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Will the United States Ever Have Universal Health Care?

The profession of social work has long been linked with efforts for health care reform. At the dawn of the 20th century, Jane Addams, Lillian Wald, and others advocated reforms to prevent the spread of communicable diseases in urban areas and raised concern about high rates of infant mortality. During the 1930s Frances Perkins, a settlement house worker, became secretary of labor and advocated compulsory universal health insurance. Social workers also played central roles in the enactment of Medicare and Medicaid, and during the 1990s, NASW developed its own legislative proposal for national health care, which Senator Daniel Inouye (D-HI) introduced in 1992 (Moniz & Gorin, 2003). The 1999 Delegate Assembly enacted a policy statement committing NASW to a "national health policy that ensures the right to universal access to a continuum of health and mental health care" (NASW, 2003, p. 172).

The failure of efforts to reform the health care system during the 1990s led to a period of disillusionment about the nation's ability to expand coverage to the uninsured population (Gorin, 1997). In recent years, however, interest in this issue has resurfaced. Since 2001, the Institute of Medicine has released a series of in-depth studies on the problem of health care coverage in the United States (http://www.iom.edu/project.asp?id=4660). The National Coalition on Health Care (NCHC), which consists of large businesses, labor unions, religious organizations, health care providers, and others representing "at least 150 million Americans," has advocated fundamental reforms aimed at instituting universal coverage (NCHC, 2004, p. 2). Other groups, such as the Universal Health Care Action Network and Physicians for a National Health Program have accelerated their efforts for reform and universal coverage.

Despite this, serious problems remain with our health care system, particularly in terms of access and coverage. Tens of millions of individuals lack health care coverage for an entire year, and millions more have only partial or inadequate coverage. Despite efforts by the Clinton administration to enact policies for universal health care, the United States remains the only industrialized nation that does not provide universal access to health care. Problems with the health care system have only grown worse during the Bush administration. This National Health Line column examines the current status of health care coverage, considers proposals for expanding coverage, and concludes with a discussion of implications for social workers.

Health Care Coverage in the United States

The precise number of individuals without health care coverage is open to debate (Congressional Budget Office [CBO], 2003). The figures most often cited come from the U.S. Census Bureau's Current Population Survey (CPS), which every March asks individuals about their insurance status during the preceding year (CBO). By this measure, in 2003 (the most recent year for which we have figures), 45 million individuals went without health insurance for the entire year (U.S. Census Bureau, 2004). However, some analysts believe that these figures exaggerate the scope of the problem (Institute of Medicine, 2001). Although the CPS ostensibly captures information about individuals who were without coverage for an entire year, data from other surveys suggests that it really measures the number of people who lack coverage at the time of the survey (CBO). According to CBO estimates, in 1998 between 21 and 31 million people were without coverage for the entire year,

CCC Code: 0360-7283/04 $3.00

whereas between 39 million and 42.6 million were without it at a particular point in time; between 56.8 million and 59 million individuals were without coverage at some time during the year. By the CPS measure 43.9 million people were without coverage in 1998, and 45 million were without it in 2003, so we can conclude that the CBO estimates for 1998 are roughly comparable to 2003. In any event, however one measures it, "the number of uninsured Americans is substantial" and increasing (Institute of Medicine, 2001, p. 3).

Because most people obtain health care coverage through their jobs, the size of the uninsured population is closely linked with developments in the job market. Between 1998 and 2000, in the midst of strong economic growth, the number of people without health care coverage (as measured by the CPS) fell by 2.1 million (Holahan & Wang, 2004). As the economy slowed and unemployment increased, the uninsured population grew. In 2002 alone, the uninsured population increased by 2.4 million, "the largest single increase in more than a decade" (Holahan & Wang). The "primary" cause of the growth in the uninsured population between 2000 and 2002 was a decline in employment-based coverage (Holahan & Wang).

According to Strunk and Reschovsky (2004), between 2001 and 2003, the "proportion" of the under-65 population insured by employers dropped "dramatically," from 67 percent to 63 percent, a decline of almost 9 million people "after accounting for population growth." The fall in employer-based coverage was particularly acute among individuals between ages 18 and 39, people in families with incomes below 200 percent of the poverty level, and Latinos (Strunk & Reschovsky). This drop was partially offset by increases in the number of children under age 18 and young adults enrolled in Medicaid and the State Children's Health Insurance Program (SCHIP).

