federal dollar spent on health care and was the source of payment for 29 percent of all expenditures for hospital care and 21 percent of expenditures for physician services (73). The use and correlates of use of preventive services for the elderly have several important implications for the Medicare program.

First, covering preventive services under the Medicare program **would probably bring about increases in the percentage of elderly receiving preventive care. However, current evidence suggests that reducing out-of-pocket expenses for patients is not sufficient to assure compliance with published preventive recommendations.** OTA's analysis of five preventive services suggested the presence of insurance beyond Medicare is associated with about a 10-percent increase in the percentage of elderly receiving each service during the period of time examined. With the exception of blood pressure measurement, which almost all elderly already receive on a routine basis, substantial portions of the elderly with additional coverage that defrays out-of-pocket expenses do not use each of the preventive services OTA examined. In addition, because the additional insurance coverage held by Medicare recipients in most instances excludes preventive services, the OTA analysis is not a direct test of the impact of coverage of specific procedures on the rates of use of these services.

Other factors enter into the physician's decision about whether to offer or provide the service and the patient's decision about whether to seek or use it. Some of these factors may be amenable to change through public policy, while other characteristics describe groups of elderly patients at relatively high or low risk of not receiving adequate preventive care.

Second, coverage of preventive services for Medicare beneficiaries could affect preventive use beyond the Medicare population itself. Medicare payment may raise interest in preventive care among health care providers and payers by placing the authority of the Federal Government behind it. In addition, consumers of health care may put more weight on preventive services in managing their own health because of the public discussion and attention focused on Medicare coverage. None of the data or literature currently available allows OTA to estimate the existence or magnitude of this potential indirect effect. A recent analysis of preventive services in Canada where such procedures are paid for by the government revealed rates of use comparable to those in the United States, suggesting that both the direct and indirect effects of government coverage may be small (76). The Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) may offer an opportunity to assess the full impact of Medicare coverage of breast cancer screening for the elderly by "analyzing trends if the use of this service is monitored.

Third, expansion of Medicare to cover preventive procedures will represent an immediate boost in the program's financial obligations even if increases in use are minimal or nonexistent. Although gaps exist between experts' recommendations and current levels of use, substantial numbers of elderly still receive a variety of preventive services at recommended frequencies. OTA's analysis indicated that at least one-half of the noninstitutionalized elderly receives each of the five services examined on a regular basis. For three of these services (glaucoma screening, eye examinations, and blood pressure measurement), rates of use were even higher. Estimates of costs attributable to expanded Medicare coverage of preventive services must take account of the program's obligation to pay for procedures whose costs are currently borne by other payers. However, some portion of these services are for patients with a related medical history or symptoms and are

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"diagnostic" and already reimbursable under Medicare. It is also probable that some physicians may categorize some examinations and screening services as "diagnostic" so that the procedure will be covered by Medicare. No existing data from published literature or the records of the Health Care Financing Administration (HCFA), the Federal agency that administers Medicare, indicate what portion of all procedures reimbursed by Medicare are actually for screening purposes.

Fourth, the conclusions of this paper about the use of medical **services such as screening and immunizations may have limited applicability for policymakers considering Medicare coverage of other preventive services such as health risk appraisals, education, counseling services, or tertiary prevention of disability among elderly suffering from chronic disease.** Many of the services listed in table 1 could rely on non-physician personnel to a greater degree than do screening and immunization, and patients could receive them in a wider array of settings than they receive most medical services. These characteristics suggest that use of preventive services not examined in this paper may be markedly different from those explored here. Hence, an understanding of the implications of Medicare coverage of services other than screening and immunizations use would require additional study.

Delivery of Preventive Services for the Elderly

Although one of the major focuses of this paper is the potential impact of insurance coverage on the use of preventive services by the elderly, the data and literature reviewed in this paper suggest that other factors are strongly related to use. This information would be useful to public policy makers who seek strategies for altering the elderly's use of preventive services. Of the patient and provider characteristics related to use, a few are immutable, some are amenable to change through policy, and others are theoretically amenable to change, although the policy interventions to accomplish these changes are unlikely to prove cost-effective.

Public policy cannot affect age, gender, rural versus urban residence, and usually, days spent in bed during the previous year, three factors correlated with the use of preventive services. However, these demographic and health status characteristics do identify segments of the population particularly at risk of not receiving adequate screening or immunizations. Knowing that on average more women than men receive such care or that recommended prevention appears to decline with age and good health may help policy makers target some of their preventive care efforts toward the more vulnerable groups. Because Medicare is an entitlement program available to all persons over 65 who receive Social Security, it is an unlikely means of focusing efforts on demographically defined subsets of the elderly population. Nevertheless, other government investments in prevention such as mass media campaigns and screening fairs may be able to narrow their target. Policy makers who want to bolster use among elderly groups unlikely to receive preventive services may wish to study the potential costs and effectiveness of such programs in detail.

Other factors related to the elderly's use of preventive care do seem amenable to policy interventions. Studies that examine influences on physician behavior suggest that better or more frequent physician education may bring about better compliance with preventive recommendations. In addition, evidence suggests that record-keeping systems and reminders to physicians (possibly aided by computer technology) have positive effects on use. This paper has discussed the potential for insurance coverage to increase somewhat the percentage of elderly receiving prevention. Government and providers could design policies to bring about these changes where they do not already exist.

The relationship between use and provider characteristics is not clear. For exam-

pie, conflicting published literature and the small number of elderly enrolled in HMOs makes it difficult to determine if the enrollment of older adults in prepaid health plans increases the amount of preventive care they receive. Additional research is also needed to establish the potential of nurses and other non-physician health professionals in providing or promoting the appropriate use of preventive services. Previous research suggests the substantial contact they have with patients in an ambulatory care setting, the availability of new screening technologies (e.g., instruments that can measure cholesterol in a physician's office from a finger prick), and the growth in "health fairs" that provide some preventive services in alternative settings may enhance the role of these professionals.

The remaining variables affecting older individuals' use of screening and immunizations - -educational level and family income --are also potentially susceptible to government interventions. However, public policies designed to change these characteristics are so much more broadly construed that they would never be implemented simply to affect the use of preventive care. If, however, the government decides for some other reason to promote education or supplement income among the elderly, long-term increases in the use of preventive procedures may be an additional benefit.