The shift in health insurance coverage from the private to the public sector during this two-year period helps illustrate the government's growing burden in health care costs and the unresolved social and political problems of our health care system. Conservatives argue that the government's burden is too large and needs to be restrained. Liberals and progressives see the growing burden as an argument for greater efficiencies through universal coverage. George W. Bush and John Kerry have developed proposals for addressing the uninsured problem. Whoever is elected president in November, the ideas expressed in these two plans reflect the likely positions the two parties will take during the next few years.

Addressing the Problem

Senator Kerry has proposed raising the maximum income allowable for eligibility for Medicaid or SCHIP to 300 percent of the poverty level for children and 200 percent of the poverty level for families ("John Kerry's Plan," 2004). Single adults and couples without children would also be eligible for Medicaid. This would provide coverage for families who now earn too much to receive public support, yet earn too little to purchase private insurance.

Kerry would also expand private sector coverage by opening up the Federal Employees Health Benefits Program (FEHBP) to companies with 50 or fewer workers, workers ages 55 to 64, and uninsured individuals between jobs. Employers would be required to pay at least half the cost of health premiums, and in return, would receive a refundable 25 percent tax credit, as well as a tax credit for all contributions in excess of 50 percent. Unemployed workers between jobs could purchase insurance through their former employers or the FEHBP pool and receive a 75 percent subsidy (for a maximum of six months). Older workers ages 55 to 64 unable to obtain employer-sponsored insurance could do so through the FEHBP pool with a 25 percent refundable tax credit. Perhaps most important, Kerry would provide individuals without coverage "assistance with costs above six percent of their income" ("John Kerry's Plan," 2004). According to Thorpe (2004), Kerry's plan would reduce the uninsured population by about 27 million, "make insurance more affordable for tens of millions more, and result in a national coverage rate of approximately 95 percent of all Americans when fully implemented." Over a 10-year period, Kerry's proposal would cost $653 billion, or $65.3 billion a year (Thorpe).

President Bush has also addressed the issue of health care coverage, although in a much narrower way than Senator Kerry. The president proposed a refundable tax credit to enable low-income workers without employer-based or public insurance to purchase coverage (Bush–Cheney, 2004). According to an analysis for the

Kaiser Family Foundation (2004), an individual would be eligible for a maximum $1,000 credit and a family of four (with annual income of $25,000), for $3,000. The president would also allow individuals who purchase insurance plans with high deductibles (a minimum of $1,000 per individual or $2,000 per family) "to deduct 100% of the premium ... from their taxes" (Bush–Cheney). In addition, the Bush plan supports the creation of association health plans that would allow small businesses to purchase insurance through large insurance pools that could help reduce administrative and other costs.

According to the Kaiser analysis, the president's tax credit proposal would increase the insured population by about 1.8 million; interestingly, the tax credit combined with the premium deduction would reduce this figure to 1.3 million (Kaiser Family Foundation, 2004). It also notes that the tax credit proposal could induce some employers to stop covering their workers. In an analysis for the American Academy of Family Physicians (2004), Thorpe estimates that over 10 years the president's plan would cost around $90 billion and provide coverage to between 2.1 and 2.4 million individuals.

Implications for Social Workers

As noted earlier, social workers have long advocated universal health care coverage. Although some observers have minimized the importance of universal coverage, recent studies for the Institute of Medicine (2001, 2003a, 2003b) have shown that lack of health insurance can have a real and adverse impact not only on the amount and quality of care an individual receives, but also on longevity and quality of life. As Reinhardt (2003) noted, "People in poor health and lacking health insurance cannot be said to have equal opportunities in a market economy" (p. 378). NASW's support for universal coverage reflects our profession's core commitments to social justice and respect for the dignity and worth of individuals (http://www.socialworkers.org/pubs/code/code.asp).

Yet, as history shows, achieving universal coverage is not an easy task. To begin with, it is expensive. Hadley and Holahan (2003) have estimated that individuals without coverage "would use $33.9-$68.7 billion (in 2001 dollars) in additional medical care if they were fully insured" (p. 250). Reinhardt (2003) argued that these figures underestimate the cost of universal coverage, which he believes would require "an additional government outlay" of $1.3 to $1.6 trillion over 10 years.

Although these figures are daunting, they pale in relation to the approximately $130 trillion in GDP expected to be "generated" during the same period (Reinhardt, 2003). Moreover, the "benefits," in terms of "improved health, increased longevity, and potentially greater national income," of covering the uninsured population likely outweigh the costs (Hadley & Holahan, 2003, p. 263). According to estimates by the Institute of Medicine (2003a), the annual cost of no insurance, in terms of "diminished health and shorter life spans," as well as "losses to productivity," amounts to $65 to $130 billion "for each year of health forgone" (p. 4). High rates of "uninsurance" also can affect a "community's health care institutions and providers" and result in reduced "access to clinic-based primary care, specialty services, and hospital-based care, particularly emergency medical services and trauma care" (Institute of Medicine, 2003b, p. 14). Bear in mind, too, that in 2000 the nation enjoyed a large budget surplus, which could have been used toward universal coverage; instead, the Bush administration and Congress chose to enact a "massive tax cut" (Reinhardt, 2003).

In the final analysis, however, it is not economics, but politics, and particularly opposition from conservatives, that appears to be the primary obstacle to universal coverage (Oberlander, 2003; Reinhardt, 2003). During the battle over President Clinton's Health Security Act (HSA), conservatives, worried that the HSA's enactment would refurbish the Democrats' image as defender of the middle class, spent a fortune to distort the intent and scope of the legislation. Conservative Republicans were particularly successful in intimidating moderates who initially seemed open to the HSA (Moniz & Gorin, 2003). Members of Congress "heard constantly ... from anti-reform groups, but almost never from advocates of reform" (Altman, 1995, p. 25).

This history is not surprising given that individuals with lower incomes, who have much more "to gain from ... universal coverage," are less likely to vote than individuals with higher incomes (Reinhardt, 2003, p. 387). Studies also show that the views of individuals with higher incomes carry much more weight with politicians than the views of those with lower incomes

(Bartels, 2003a). In recent years opposition to universal coverage has largely emanated from Republicans, who have increasingly come to represent the interests of wealthy people (Bartels, 2003b).

Opposition from conservatives, both Republicans and Democrats, has not been the only problem, however. Another important obstacle to President Clinton's effort was opposition from some progressives, who insisted on a Canadian-style, single-payer system as the sole path to universal coverage (Moniz & Gorin, 2003). With the resurgence of conservatives under George W. Bush, many progressives have recognized the importance of uniting with moderates to seek alternative, perhaps more politically feasible, paths to universal coverage (Frisof, 2003; Oberlander, 2003). The coalescence of many progressives behind the candidacy of first Howard Dean, and now John Kerry, also suggests a new pragmatism on the issue of universal health care.

What, then, is the future of universal coverage? Oberlander (2003) suggested that without change in the "political environment," incremental reforms offer the best, and perhaps "only," way of changing our health care system. Yet, he noted that, despite the "good" they may accomplish, incremental reforms, such has SCHIP and HIPAA, have only minimally reduced the "rate of uninsurance" (Oberlander). He concluded that the failure of these reforms to "control costs or assure universal coverage" may ultimately lead to demands for more fundamental change (Oberlander, p. 403).

Reinhardt (2003) was less optimistic about the possibility of universal coverage, but his conclusions are not very different from Oberlander's. Despite the powerful forces opposing reform, he noted, "every so often the stars do align ... to make breakthroughs in public policy possible" (he points to SCHIP and Medicare as examples) (Reinhardt, p. 388). He acknowledged that "hard-won incremental" reforms have often seemed little more than "small steps on a downward-rolling escalator" (Reinardt, p. 389). However, in words that social workers can take to heart, he argued that "the fight on behalf of the uninsured" is well worth waging, for without these reforms, "the less fortunate of society ... would be much worse off" (Reinhardt, p. 389). He concluded by urging advocates to continue to develop "analyses" and gather facts in preparation for the day when politicians will again take seriously the problems of our health care system. HSW

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